PAClinicalNetwork
AT THE PENNSYLVANIA MEDICAL SOCIETY

Transition Care Management
(procedural process not HEDIS measure)

Transition Care Management (TCM) includes services provided to a patient with medical and/or psychosocial problems. TCM service involve a transition of care from one of the following hospital settings:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care hospital
- Skilled nursing facility
- Inpatient rehabilitation facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a community mental health center

Evidence suggests that patients who see a doctor within 7-14 days of being discharged are significantly less likely to end up back in the hospital. This time frame may be more aggressive (shorter) with certain conditions and with different value-based contracts.

TIPS

The billable codes (not all inclusive) for the types of service include:

- 99495
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of at least moderate complexity during the service period
  - Face-to-face visit within 14 calendar days of discharge or sooner as noted above
- 99496
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision making of at least moderate complexity during the service period
  - Face-to-face visit within 14 calendar days of discharge or sooner at noted above

Source:
www.aafp.org
www.cms.org

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