McLAREN MEDICAL GROUP

TRANSITIONAL CARE MANAGEMENT SERVICES

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McLAREN MEDICAL GROUP

- McLaren Medical Group (MMG) employs healthcare providers throughout the areas that are served by McLaren Health Care's hospitals. MMG participates in quality programs to enhance the health care delivery system by optimizing value and improving patient outcomes. To assist in providing quality health care services, one of the programs MMG's Population Health Department operates is the Transitional Care Management Program (aka Transition of Care, TOC).

Know the difference:

- McLaren Physician Partners (MPP) is a liaison between the McLaren Healthcare System, health plans, employers, physicians, and patients. MPP promotes quality incentive programs. You can contact MPP at (248) 484-4928 for further information regarding their programs.

TRANSITIONAL CARE MANAGEMENT SERVICES

- Transitional Care Management (TCM), also known as Transition of Care (TOC), provides services that help promote a safe and timely transition of a patient from one care setting to another.
- Health care professionals that furnish TCM services include Physicians (any specialty), Certified Nurse-Midwives, Clinical Nurse Specialist, Nurse Practitioners, and Physician Assistants.
- The health provider takes responsibility to coordinate care for 30 days post discharge and prevents gaps while a patient is transitioning from a health care facility-based setting to a community setting.
- Benefits of TCM include improved quality of care, positive patient experiences, reduction in readmissions, and controlling costs over the continuum of care.

ELIGIBILITY

- A patient must be discharged from an inpatient hospital setting.

  Inpatient settings include:
  - Inpatient Acute Care Hospital
  - Inpatient Psychiatric Hospital
  - Skilled Nursing Facility
  - Inpatient Rehab Facility
  - Hospital Outpatient Observation
- A patient must be returning to their community

  Community settings include:
  - Home
  - Assisted living
- A patient must require moderate or high complexity medical decision making.
- Only one Transitional Care Management Service is allowed in 30 days. A TCM period begins on the date of discharge and continues for the next 29 days.
- An Interactive Contact (direct contact, telephone, or electronic) with the patient or caregiver must occur within 2- business days of discharge. Weekends and federal holidays do not count as business days.

NOTIFICATION

- The TOC team must be aware of a real-time discharge to perform outreach within 2 business days after discharge. There are several ways that the TOC team can be notified of a real-time discharge.
  1. The TOC teams are notified of a real-time discharge from Great Lakes Health Connect (GLHC) discharge feed. GLHC is a Health information exchange in Michigan. GLHC depends on the patient identifying their PCP in the hospital and that the feed has appropriately been directed to the GLHC portal.
  2. The TOC teams are notified of a real-time discharge from McLaren Physicians Partners discharge notifications called PINGS.

3. When office staff are notified within 24 hours of discharge and do not locate a documented TOC outreach, they may use the TOC notification form to request a TOC phone outreach to be completed.

SCHEDULING

- TOC Team scheduling
  - The TOC team will schedule appointments in the EMR using available time slots.
  - If the patient is willing to have an appointment scheduled, and no appointment is available within 14 calendar days, the TOC team will contact the office to schedule the appointment.
  - If the patient requests to schedule their appointment themselves, they will be encouraged to contact the provider's office.
- Office scheduling
  - To qualify as a TOC, the appointment must be scheduled with the provider within 14 calendar days after discharge. It is McLaren's best practice to have the Transitional Care (Hospital Follow-up) appointment within 7-days of discharge.
  - Charts should be reviewed for TCM/ TOC visits within the last 30 days, as only one TOC code can be billed in a 30-day period.
  - A hospital discharge summary should be obtained and available for the face to face visit with the provider.

2-BUSINESS DAY POST DISCHARGE INTERACTIVE CONTACT

- An interactive contact MUST be made with the patient or caregiver within 2-business days following discharge, but not on the day of discharge. Interactive contact can be via telephone or face to face.
- The TOC team will call the patient and document the call during the 2-day post-discharge period. If the calls are unsuccessful and the TOC team has documented two attempts, the TCM may still occur.
- The TOC will be documented under a task in Allscripts and under documentation in Cerner. If an office is using paper charts, a copy of the TOC outreach note will be faxed.
- On the day of the TOC phone outreach, TOC staff services may include:
  - Communication with the patient or family regarding aspects of care.
  - Communication with home health agencies and other community services used by the patient.
  - Education for patient and family to support self-management, independent living, and ADL's.
  - Assessment and support for treatment regimen adherence and medication management.
  - Identification of available community and health resources.
  - Facilitate access to care needed by the patient and family.

1-2 BUSINESS DAYS FACE-TO-FACE VISIT

- If a patient is seen in the office within 2-business days following a discharge, a TCM visit CAN BE performed without a TOC phone call. The face to face office visit will be considered the interactive contact if the following is performed:
- A Staff member should obtain the hospital discharge summary.
- A Staff member is to confirm TOC eligibility (see page 2).
- An appointment should be booked as Transition of Care.
- The Staff and the Physician should follow documentation guidelines (see page 4).

TOC NOTIFICATION FORM

Date: _____

Patient Name: _____

Patient Date of Birth: _____

Admission Date: _____

Discharge Date: _____

Hospital: _____

Diagnosis: _____

Provider: _____

Scheduled Appointment: _____

Form Completed By: _____

Contact Information: _____

_____

_____

Please send the completed form to:

TOCNorthTeam@Mclaren.org, Allscripts task- TOC North task, or Fax (810)- 600- 7994 for clinics located in the:
Bay Region Central Region Lansing Region Northern Region Thumb Region West Branch Region

TOCSouthTeam@Mclaren.org, Allscripts task- TOC South task, or Fax (810) 600- 7925 for clinics located in the:
Flint Region Lapeer Region Macomb Region Oakland Region Port Huron Region

Medication Review

16. Are there any new medications prescribed at discharge? ❑ Yes ❑ No
    List: _____
17. Are there any changes to medications the patient was taking prior to this inpatient stay? ❑ Yes ❑ No
    List: _____
18. Did the patient get their new medication prescriptions filled? ❑ Yes ❑ No
19. Is the patient taking all their prescribed medications? ❑ Yes ❑ No
20. Were all questions regarding medications answered? ❑ Yes ❑ No

Barriers

21. Does the patient have transportation to the TOC office visit?
    ❑ Yes ❑ No _____
22. Are there any barriers that would prevent the patient from showing up to the TOC office visit?
    ❑ Yes ❑ No _____
23. Are there any financial barriers to seeking care?
    ❑ Yes ❑ No _____
24. Are there any safety concerns?
    ❑ Yes ❑ No _____
25. Are there any language barriers?
    ❑ Yes ❑ No _____
26. Are there any cultural barriers?
    ❑ Yes ❑ No _____
27. Other noted barriers: _____

Follow-Up

Primary Care provider: _____ Scheduled TOC appointment: _____
Specialist:_____ Scheduled follow-up appointment:_____
Specialist:_____ Scheduled follow-up appointment:_____
Physical Therapy Agency:_____ Contact number: _____
Home Care Agency: _____ Contact number: _____

28. Has the patient recently been hospitalized? ❑ Yes/Date_____ ❑ No
29. Was the patient informed to contact the PCP with concerns or if signs and symptoms worsen? ❑ Yes ❑ No

Plan of Care

_____

_____

Inpatient Summary

_____

_____

Notes to PCP

_____

_____

Name of caller and credentials: _____

7-14 CALENDAR DAYS FACE-TO-FACE VISIT

- An interactive outreach (phone call) must have occurred 2-business days post discharge.
- The patient must be seen by the provider within 7-14 calendar days post discharge.
  - 99496 - High complexity of care requires the patient to be seen no later than 7 calendar days post discharge.
  - 99495 - Moderate complexity of care requires the patient to be seen no later than 14 calendar days post discharge.
- Medication reconciliation must occur no later than the office visit.
- The discharge summary is to be reviewed.
- Staff and Physician should follow documentation guidelines.

DOCUMENTATION

When a Provider Performs the Face to Face component of Transition Care Management, documentation should include:

Discharge date

Type of admission visit:

Acute inpatient, Observation, Rehabilitation, Skilled Nursing Facility, Inpatient Psychiatric

Diagnosis at discharge

A summary of the reason for admission.

Discharge summary statement to include:

- A discharge summary has been reviewed.
- A discharge summary is not available to be reviewed.
- A discharge summary is not necessary to be reviewed because
  - Example - Provider was the Provider in the hospital/facility).

Medication reconciliation

Performed by the provider no later than the face to face visit with a statement to include:

- Medications reviewed - no changes indicated
- Medications reviewed - the following changes were made:
  - Example - completed a course of antibiotics.
  - Example - Added or discontinued a medication.

Additional non-face to face items if deemed indicated and provided should include:

- Reviewed the need for or follow-up on pending diagnostic test.
- Interaction with other health care professionals who will assume or re-assume care of the patient's system-specific problems.
- Education provided to the patient, family, guardian, and/or caregiver.
- Establish or re-establish referrals and arrange for needed community resources.
- Assisted in scheduling required follow-up with community providers and services.

CODING

Medical Decision Making

High medical decision complexity

- Face to Face visit within 7 calendar days of discharge.
- CPT code- 99496.
- An extensive number of possible diagnosis and/or management options.
- An extensive amount and/or complexity of data to be reviewed.
- High risk of significant complications, morbidity, and/or mortality.

Moderate medical decision complexity

- Face to Face visit within 14 calendar days of discharge.
- CPT code- 99495.
- A multiple numbers of possible diagnosis and/or management options.
- A moderate amount and/or complexity of data to be reviewed.
- A moderate risk of significant complications, morbidity, and/or mortality.

BILLING

- TOC codes should be billed as soon as the face to face visit occurs.
- Only one TOC code can be billed in a 30-day period.
- If several providers bill a TOC in the same 30-day period, the first one received by insurance will get paid, and any others will be rejected and need to be rebilled as an E/M code.
- The face-to-face visit must not occur on the same day of discharge.
- Eligibility and documentation requirements must be fulfilled.
- Billing is performed at the clinic level.

CONTACT INFORMATION

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MMG TRANSITION OF CARE PHONE QUESTIONNAIRE

Patient Name:_____ Date of Birth: _____ PCP:_____

Admission Date:_____ Discharge Date:_____ Hospital or SNF Facility Name: _____

1. Type of Visit:
   a. Inpatient Acute Care Hospital
   b. Inpatient Psychiatric Hospital
   c. Skilled Nursing Facility
   d. Inpatient Rehabilitation
   e. Hospital Outpatient Observation

Reason for Visit:_____

_____

New diagnosis of a Chronic Disease: ❑ Yes ❑ No

Communication

1. Was the patient/caregiver contacted within 2 business days of discharge? ❑ Yes ❑ No
2. If Yes:
   a. TOC Date: TOC TIME: TOC Duration: minutes
   Who participated in TOC questionnaire? ❑ Patient ❑ Caregiver
3. If No:
   a. Two attempts were made to contact patient within 2 business days
   ❑ Yes 1st attempt: **date**:_____ **time**: _____
   2nd attempt: **date**: _____ **time**: _____
4. Billing code:
   ❑ **GC001** under 5 minutes ❑ **98966** 5-10 minutes ❑ **98967** 11-20 minutes ❑ **98968** 21-30 minutes

Functional Status

5. Can the patient/caregiver verbalize the reason for the hospitalization? ❑ Yes ❑ No
6. Is the patient/caregiver able to understand discharge instructions? ❑ Yes No
7. Are there any recent changes in functional status? ❑ Yes ❑ No
8. What level is the patient's ADLs? ❑ independent ❑ needs assistance ❑ dependent
9. Is the patient following the recommended activity level? ❑ Yes ❑ No
10. Does the patient use medical equipment? ❑ Yes ❑ No
    a. ❑ Walker ❑ Cane ❑ Wheelchair_____
11. Was any medical equipment ordered at discharge? ❑ Yes ❑ No
    a. If Yes, does the patient have the medical equipment? ❑ Yes ❑ No
    b. Name of DME: _____

Nutritional Status

12. Patient is eating a_____ diet.
    a. Is patient following the recommended discharge diet: ❑ Yes ❑ No
13. Was patient given an oral nutritional shake such as Ensure or Glucerna while in the hospital? ❑ Yes ❑ No
14. Has the patient been able to eat the amount of food they normally eat? ❑ Yes ❑ No
    If No, what is the reason: ❑ Poor appetite ❑ Difficulty eating ❑ Fatigue
15. Was a referral sent to a health care navigator? ❑ Yes ❑ No