QI Weekly

Transitional Care Billing

Patients who are transitioning out of the hospital or other post-acute setting are contacted by the case manager, and a TCM (or TOC) note is started. However, not every patient needs Transitional Care Management services.

It is the provider's responsibility to determine, when the patient comes in for their appointment, if TCM is necessary, or if the visit just needs to be a standard hospital follow-up. Since the case manager doesn't know if it will qualify for a TCM at the time of the phone call, the provider will need to make that determination at the time of the visit.

- We realize this is a change from prior workflows, so further TCM billing education will continue to be shared with providers via QI meetings and QI Weeklies in 2021

2021 Evaluation and Management (E/M) Services Guidelines:

- TCM coding will require that the patient have an ongoing medical condition requiring management of the transition from the facility to the home, and moderate- to high-complexity medical decision-making will be required from the provider.

  Example: A patient who had a serious fall at home and was discharged from the hospital with orders for home health and DME will need additional services and monitoring that will require coordinated care. This hospital follow-up would be appropriate for TCM billing.

Defining Medical Decision-Making:

- **Minimal** – minimal or no complex data to review / minimal risk of complications and/or morbidity or mortality / and the decision-making is straightforward.
- **Moderate** – multiple diagnoses or management options / complexity of data to be reviewed is moderate / risk of complications or morbidity and mortality is moderate / decision-making is moderate.
- **High** – extensive diagnoses / high risk of complications, and morbidity and mortality