Sentara

Protocol:	Transitional Care Management		
Manual:	Sentara Ambulatory Services Division	**Original Date:**	4/1/2025
Section:	Administrative	**Revision Date:**	Click here to enter a date.
Location(s):	SMG (including Telehealth), SMJMG, SRMG, SDHMA	**Approved By:**	Quality and Safety Committee & Clinical Effectiveness & Standards Group
		Process Owner:	SMG Director of APP Development, Primary Care

Revision Description (Most Recent): Click here to enter Most Recent Revision.

Purpose:
Outline established protocol for transitional care management (TCM) across multidisciplinary teams, with the **goals to reduce potentially avoidable hospital readmissions and meet or exceed quality performance targets.**

Transitional care management applies only to hospital discharges and **not emergency department encounters.**

Payment for TCM assumes the billing provider will deliver ongoing care for the discharge condition for at least 30 days.

Definitions:

TCM – Transitional Care Management
"Hospital discharge follow-up"
Includes the array of services and resources available to patients to ensure continuity during the transitional period between hospital discharge and return to the home setting.

Responsible Roles:

TICM – Transitions Integrated Care Manager
*Responsible for 2-day outreach, chronic care management for higher risk patients (hospital score ≥ 5)
CCS RN – Central Clinical Services Registered Nurse
*Responsible for 2-day outreach, chronic care management for lower risk patients (hospital score < 5)
Physician – Primary **or** specialty care MD or DO
*Billing provider
APP – Primary **or** specialty care PA or NP
*Billing provider

Procedure:

- ***Monitoring: required update/review yearly***

Required Action Steps	Performed By	Supplemental Guidance
1. Identification of appropriate patients for TCM	TICM, CCS RN, Clinical Staff, Physician, APP	▪ **Inclusion Criteria:** ○ Non-elective medical / high-risk surgical discharges (i.e., CHF, COPD, sepsis, acute appendicitis, SBO) ○ Discharged from a Sentara hospital ○ Observation / short stay ○ Medicare > Medicaid > commercial insured ▪ **Exclusion Criteria:** ○ Surgical discharges part of global period ○ ED visit ○ SNF discharge *(although this is qualifiable for TCM billing if required components are met, it is not measured in the performance metric)*

Required Action Steps	Performed By	Supplemental Guidance
		▪ Physicians and APPs may identify eligible TCM patients at the time of visit if it has not been previously captured by other teams
2. Patient Outreach for TCM	TICM, CCS RN, Clinical Staff	▪ **Outreach must be performed within 2 business days of hospital discharge** ▪ Daily Epic report used by RN teams to identify discharged patients for outreach ▪ If HOSPITAL score ≥ 5 → TICM team ▪ If HOSPITAL score 4 → CCS RN ▪ If HOSPITAL score < 4 → Per capacity, CCS RN ▪ A **second outreach attempt must be attempted** if initial is unsuccessful ▪ **If non-nursing clinical staff completes outreach, their note must be cosigned & attested to by physician or APP** ▪ *Telephonic outreach is not required if provider completes visit within 2 business days of discharge*
3. Timing of TCM Appt	TICM, CCS RN, Clinical Staff	▪ If hospital score ≥ 5 or CHF, COPD, sepsis, or pneumonia discharge, strong consideration for 7 calendar day follow-up ▪ Others reasonable to schedule within 14 calendar days ▪ ***If PCP office unable to facilitate visit within 7-14 days, consider referral to Senior Health Services (Hampton Roads) for Medicare pts***
4. TCM Encounter Documentation Requirements	Physician, APP, clinical staff (PVP)	▪ 2-day outreach validation ▪ Medication reconciliation ▪ Communication amongst care team ▪ Services arranged post-discharge ▪ Discharge to location ▪ **SmartPhrase: .TCMAMB** (all required billing components included)

Required Action Steps	Performed By	Supplemental Guidance
5. Clinical Management Components	Physician, APP	▪ **Diagnostic test review & follow-up** ○ Review tests performed in the hospital (i.e., labs, imaging, cardiac testing, etc.) ○ Are there any tests not yet resulted? ○ Did abnormal results improve by discharge? ○ Are there any tests needing follow up? (i.e., 1 week BMP, 3-month CT chest) ▪ **Medication reconciliation** ○ What medications were started? ○ What medications were stopped? ○ What medication dosages were changed? ○ Is patient consistent with med changes? ○ Is the patient tolerating medication Changes? ○ Does the patient need long-term refills? ▪ **Discharge orders – Examples:** ○ Specialty referrals ▪ Were they scheduled / completed? ○ Home Health ▪ Has contact been made? ▪ Does this need to be ordered? • *You have 30 days post-discharge to order Home Health with appropriate F2F documentation* ○ PT/OT ▪ Outpatient or home health ○ Chronic Care Management ▪ If 2+ chronic conditions ○ DME ▪ Ambulatory assist device, respiratory equipment ○ Remote patient monitoring (RPM) ○ BP cuff ▪ BP management ○ CGM / glucometer & supplies ▪ Glycemic control ▪ Advanced Care Planning ▪ Evaluation for Palliative Care

Required Action Steps	Performed By	Supplemental Guidance
6. ICD10 Coding	Physician, APP	▪ Use ICD10 Z.09 "Hospital Discharge Follow-up" as **primary diagnosis** ○ Note: numerous verbiages exist in Epic for Z.09 ▪ List all acute and acute on chronic conditions managed throughout the hospitalization that are being addressed during the TCM encounter ○ Opportunity for **HCC coding optimization** ○ *Stable chronic conditions non-contributory to the hospitalization are not relevant to include* ▪ Remove ICD10s from **Problem List** that are resolved or no longer applicable ○ Resolve acute conditions (i.e., MI, CVA, sepsis) – convert to "history of" ○ Resolve symptom diagnoses (unless chronic and relevant) ○ Remove duplicative diagnoses ○ Convert acute or exacerbated conditions to chronic form, if applicable (i.e., CHF, COPD, chronic respiratory failure)
7. Billing	Physician, APP	**99496** – within 7 days AND high complexity MDM **99495** – within 14 days OR moderate complexity MDM *Enter in LOS under Wrap Up **2-day outreach MUST be completed to use these LOS codes** *2 unsuccessful attempts satisfy this requirement -Only 1 provider can bill TCM code per hospitalization *(coding / billing team will change second submission to E/M)* -TCM codes CAN be billed concurrently with AWVs and CCM initiation; however, they cannot be combined with G2211 code
8. Reporting of Medication Reconciliation Post-Discharge (MRPD)	TICM, CCS RN, Clinical Pharmacist, Physician, APP	**1111F** – within 30 calendar days of discharge *Entered in **Order Entry** *(this is **not** a reimbursable code)* *TICM/CCS RNs will also attempt to perform this during outreach calls within the first 30 days. ***Surgical discharges typically do not receive RN outreach.* It is not necessary to report 1111F if billing a 99496 or 99495.

Required Action Steps	Performed By	Supplemental Guidance
9. TCM 30-day period	TICM, CCS RN	ALL TCM Discharges: • Outreach and engage patients within 2 business days of discharge • Complete a medication reconciliation (1111F) • Schedule or confirm the hospital follow-up appt ***within*** *7 days for hospital scores of ≥ 5* or within 14 days for hospital scores < 5 • Assist the patient with any resource needs • Educate the patient and family on their discharge plan of care If Hospital Score >/= 5: • **TICMs** complete weekly outreach to the patient and family for **30 days** ○ After 30 days: hand-off patient for continued care management for patients who need continuation of care If Hospital Score < 5: • After initial outreach call: **CCS RNs** hand-off patient for continued care management for patients who need continuation of care

Related Documents:

Policy	Transitional Care Management
Procedure	
Job Aids	Hospital Score in Epic TCM Provider Overview PPT TCM SharePoint Site
Regulatory References	CMS - TCM Services - 2024