ChronicCare

Transitional Care MANAGEMENT (TCM)

Care Coordination for Value-Based Care Success

TCM helps providers coordinate care for patients in the first 30 days after a hospital discharge. It aims to prevent readmissions across a care transition.
Our approach to TCM is meant to improve the patient's care post-acute discharge and ensure the patient is transitioned back into ambulatory setting.

- Track time-sensitive service requirements
- Create and share comprehensive discharge reports
- Capture reimbursement from Medicare with accurate billing support
- Address hospital readmissions by closing gaps in patient care transitions

MODERATE COMPLEXITY*	HIGH COMPLEXITY*
• Face-to-face visit within **14** days of discharge • Bill code **99495** • National reimbursement rate: $203.34	• Face-to-face visit within **7** days of discharge • Bill code **99496** • National reimbursement rate: $275.05

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