2023 Transitions of Care Network Performance Improvement Presentation Series

Effectiveness of Care HEDIS® measure

Updated July 2023

The Transitions of Care, or TRC, Network Performance Improvement presentation is intended to educate providers on the TRC HEDIS measure, assist in identifying potential barriers and suggest opportunities to improve processes when completing this measure.

If you have questions related to this presentation, contact Christina Caldwell (ccaldwell@bcbsm.com)

Overview

What is it? Why does it need to be done?

Transitions of Care, or TRC, is a HEDIS measure and 2023 Star measure that must be completed for Medicare Advantage members age 18 or older with an eligible inpatient discharge between Jan. 1 and Dec. 1 of the measurement year.

TRC includes four components, including **Patient Engagement After Inpatient Discharge** and **Medication Reconciliation Post-discharge**. Both PE and MRP are measures in the 2023 Performance Recognition Program.

TRC affects the quality of care that members receive and is important to ensure appropriate coordination of inpatient and outpatient care.

While each component has a specific completion time frame (see next slide for details), all components of TRC must be completed **within 30 days of discharge** from an eligible inpatient stay. An eligible inpatient stay includes admission to an acute or nonacute care inpatient setting. Discharges following a hospital observation or emergency department visit are not included in the TRC measure.

The need for TRC is based on discharges, not members. If a member has more than one eligible discharge, **TRC components must be completed following each eligible discharge.**

TRC components

TRC includes four components, all of which must be met to satisfy HEDIS requirements.

Component	Timeline	Administrative specification Value sets include	Medical record documentation requirements[1] Documented in any outpatient medical record accessible to the primary care provider or ongoing care provider
1. Notification of Inpatient Admission Including documentation of the date of admission and the date the documentation was received.	Day of admission through two days after admission (three days total)	Not applicable	Any of the following meet criteria: • Communication about admission between primary care provider/ongoing care provider and inpatient provider, emergency department or health plan (fax, email, phone call) • Communication about admission to the patient's primary care provider/ongoing care provider via a health information exchange (HIE) or admission, discharge and transfer (ADT) notification • Communication about admission with the patient's primary care provider/ongoing care provider through a shared electronic medical record, or EMR • Indication that the primary care provider/ongoing care provider admitted the patient or was aware of the admission • Indication that the primary care provider/ongoing care provider placed orders during inpatient stay • Preadmission exam or planned admission documentation (not limited to three-day time frame if documentation clearly indicates the exam is related to the admission)
2. Receipt of Discharge Information Including documentation of the date of discharge and the date the documentation was received.	Day of discharge through two days after discharge (three days total)	Not applicable	At a minimum, the discharge information must include **all** of the following: • Practitioner responsible for the patient's care during the inpatient stay • Procedures or treatment provided • Diagnoses at discharge • Current medication list • Test results, documentation of pending tests or statement that no tests are pending • Post-discharge care instructions

[1]HEDIS specifications should be reviewed for exact requirements of medical record documentation for each component.

TRC components, continued

Component	Timeline	Administrative specification Value sets include	Medical record documentation requirements[1] Documented in any outpatient medical record accessible to the primary care provider or ongoing care provider
3. Patient Engagement After Inpatient Discharge	Within 30 days of discharge (does not include day of discharge)	• Outpatient visit • Telephone visit • Transitional care management, or TCM, services • Online assessment	Any of the following meet criteria: • Outpatient visit (office/home) • Telephone visit • Telehealth visit (real-time audio and video interaction) • E-visit/Virtual check-in (two-way interaction that was not real-time)
4. Medication Reconciliation Post-discharge Conducted or cosigned by a prescribing provider, clinical pharmacist, registered nurse or physician assistant. Medication reconciliation doesn't require a visit.	Date of discharge through 30 days after discharge (31 days total)	• Medication reconciliation encounter • Medication reconciliation intervention	Must include evidence of medication reconciliation and date completed. Examples of documentation include: • Current medication list with notation of reconciliation of current and discharge medications • Current medication list with reference to discharge medications (for example, same meds at discharge) or discharge medication list review • Current medication list and discharge medication list with evidence both lists were reviewed on the same date of service • Documentation of current medications with evidence that the member was seen for post-discharge follow-up care with evidence of medication reconciliation or review • Discharge summary medication list that was filed or received in the outpatient record within 30 days with documentation of reconciliation • Notation of no medications prescribed or ordered upon discharge

[1]HEDIS specifications should be reviewed for exact requirements of medical record documentation for each component.

How to satisfy the PE and MRP components with claims

Blue Cross Blue Shield Blue Care Network of Michigan

Component	Submitted on a claim in the appropriate time frame		
	Transitional Care Management or care planning service CPT® code[1]	**CPT II code *1111F and eligible visit from PE value set[2]**	**CPT II code *1111F without an eligible visit from the PE value set**
Patient Engagement, or PE	✓	✓	
Medication Reconciliation Post-discharge, or MRP	✓	✓	✓

[1] TCM codes refer to CPT codes *99495 and *99496; care planning service code refers to CPT code *99483.
[2] HEDIS specifications should be reviewed for the list of visit value sets that are eligible to satisfy the PE component.

Note: Even if procedure codes are submitted to close the gap for PE and MRP, the components must be appropriately documented in the outpatient medical record. Review HEDIS specifications for exact documentation requirements for each component.

FAQs: Medication reconciliation component of TRC

Why does medication reconciliation need to occur after every discharge?

Performing medication reconciliation after every discharge ensures that patients understand any new medications they may have been prescribed and that they're aware of any previously prescribed medications that may have been discontinued.

Who can conduct medication reconciliation post-discharge?

Medication reconciliation must be conducted by a prescribing provider, clinical pharmacist, registered nurse or physician assistant.

Medication reconciliations can also be completed by a medical assistant, certified nursing assistant or licensed practical nurse. When this happens, a prescribing provider, clinical pharmacist, registered nurse or physician assistant must sign off on the documentation.

Comparing CPT Transitional Care Management codes and CPT II code *1111F

This table highlights differences between TCM codes and CPT code *1111F. The table continues on the next slide.

	TCM codes (*99495 and *99496)	CPT code *1111F
Component(s)	Includes three components: 1. Interactive contact 2. Certain non-face-to-face services 3. Face-to-face (in-person/telehealth) visit (including completion of medication reconciliation no later than the day of the face-to-face visit)	Medication reconciliation post-discharge
Patient visit required	Yes; an office/telehealth visit is required	No; an office/telehealth visit isn't required, but it is encouraged
Telehealth eligible	Yes	Yes
Reimbursement	Reimbursable by Blue Cross or BCN and Original Medicare	Reimbursable by Blue Cross or BCN, but not by Original Medicare
Time frame	• All services must be complete within 30 days of discharge (day of discharge plus 29 days following discharge) • Initial contact within two days of discharge; visit within 7 to 14 days of discharge (based on medical decision-making complexity) • Can be billed as early as the date of the face-to-face visit	• Within 30 days of discharge • Billed for on the date of the medication reconciliation service
Facility restrictions	• Some facilities don't use TCM codes • There are no restrictions for use at rural health clinics or federally qualified health centers	• Some facilities don't use F codes • There are no restrictions for use at RHCs or FQHCs
Barriers to use	Difficult to track timeline of all components	Medicare does not reimburse

Comparing CPT Transitional Care Management codes, or TCM and CPT II code *1111F, continued

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This table is continued from the previous slide.

	TCM codes (*99495 and *99496)	CPT code *1111F
Fee schedule	Medicare Plus Blue℠ and BCN Advantage℠ reimburse in alignment with the CMS fee schedule	Medicare Plus Blue and BCN Advantage reimburse $35
Frequency limitation	Once per TCM service period (day of discharge plus 29 days post-discharge)	Once per discharge
Services furnishable by	Provider type is dependent on the component (see next slide)	Performed or cosigned by a prescribing provider, clinical pharmacist, registered nurse or physician assistant
Minimum medical record documentation requirements	• Date the member was discharged • Date of interactive contact with the member and/or caregiver • Date the face-to-face visit took place • The complexity of the medical decision making (moderate or high)	• Notation that provider was aware of the admission/hospitalization • Hospital discharge date • Date of completion of the medication reconciliation • Name and credentials of the person who completed the medication reconciliation • Current medication list and documentation of reconciliation of current and discharge medication list

Components of CPT Transitional Care Management codes

TCM includes the following three components:

Component	Timeline	Mode of communication	Service can be provided by	Additional information
Interactive contact	Day of discharge through two business days after discharge (three days total)	Telephone, email or face-to-face visit	Provider or clinical staff with capacity to address patient status and any needs beyond scheduling follow-up care	TCM services may still be reported if two or more unsuccessful but timely attempts to contact the patient are completed and documented in the medical record. Attempts to contact the patient should continue until successful.
Certain non-face-to-face services	Day of discharge through 29 days post-discharge (30 days total)	Dependent on service provided	Provider; some services may be furnished by clinical staff under provider direction	Services needed are dependent on the patient's medical need. Clinical staff under physician/nonphysician practitioner direction may provide some non-face-to-face services.
Face-to-face visit (including medication reconciliation)	Within 14 calendar days of discharge for moderate-complexity medical decision making (*99495) Within seven calendar days of discharge for high-complexity medical decision making (*99496)	In-person or telehealth	Provider	Medical decision making (establishing a diagnosis and selecting a management plan) occurs during this visit. **Medication reconciliation must be furnished no later than the date of the face-to-face visit.**

See the Medicare Learning Network booklet Transitional Care Management Services** for additional details.

FAQs: Concurrent billing of CPT TCM codes and CPT II code *1111F

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Can *1111F and a TCM code or care planning service code[1] be submitted for the same patient's discharge?

Yes. Although reimbursement for transitional care management services (*99495 and *99496) and care planning services (*99483) include medication reconciliation, there are no billing or coding restrictions for billing both a TCM code or a care planning service code and *1111F for the same patient's discharge.

Under what circumstance is it appropriate to submit *1111F along with a Transitional Care Management code (*99495 or *99496) or a care planning service code for individuals with a cognitive impairment code (*99483) for the same patient's discharge?

While medication reconciliation was being completed early on following a discharge, many offices were waiting for all components of the TCM codes to be completed to report the completion of medication reconciliation as a component of TCM services. The complexity of tracking TCM code components led to medication reconciliation services being provided but not reported. **Therefore, providers are encouraged to bill *1111F when medication reconciliation is complete, as opposed to waiting for all components of the TCM or care planning services codes to be met.** If a TCM code is submitted on a claim following an *1111F claim being submitted, the claim for TCM services will still be eligible for reimbursement.

Does a claim need to be submitted for both a TCM or care planning service code[1] AND *1111F to complete Medication Reconciliation Post-discharge (MRP) and pay providers for the MRP PRP incentive?

No. Submitting a claim for one TCM or care planning service code[1] **or** for code *1111F is sufficient to close the MRP gap and pay providers for the MRP PRP incentive.

[1]TCM codes refer to CPT codes *99495 and *99496; care planning service code refers to CPT code *99483.

Potential barriers for PE and MRP billing and gap closure

This table outlines questions to consider if PE and MRP services are provided and billed but the gap remains open.

Check for	Questions to consider	Guidelines
Multiple discharges	✓ Does the patient have multiple discharges within the measurement year? ✓ Was PE and MRP complete and billed for all eligible discharges?	• TRC must be completed for **all** eligible discharges • Confirm eligibility of each discharge using revenue codes
Time frame	✓ Was an eligible code for PE and/or MRP billed with a date of service within the appropriate timeframe?	• Codes reporting PE must be submitted on a claim with a service date between the day after discharge and 30 days following discharge. • Codes reporting MRP must be submitted on a claim with a service date between the date of discharge and 30 days following discharge.
Billing Codes	✓ Was an appropriate billing code used? ✓ Did the biller/coder use TCM codes and/or *1111F?	• Codes that satisfy the PE and MRP components can be found in the Patient Engagement and Medication Reconciliation 2023 HEDIS value sets, respectively • Submitting one of the following CPT codes will satisfy both the PE and MRP components: *99483, *99495 or *99496 • CPT II code *1111F satisfies only the MRP component of TRC

MiHIN notifications can improve Transitions of Care

The **Michigan Health Information Network, or MiHIN, Shared Services** is Michigan's health information network that creates the technology and resources that allow for the safe and secure sharing of electronic health information statewide. Many hospitals, physician practices, reference labs, radiology centers and other health care providers in Michigan process clinical information through MiHIN using sub-state Health Information Exchanges.

Providers can use real time **admission, discharge, transfer (ADT) notifications** and **Consolidated Clinical Document Architecture (CCDA)** obtained through MiHIN to coordinate transition of care efforts. Provider organizations can also leverage Health Information Exchange, or HIE, data to help identify missed opportunities for billing medication reconciliation.

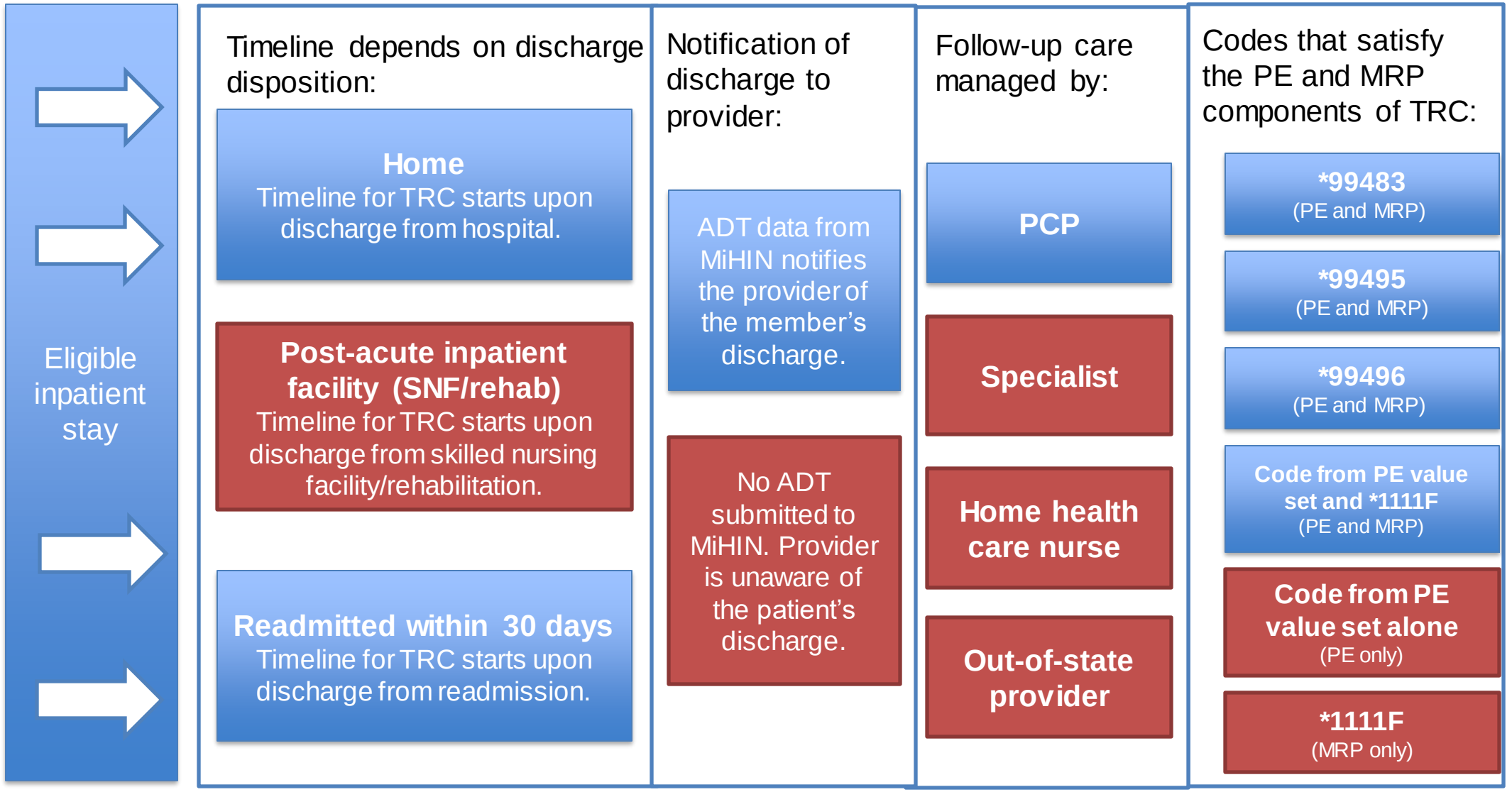
For successful Transitions of Care, we encourage providers to use ADT feeds. For this to be effective:

- Facilities must send admission and discharge information to MiHIN consistently.
- Providers must contact facilities if they aren't receiving information about their patients' admissions/discharges.
- Physician organizations must monitor ADTs at a population level to help develop strategies around best practice education for provider ADT utilization.

Post-discharge process and common barriers to completing both the PE and MRP requirements

Blue Cross Blue Shield Blue Care Network of Michigan

Boxes shaded red indicate potential for breakdown in completing both the PE and MRP process.



*Visit can be in-person or telehealth. See Patient Engagement component on the Transitions of Care Components slide for acceptable visit types.

Potential barriers for completing PE and MRP by provider type

Certain types of providers may encounter barriers to completing TRC requirements, including PE and MRP.

Boxes shaded red indicate potential for breakdown in the TRC process.

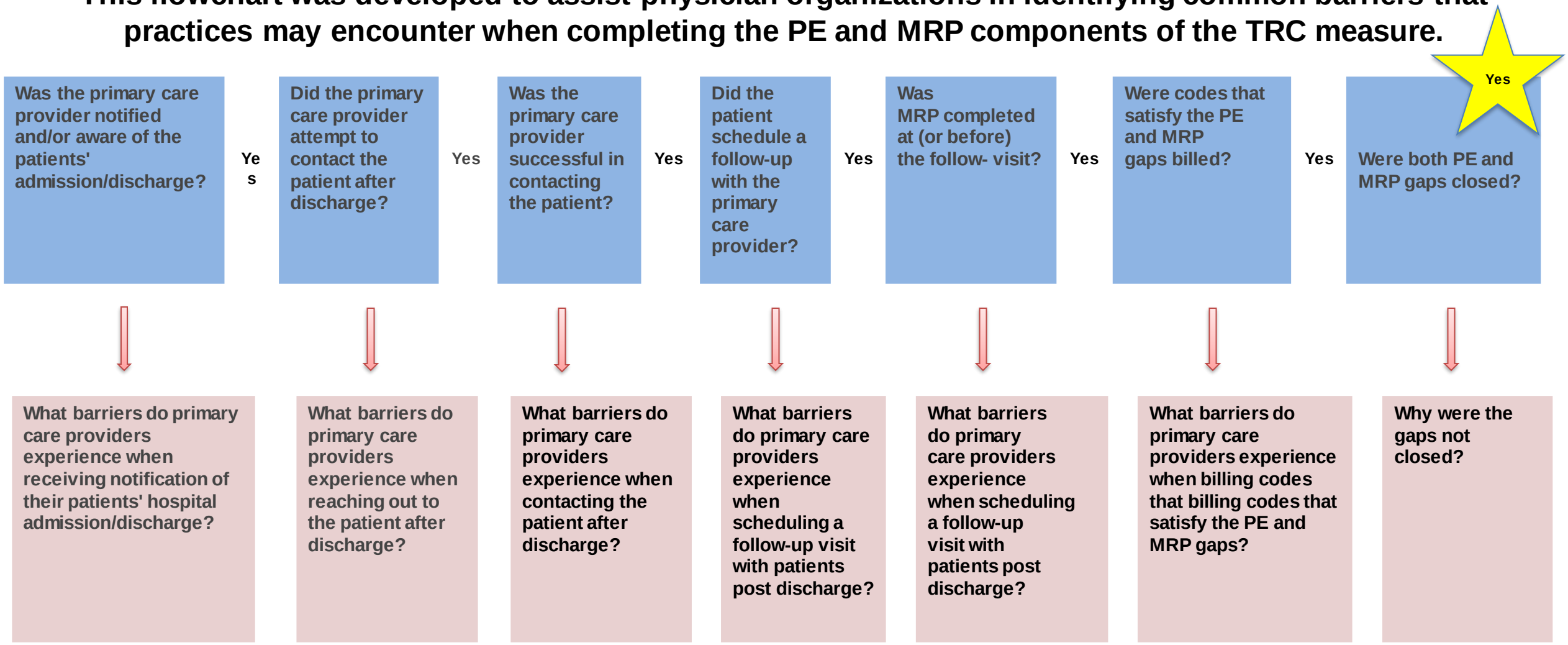
Follow-up care coordinated by	Able to complete PE and MRP[1]	Common practice to bill for PE and MRP	Notification of need for TRC	Incentivized through PRP for completing PE and MRP
PCP	Yes	Yes	ADT	Yes
			No ADT	
Specialist	Yes	Yes	Unaware of need for TRC	No
Home health care nurse	Yes	No	Unaware of need for TRC	No
Out-of-state provider	Yes Out-of-state claims to Blue Cross will still close gap	Yes	Unaware of need for TRC	No

[1] Medication reconciliation must be performed or cosigned by a prescribing provider, clinical pharmacist, registered nurse or physician assistant in any of these outpatient settings.

Identifying barriers to completing PE and MRP using Blue Cross and BCN member-level data report

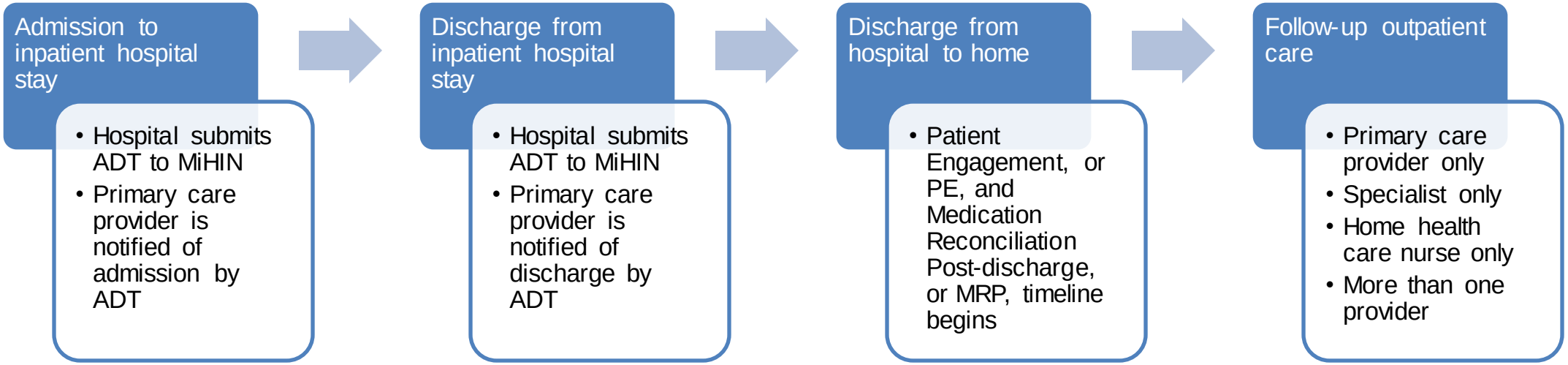
Blue Cross Blue Shield Blue Care Network of Michigan

This flowchart was developed to assist physician organizations in identifying common barriers that practices may encounter when completing the PE and MRP components of the TRC measure.



TRC process for discharge

Determining who is providing outpatient follow-up care can help identify who is responsible for completing TRC.



Questions to consider based on which provider is managing patient's follow-up care

Consider the following questions based on which provider is managing the patient's follow-up care.

No follow-up visit	Follow-up visit with multiple providers	Follow-up visit with primary care provider only
• What proportion of this group is not attributed? • Are these patients being contacted by a provider after discharge? • What barriers are primary care providers experiencing when they try to get patients to come in for visits?	• Is the goal for the primary care provider to complete TRC? • Should the provider who completes TRC be based on the timeline of who sees the patient first (that is, the first provider to meet with the patient post-discharge)? • How can double billing be prevented? • Could this potentially result in friction between providers (that is, the second provider who bills won't get paid)?	• If the patient has a follow-up visit but ADT data isn't submitted, how does the primary care provider know to complete/bill for TRC components? • Is PE/MRP being completed but not being billed? • Is PE/MRP being billed but the gap remains open? (See the Potential barriers for PE and MRP billing and gap closure slide.)

Questions to consider based on which provider is managing patient's follow-up care, continued

Blue Cross Blue Shield Blue Care Network of Michigan

Follow-up visit with specialist only

- Is the goal (1) to have the specialist bill for PE and MRP or (2) to direct the patient to their primary care provider for follow-up?
- How are the specialist and primary care provider communicating about the patient's care?
- Are specialists able/willing to bill for PE and MRP? Or are they willing to bill only for specific codes (*1111F or TCM codes)?
- Are there concerns from primary care providers about specialists completing MRP?
- Does the medication reconciliation need to be in the primary care provider's chart or can it be in a specialist's chart if the specialist is managing outpatient care?
- If medication reconciliation is in the specialist's chart, how does that information make it to the primary care provider's chart?
- How can specialists be educated on TRC?

Follow-up visit with home health care, or HHC, nurse only

- Is the goal (1) to have the HHC nurse bill for MRP or (2) to direct the patient to their primary care provider for follow-up?
- How are the HHC nurse and primary care provider communicating about the patient's care?
- Is the HHC nurse able/willing to bill for MRP or they willing to bill only specific codes (*1111F or TCM codes)?
- Are there concerns from primary care providers about the HHC nurse completing MRP?
- Does the medication reconciliation need to be in the primary care provider's chart or can it be in the HHC nurse's chart if the nurse is managing outpatient care?
- If medication reconciliation is in the HHC nurse's chart, how does that information make it to the primary care provider's chart?
- How can HHC nurses be educated on MRP?

TRC timeline for transfers to non-acute inpatient facilities

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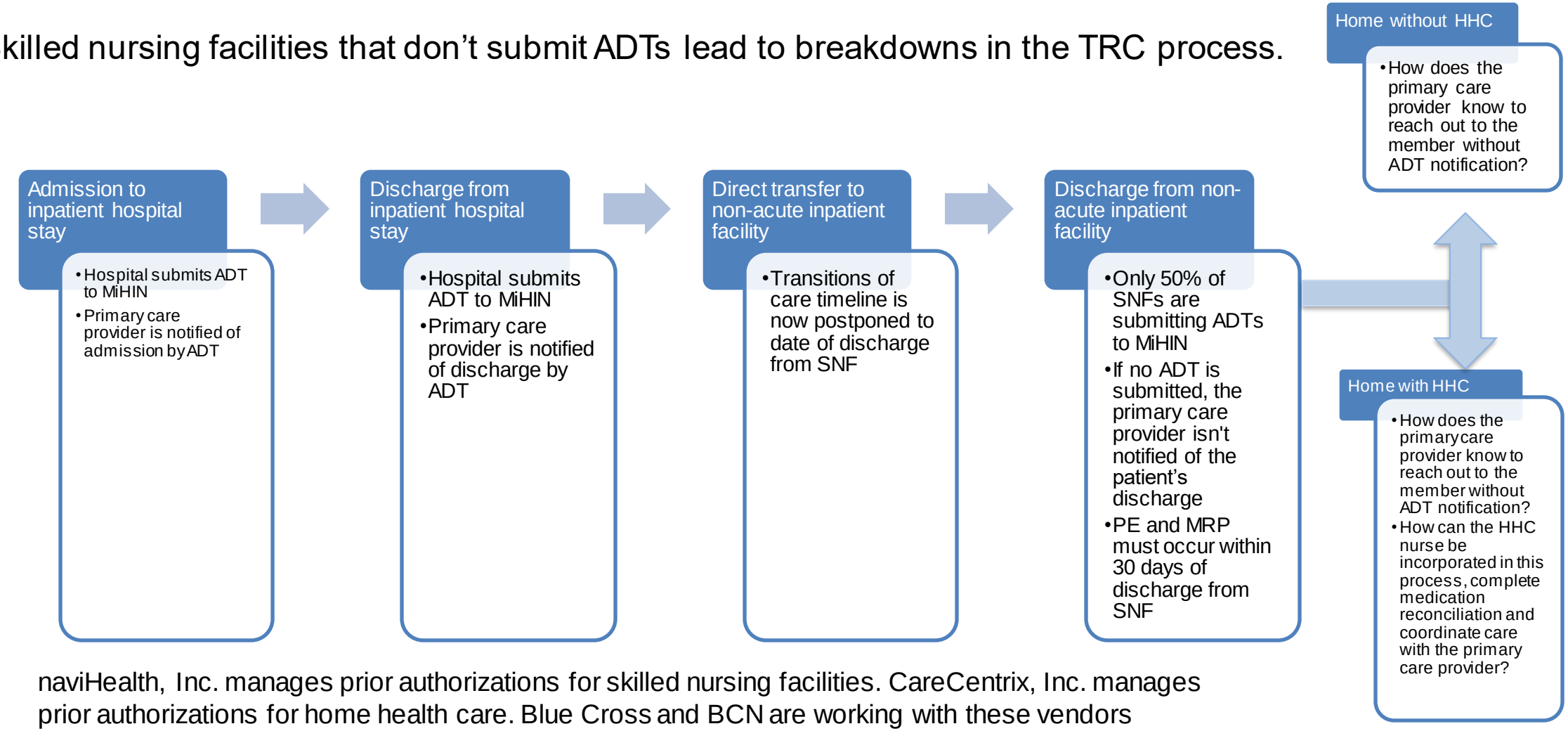
Skilled nursing facilities that don't submit ADTs lead to breakdowns in the TRC process.



naviHealth, Inc. manages prior authorizations for skilled nursing facilities. CareCentrix, Inc. manages prior authorizations for home health care. Blue Cross and BCN are working with these vendors to identify opportunities to improve processes.

Additional resources

CMS resource - Transitional Care Management Services** (*99495 and *99496)

The Record – April 2022 - Billing chart: Blue Cross hights medical benefit changes

Commercial BCBSM fee schedule change for *1111F in the Billing Chart section

Additional resources for the provider network

Blue Cross Blue Shield Blue Care Network of Michigan

Star Tip Sheets / Network Performance Improvement Documents

- availity.com** > Payer Spaces > BCBSM and BCN logo > Resources > Secure Provider Resources (Blue Cross and BCN) > Member Care > Clinical Quality >Tip Sheets >Transitions of Care (TRC) >Medication Reconciliation Post-Discharge (TRC-M)
- PGIP Collaboration Site > Initiatives/Projects/Workgroups > Quality Rewards

2023 Quality Rewards Booklet

- availity.com* > Payer Spaces > BCBSM and BCN logo > Applications > Health e-Blue tile > Health e-Blue home page > Incentive Documents

2023 Quality Measurement Description Booklet

- availity.com* > Payer Spaces > BCBSM and BCN logo > Applications > Health e-Blue tile > Health e-Blue home page > Health Management Program Supporting Documents

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Revision log

Version	Slide Title	Update
July 2023	Slide deck	• Updated year and formatting (created two slides for identifying barriers)
May 2022	TRC components (slide 4)	• Clarified component names (bolding added) '*Patient Engagement **After Inpatient Discharge***' and '*Medication Reconciliation **Post-discharge***' • Medical record review column updated for all components to provide additional details from specifications
	How to satisfy the PE and MRP components with claims (slide 5)	• Changed title from "How to Satisfy the Components of the TRC HEDIS® Measure" • Revised slide to outline how PE and MRP can be completed through claims
	Comparing CPT® Transitional Care Management codes (TCM) and CPT® II code *1111F (slide 7)	• Clarified *1111F component as 'Medication reconciliation ***post-discharge***' • Clarified frequency limitation for TCM codes
	Components of CPT® Transitional Care Management (TCM) codes (slide 8)	• Clarified timeline is 30 days total (day of discharge through 29 days following discharge) for non-face-to-face services
	FAQs: Concurrent billing of CPT® TCM codes* and CPT® II code *1111F (slide 9)	• Clarified in third Q and A that '*MRP incentive*' is the '*MRP **PRP** incentive*'
	Potential barriers for PE and MRP billing and gap closure (slide 10)	• Changed '*TRC **needs to be billed** for ALL eligible discharges*' to '*TRC **must be completed** for ALL eligible discharges*' • Changed '*Was an eligible code for PE and/or MRP billed within the appropriate timeframe?*' to '*Was an eligible code for PE and/or MRP billed **with a date of service within the appropriate timeframe?***' • Clarified time frame guidelines to outline time frame for PE and MRP separately
	Utilizing MiHIN notifications can improve Transitions of Care (slide 11)	• Added fourth bullet point to list of tips

Revision log

Version	Slide Title	Update
May 2022	Post-discharge process and barriers to completing PE & MRP requirements (slide 12)	• Changed "*TRC*" to "*PE & MRP*" in title and description as the flowchart is focusing on those 2 components not the entire TRC measure • Revised '*Codes that satisfy the PE & MRP components of TRC*' column to clarify which gap(s) each code will close. Codes which only satisfy 1 of the 2 components are highlighted in red.
	Potential barriers for completing PE & MRP by provider (slide 13)	• Changed "*TRC*" to "*PE & MRP*" in title and description as the flowchart is focusing on those two components not the entire TRC measure • Changed specialist common to bill PE and MRP from "*No*" (red) to "*Yes*" (blue) as we have found specialists do commonly bill the service codes which can close these gaps
	Identifying barriers to completing PE & MRP using BCBSM member-level data report (slide 14)	• Changed "*TRC*" to "*PE & MRP*" in title and description as the flowchart is focusing on those two components not the entire TRC measure
	Transitions of Care timeline for transfers to non-acute inpatient facility (slide 16)	• Changed title from "*Transitions of Care timeline for post-acute inpatient stay (SNF)*" • Changed third box on timeline from "*Admission to acute inpatient facility (SNF)*" to "*Direct transfer to non-acute inpatient facility*" • Changed fourth box on timeline from "*Discharge from **acute** inpatient facility*" to "*Discharge from **non-acute** inpatient facility"*
	Additional Resources (slide 17)	• NEW slide

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Version	Slide Title	Update
May 2022	Throughout deck	• Added **physician assistant** to list of providers that can complete or cosign medication reconciliation post-discharge based on specification changes
	Transitions of care overview (slide 3)	• Updated measure information on 2022 Star program and PRP • Changed 'A hospital observation or emergency department visit does not require TRC.' to 'Discharges following a hospital observation or emergency department visit are not included in the TRC measure.'
January 2022	Transitions of Care (slide 2)	• Added details for both 2021 and 2022 PRP measures in second paragraph – previously only 2021
	Comparing CPT® Transitional Care Management Codes (TCM) and CPT® II Code *1111F (slide 6)	• Updated 'Fee schedule' row to reflect Medicare lines of business only as TRC is a Medicare-only measure
	FAQs: Concurrent Billing of CPT® TCM Codes* and CPT® II Code *1111F (slide 8)	• Added second bullet Q and A to clarify when billing both codes would be appropriate
	Throughout deck (specifically slides 9, 12, 13, 14, 15, 16)	• Updated slide to reflect PE and MRP measures in the 2022 PRP program and TRC in the 2022 Star program, previously focused on MRP
October 2021	Throughout deck	• Added CPT and HEDIS trademarks where appropriate throughout deck • Expanded MRP and TRC acronyms where appropriate throughout deck
July 2021	Throughout deck	• Removed internal use only footer as this deck is intended to educate our provider network

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Version	Slide Title	Update
June 28, 2021	Transitions of Care (slide 2)	• Added that TRC is an ***anticipated 2022 Stars measure*** • Specified that this measure is specific to the ***Medicare*** member population • Added note to ***see next slide for details*** on the specific component time frames
	Transitions of Care Components (slide 3)	• Added '***date of admission***' to NIA component box and '***date of discharge***' to RDI component box • Changed last column header from ***Medical Record*** to ***Medical Record Documentation Requirements*** • Added footnote that applies to the Medical Record Documentation Requirements column: ***HEDIS® specifications should be reviewed for exact requirements of medical record documentation for each component*** as there are very specific requirements for medical record documentation and does not have the capacity to cover that level of detail • For Medication Reconciliation component, added note that ***Medication reconciliation does not require a visit to complete*** • For NIA component, clarified that the Medical Record Documentation ***'EMR notification'*** must be a ***'Shared EMR notification'*** AND changed ***'Indication of admission by PCP or specialist'*** to ***'Indication of admission by PCP or ongoing care provider'*** • For MRP component, changed the last bullet of the Medical Record Documentation from ***'Notation of no inpatient scripts'*** to ***'Notation of no medications prescribed upon discharge'***
	How to Satisfy the Components of TRC (slide 4)	• Revised visual to clarify how all four components can be met
	FAQs: Medication Reconciliation Component of TRC (slide 5)	• Revised response to ***"Who can conduct medication reconciliation post-discharge?"***

Revision log

Version	Slide Title	Update
June 28, 2021, cont'd	Comparing Transition Care Management Codes and *1111F (slide 6)	• Fee schedule for *1111F changed from '***BCN amount is dependent on contracted fee schedule**' to ***'BCN does not reimburse for *1111F'*** • Clarified the time frame within 30 days of discharge for TCM codes includes the '***day of discharge + 29 days following discharge***' • Added ***'Frequency limitation'*** row • Added to the Minimum Medical Record Documentation Requirements for *1111F ***'The name and credentials of person who completed the med rec'*** • Services furnishable by for TCM codes changed from NPP to ***APP*** and expanded acronyms for NP, PA, CNM and CNS
	FAQs: Concurrent Billing of TCM Codes and *1111F (slide 8)	• Clarified reimbursement for concurrent billing for each line of business
	Potential Barriers for TRC/MRP Billing/Gap Closure (slide 9)	• Clarified billing timeline for both TCM codes and *1111F based on date of service, previously may have been confused with date of claim submission; states '***TCM codes and *1111F must be submitted on a claim with a service date no later than 30 days following discharge***' • Changed '***TRC and MRP gap can be closed by submitting *99483, *99495, *99496***' to '***The PE and MRP components of TRC are satisfied by submitting *99483, *99495, *99496***' • Changed '***billing company***' in second column of 'Billing codes' row to '***biller/coder***'
	Post-discharge Process and Barriers to Completing Transitions of Care Requirements (slide 11)	• Changed last column '***Codes that satisfy TRC requirements***' to '***Codes that satisfy the PE & MRP components of TRC***'

Revision log

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Version	Slide Title	Update
June 16, 2021	Transitions of Care Components (slide 3)	• Changed '***Receipt of Admission***' to '***Notification of Inpatient Admission***' • Changed '***Receipt of Discharge***' to '***Receipt of Discharge Information***'
	Using TCM Codes and *1111F to Satisfy TRC Requirements (slide 4) *Slide replaced with revised version in later June 2021 version*	• Clarified that NOIA and RODI are unable to be closed administratively and will require medical record review • Clarified the components that TCM codes and *1111F will satisfy • Added statement '***All 4 components must be appropriately documented in the medical record (see previous slide for documentation requirements)***'
	Comparing Transitional Care Management Codes (TCM) and *1111F (slide 6)	• Added '***(including completion of Med Rec no later than the day of the face-to-face visit)***' to the Face-to-face visit component of TCM codes
	Components of CPT® Transitional Care Management (TCM) Codes (slide 7)	• Added '(including medication reconciliation)' to the Face-to-face visit component of TCM • Bolded '***Med rec must be furnished no later than the date of the face-to-face visit.'***
	Potential Barriers for TRC/MRP Billing/Gap Closure (slide 9)	• Changed '***1111F must be billed within 30 days of discharge***' to '***1111F must be submitted on a claim with a service date no later than 30 days following discharge'***
	Post-discharge Process and Barriers to Completing Transitions of Care Requirements (slide 11)	• Changed SNF/rehab box to **RED** as it has been identified as a common barrier to completion of the TRC/MRP process