AaNeel

PROVEN PLAYS. BETTER CARE.

A Practical Playbook for Care Teams

Seven plays for prevention, coordination, and follow-through.

CONFERENCE EDITION

OCTOBER 2026

Put the Plays to Work

The fundamentals still matter.

A well-run huddle. A prevention plan that leads to action. A medication the patient can obtain. A safe return home. These everyday practices shape how patients experience care.

This book brings seven practical plays together so care teams can identify needs, coordinate a response, and verify what happened next.

How to Use This Book

1

Choose a play

Start with a workflow that matters to your patients and where your team sees an opportunity to improve.

2

Review the actions

Use the checkboxes to assess current practice. Identify what happens consistently and what needs attention.

3

Use your team

Clarify who gathers information, who makes clinical decisions, and who follows through.

4

Close the loop

Give each open issue an owner, a next action, and a due date. Confirm completion rather than assuming it.

Use the Guidance in Context



Coaching tips support team workflows.

Medicare rules identify key billing requirements where relevant. Operational completion and billing eligibility are separate checks; neither substitutes for the other.



Apply clinical judgment and verify

Verify current CMS guidance, CPT instructions, Medicare Administrative Contractor guidance, payer rules, and organizational policies before billing. References appear within

The next step should be clear to the patient and the team.

Table of Contents

Seven practical plays. One shared commitment to better-connected care.

PLAY 01 **Morning Huddle** 03

Start the day with shared priorities, clear owners, and action.

PLAY 02 **Annual Wellness Visit** 06

Identify risks and turn the personalized prevention plan into follow-through.

PLAY 03 **Advance Care Planning** 09

nderstand patient wishes and make them available when decisions are needed.

PLAY 04 **Run the 100 Day Prescription Play** 12

Reduce refill barriers when a longer medication supply is appropriate.

PLAY 05 **Chronic Care Management** 14

Keep the care plan current and respond as patient needs change.

PLAY 06 **Frequent Emergency Department Use** 17

Understand repeat visits and connect patients to reliable care.

PLAY 07 **Transition of Care** 19

Support a safe return home and distinguish qualifying TCM from ED-only follow-up.

Put Your Next Play Into Action 22

Choose an improvement, assign ownership, and set a review date.

Play 01

Morning Huddle

The Play for a Team Ready to Act

Know what changed. Identify who needs attention. Agree on what happens today.

Use this section to launch a huddle or assess an existing one. Check each practice that happens consistently. Turn unchecked items into specific improvements with an owner and a review date.

Organization or team: _____ Date: _____

Huddle lead: _____ ☐ New huddle ☐ Existing huddle

Prepare the Huddle

- ☐ Set a consistent time, place, and facilitator. Aim for 10 minutes; keep the huddle to 15 minutes or less.
- ☐ Include the people who can act on the discussion, or establish a clear handoff.
- ☐ Make today's schedule, clinical and utilization updates, and unfinished work available before the discussion.

Review What Changed

- ☐ Identify relevant admissions, discharges, emergency visits, new results, medication changes, urgent messages, and changes in condition.
- ☐ Revisit unresolved referrals, authorizations, outreach, and patient concerns from prior days.
- ☐ Focus on changes that require action rather than reading every update aloud.

Identify People Who Need Attention

- ☐ Prepare for scheduled patients with new information, care gaps, transitions, or follow-up needs.
- ☐ Identify patients outside today's schedule who need outreach or care coordination.
- ☐ Confirm interpreter, transportation, caregiver, record, test result, and specialist note needs.

Remove Barriers and Assign Action

- ☐ Identify staffing, records, referral, and workflow barriers that could prevent the next step.
- ☐ Give each priority a specific action, one accountable owner, and a completion or review time.
- ☐ Record issues too large for the huddle and route them to an operational or quality improvement owner.

Close the Loop

- ☐ Before ending, confirm what will happen today because of this huddle.
- ☐ Check whether yesterday's actions were completed, remain open, or need escalation.
- ☐ Periodically assess whether the huddle supports timely outreach, completed follow-ups, and fewer recurring barriers.

Coaching Tip — Keep the Team Moving

Identify the issue, assign the next step, and take longer problem-solving discussions offline. Address urgent safety concerns immediately through the appropriate clinical escalation process.

Turn the Assessment Into Action

Choose up to three unchecked items to address first. A new team can use these as launch decisions; an established team can use them as improvements.

Priority and change to make	Owner	By when	How we will know

Next review date: _____

One change we expect to see in the workday:

_____

_____

Rules of the Play

- [ ] Use the huddle to anticipate needs, coordinate work, and adjust the day's plan.
- [ ] Give every team member a clear opportunity to raise a concern or request help.
- [ ] Keep the action list visible to the responsible team and update its status.
- [ ] Record patient-specific clinical decisions and follow-up in the appropriate patient record; the huddle action list does not replace clinical documentation.
- [ ] Use an appropriate private setting and protect patient information on screens, boards, and printed lists.

Coaching Tip — Measure the Follow-Through

At the next review, look at a small sample of assigned actions. Were they completed when promised? If not, identify the barrier and adjust the workflow. Attendance alone does not show whether the huddle is helping.

Daily closeout prompt: What will happen today because we huddled?

A shared plan starts the day. Follow-through makes the huddle count.

Practice references • Reviewed October 15, 2026
Institute for Healthcare Improvement — Huddles
https://www.ihi.org/library/tools/huddles

Agency for Healthcare Research and Quality — Implementing Primary Care Team Huddles Worksheet
https://www.ahrq.gov/evidencenow/tools/team-huddles.html

Adapt to organizational privacy, documentation, and clinical escalation policies. This is an operational improvement tool, not a CMS billing checklist.

Play 02

Annual Wellness Visit

The Play for Prevention That Leads to Action

Identify risks. Build a personalized plan. Keep the next steps moving.

The Annual Wellness Visit focuses on prevention, health risks, and planning. Use the visit to connect each finding to an action, an owner, and follow-through throughout the year.

Before the Visit

- [ ] Confirm Medicare eligibility, the Part B start date, & previous wellness claims before selecting the visit type.
- [ ] Explain that the AWV focuses on prevention and planning. It is not a routine physical examination.
- [ ] Request completed forms, medications and supplements, medical and immunization records, family history, and a current provider and supplier list.
- [ ] Review recent utilization, active conditions, preventive care gaps, prior referrals, and cognitive, behavioral health, functional, or safety concerns.
- [ ] Address language, transportation, technology, accessibility, cost, mobility, and caregiver barriers.



Coaching Tip — Make It a Morning Huddle Conversation

Identify missing information, overdue services, and patients who may need additional clinical attention. Assign the assessment, documentation, and follow-up tasks before the visit begins.

During the Visit

- [ ] Complete or update the health risk assessment, including health status, psychosocial and behavioral risks, daily activities, and ability to manage medications, transportation, shopping, and finances.
- [ ] Review medical, surgical, and family history; medications, supplements, allergies, providers, suppliers, specialists, and recent care changes.
- [ ] For the first AWV, record height, weight, BMI (or waist circumference, if appropriate), and blood pressure. At subsequent AWVs, record weight (or waist circumference, if appropriate), blood pressure, and other appropriate measurements.
- [ ] Detect cognitive impairment through observation and patient or caregiver reports; arrange further evaluation when indicated.
- [ ] Review depression risk, social isolation, substance use, tobacco and alcohol use, physical activity, nutrition, oral health, sexual health, and other psychosocial or behavioral risks.
- [ ] Review fall risk, mobility, hearing, home and community safety, daily activities, and driving safety when appropriate.

- [ ] Review current opioid prescriptions, pain severity, treatment effectiveness, opioid use disorder risks, and non-opioid options; refer when appropriate.
- [ ] Identify overdue screenings, immunizations, counseling, and other preventive needs. Offer advance care planning at the patient's discretion.

Turn Findings Into Action

- [ ] Establish or update the written screening schedule for the next 5–10 years, based on patient risks, screening history, and current preventive recommendations.
- [ ] Document the patient's risk factors and conditions, recommended interventions, personalized health advice, and clinical or community referrals.
- [ ] Prioritize urgent and higher risk concerns. Identify an owner and a completion timeframe for each screening, referral, conversation, or intervention.
- [ ] Arrange screenings, referrals, and follow-up appointments before the patient leaves whenever possible.
- [ ] Give the patient the personalized prevention plan in a clear format. Confirm understanding and address barriers to follow-through.

Close the Loop

- [ ] Track whether recommended screenings, referrals, and preventive services were scheduled and completed.
- [ ] Respond to abnormal findings and contact patients when recommended actions remain incomplete.
- [ ] Bring unresolved actions to the huddle and keep them visible until addressed.
- [ ] Document the outcome. Close an action when completed or when a decision, such as patient refusal or clinical deferral, is documented.

CMS Rules of the Play

- [ ] Use the correct service and confirm eligibility and frequency requirements:

Service	Code and eligibility
Welcome to Medicare	G0402 — separate IPPE service, once in the first 12 months of Part B; follow IPPE requirements.
First AWV	G0438 — once per lifetime, after 12 months of Part B; not within 12 months of an IPPE.
Subsequent AWV	G0439 — once per 12-month period; verify the next eligible date.

- [ ] Document all components required for the initial or subsequent AWV.

- [ ] Confirm eligible personnel and supervision requirements for team delivery. Apply separate requirements to additional services.
- [ ] If a significant, separately identifiable, medically necessary problem-focused E/M service is performed, document it separately and append modifier 25 to the E/M code—not the AWV. Explain potential additional patient cost sharing.

Coaching Tip — Match the Modifier to the Service

For separately billed ACP with an AWV, follow the modifier 33 and cost-sharing rules in the Advance Care Planning play.

Final Check

Confirm the service is documented, the patient has the plan, urgent concerns are escalated, and next steps have owners and tracking.

The AWV takes place on one day. The plan should guide the next twelve months.

CMS reference:
Medicare Wellness Visits and Annual Wellness Visit
Reviewed October 15, 2026
https://www.cms.gov/medicare/coverage/preventive-services/medicare-wellness-visits/annual-wellness-visit
Confirm current CMS guidance, payer requirements, and organizational billing policies before use. Follow setting-specific rules for FQHCs and RHCs.

Play 03

Advance Care Planning

The Play for Care That Honors Patient Wishes

Start the conversation. Understand what matters. Make the patient's wishes available when care decisions are made.

Advance care planning helps patients prepare for future medical decisions if they become unable to speak for themselves. The goal is a shared understanding of what matters to the patient—and a plan the care team can use.

Recognize the Right Moment

- [ ] Make advance care planning part of routine preventive care, including Annual Wellness Visits.
- [ ] Recognize changes in function, symptoms, utilization, treatment, or caregiver support that warrant a conversation.
- [ ] Include advance care planning in care transitions and serious illness workflows.
- [ ] Assign responsibility for initiating the conversation and coordinating follow-up.

Prepare the Conversation

- [ ] Explain the purpose of advance care planning, ask permission to begin, and confirm participation is voluntary.
- [ ] Confirm the patient's preferred language and communication needs.
- [ ] Identify the person the patient trusts to make medical decisions if needed; confirm contact information and assist with formal designation when appropriate.
- [ ] Include the patient's chosen decision maker or support person with the patient's permission.
- [ ] Review existing advance directives and previously documented goals of care.



Coaching Tip — Use Your Care Team

A nurse or social worker can help patients identify their decision maker, gather existing documents, explore care preferences, and prepare questions. The physician or qualified practitioner can build on that preparation to clarify medical choices and connect the plan to the patient's goals.

Understand What Matters

- [ ] Ask what the patient understands about their health and how much information they want about what may come next.
- [ ] Explore the patient's values, hopes, worries, and definition of quality of life.

- [ ] Discuss treatments, burdens, and outcomes in the context of the patient's health and priorities.
- [ ] Confirm that the chosen decision maker understands the patient's preferences and their role.
- [ ] Recommend next steps that reflect the patient's goals.

Document and Connect

- [ ] Document voluntary participation, who was present, the explanation of advance directives, the discussion, and ACP time.
- [ ] Record the decision maker's name and contact information, the patient's priorities, and any decisions or unresolved questions.
- [ ] Assist with appropriate forms when the patient is ready; a completed form is not required for an otherwise qualifying ACP service.
- [ ] Store the current conversation summary and documents in a consistent, easy-to-find location in the medical record.
- [ ] Share current information with the care team during referrals and transitions.
- [ ] Provide the patient and decision maker with copies and explain where the information can be found.

Revisit the Plan

- [ ] Review preferences after hospitalization, functional decline, a new diagnosis, or another meaningful change in health.
- [ ] Ask whether the patient's wishes or chosen decision maker have changed.
- [ ] Resolve outdated or conflicting documentation and clearly identify the current version.
- [ ] Assign an owner and follow-up date for unfinished conversations or documents.

CMS Rules of the Play

- [ ] Confirm the service meets Medicare requirements and is furnished by an eligible physician or qualified practitioner.
- [ ] The billing clinician must participate and meaningfully contribute. A brief chart review or signature alone is insufficient; applicable time, documentation, supervision, and incident to requirements must be met.
- [ ] Use documented ACP time to select codes:

ACP time	Code(s)
15 minutes or less	Do not bill ACP codes
16–45 minutes	99497
46–75 minutes	99497 + 99498, one unit
76–105 minutes	99497 + 99498, two units

- [ ] Exclude time spent on other services or active management of medical conditions.
- [ ] For waived Medicare Part B deductible and coinsurance, provide ACP with a covered AWV—G0438 or G0439—by the same provider, on the same date and claim, with modifier 33 applied to ACP.
- [ ] Explain potential patient cost sharing when waiver requirements are not met.
- [ ] For repeat billing, document changes in health status and/or care wishes.

A document records the plan. Connected care makes it actionable.

CMS reference:
Advance Care Planning, MLN909289, March 2026
https://www.cms.gov/files/document/mln-advanced-care-planning.pdf

Team-based ACP reference:
CMS Frequently Asked Questions about Billing ACP Services, question 4
https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-advance-care-planning.pdf

Confirm current CMS guidance, payer requirements, state law, and organizational billing policies before use.

Play 04

Run the 100 Day Prescription Play

Reduce refill barriers for stable maintenance medications.

A longer supply is not appropriate for every patient or medication. Confirm clinical fit, patient preference, and coverage before changing the prescription.

Identify the Opportunity

- [ ] Identify patients receiving 30-day supplies of stable maintenance medications.
- [ ] Identify upcoming refills, medication gaps, and late refills.
- [ ] Look for multiple medications with different refill dates.

Review the Patient and Medication

- [ ] Confirm the medication and dose are stable without an expected change.
- [ ] Confirm required laboratory testing and clinical monitoring are current.
- [ ] Have the prescriber determine whether a longer supply is clinically appropriate.
- [ ] Consider patient preference, safe storage, and ability to manage a larger supply.

Confirm Access

- [ ] Confirm whether the plan covers 100 days for this medication; consider a covered 90-day supply when appropriate
- [ ] Confirm the selected pharmacy can dispense the approved quantity, including any network, packaging, or medication restrictions.
- [ ] Review the actual out-of-pocket cost and coverage differences with the patient.
- [ ] Ask the pharmacy whether refill dates can be aligned to reduce trips.

Coaching Tip — Use Your Care Team

Nurses, care managers, and pharmacy staff can identify refill barriers and verify benefits. The prescriber authorizes changes; the pharmacist confirms dispensing requirements. A longer supply does not replace clinical follow-up.

Close the Loop

- [ ] Confirm the patient understands the medication and refill plan.
- [ ] Schedule the next appointment and required laboratory tests as clinically indicated.
- [ ] Update the prescription and medication list so the care team can see the current plan.
- [ ] Confirm the medication was received; assign follow-up for unfilled prescriptions.

The Final Play Call

Is the current prescription duration based on the patient's clinical needs, or is 30 days simply the default?

Sometimes the most effective play is not changing the treatment. It is removing one more obstacle between the patient and the medication they need.

Rules of the Play: A 100-day supply is not a universal Medicare benefit. Verify the patient's current plan and medication rules. Keep shorter supplies when clinically appropriate.

References

Medicare — Using Your Drug Coverage
https://www.medicare.gov/health-drug-plans/part-d/using-drug-coverage

CDC — Pharmacy-Based Interventions to Improve Medication Adherence
https://www.cdc.gov/cardiovascular-resources/php/medication-adherence/index.html

Reviewed October 15, 2026. Confirm current plan coverage, dispensing requirements, and clinical appropriateness before use.

Play 05

Chronic Care Management

The Play for Coordinated Care as Needs Change

Move beyond monthly activity. Identify what changed, coordinate the response, and confirm what happened next.

Identify the Right Patients

- [ ] Confirm two or more chronic conditions expected to last at least 12 months or until death, with significant risk of death, acute exacerbation, decompensation, or functional decline.
- [ ] Have a qualified practitioner confirm medical necessity; prioritize utilization, medication complexity, functional needs, caregiver support, and barriers to care.
- [ ] Complete the initiating visit when required—for new patients or those not seen within the previous year—and discuss CCM during that visit.
- [ ] Explain the service, possible cost sharing, one-practitioner-per-calendar-month billing rule, and right to stop participating.
- [ ] Document written or verbal informed consent before billing.

Make the Care Plan Usable

- [ ] Maintain a comprehensive electronic care plan reflecting medical, functional, cognitive, psychosocial, environmental, and caregiver needs.
- [ ] Include measurable goals, planned interventions, medication management, and symptom monitoring as appropriate.
- [ ] Give each care priority an owner and next step; identify outside practitioners, community resources, and caregiver involvement.
- [ ] Make the plan promptly available to appropriate care team members and provide the patient or caregiver a copy when necessary.
- [ ] Update the plan when hospitalization, medication changes, worsening symptoms, missed referrals, or new barriers change the patient's needs.

Build a Clear Response Process

- [ ] Identify new hospital, ED, specialist, and post-acute care activity.
- [ ] Base outreach on current needs rather than a generic monthly script.
- [ ] Define what team members can address, what requires practitioner review, and when to escalate.
- [ ] Route medication concerns to the appropriate practitioner; keep referrals, tests, and transitions visible until the next step is confirmed.
- [ ] Provide 24/7 access to a practitioner or clinical staff who can address urgent care management needs.
- [ ] Support continuity through a designated practitioner or care team member who knows the patient's plan.

Document and Verify the Care Delivered

- [ ] Record the date, person, role, activity, and actual time spent.
- [ ] Explain what was identified, why it mattered, and the decision or action taken.
- [ ] Document the responsible person, next action, and required follow-up.
- [ ] Distinguish clinical staff and practitioner time as needed for the selected code.
- [ ] Do not round up, invent time, or count the same time toward another billed service.
- [ ] Keep unresolved concerns visible until addressed or transferred to an accountable owner.
- [ ] Update the care plan when new information changes goals, risks, or interventions.



Coaching Tip — Use Your Care Team

Clinical staff can deliver eligible CCM activities under the billing practitioner's general supervision, consistent with state law and scope of practice. Nurses, social workers, and care managers can help coordinate care within their roles. Confirm that the person and activity qualify before counting time; practitioner-only codes require the practitioner's own time.

Confirm That the Program Is Working

- [ ] What changed for this patient?
- [ ] Did the change require a clinical or operational response?
- [ ] Who became responsible for the next step?
- [ ] Was that step completed or assigned for continued follow-up?
- [ ] Does the care plan still reflect the patient's current needs?

If an answer is unclear, the team may have completed monthly activity without completing the coordination the patient needed.

Medicare Rules of the Play

Select the code by the work delivered, who performed it, and qualifying time per calendar month. Meet the full applicable time requirement; a monthly call alone does not establish eligibility.

- **99490:** first 20 minutes of qualifying clinical staff CCM; +99439 for additional 20-minute increments.
- **99491:** first 30 minutes personally provided by the practitioner; +99437 for additional 30-minute increments.
- **99487:** first 60 minutes of complex CCM, with moderate or high medical decision making; +99489 for additional 30-minute increments.

Apply add-on limits and code-specific requirements. Do not combine incompatible CCM code families. Check concurrent-service rules, including APCM, and avoid duplicate time or payment.

CMS Sources

Chronic Care Management Services, MLN909188, June 2025
https://www.cms.gov/files/document/chroniccaremanagement.pdf

Chronic Care Management for Complex Conditions
https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/chronic-care-management-complex-conditions

Manage Your Chronic Condition
https://www.cms.gov/priorities/health-equity/c2c/manage-your-chronic-condition

Educational and operational guidance. Confirm current CMS, CPT, Medicare Administrative Contractor, and payer-specific requirements before billing. Reviewed October 15, 2026.

Play 06

Frequent Emergency Department Use

The Play for Connecting Patients to Reliable Care

Every repeated emergency department visit should trigger a care review, not simply another discharge.

Repeated emergency department (ED) visits can signal changing clinical needs, barriers to care, or an incomplete connection to services. Work with the patient to understand the pattern and build a response they can realistically use.

Recognize the Pattern

- [ ] Review ED visits across available facilities and care settings; use encounter alerts when available.
- [ ] Identify repeated conditions, symptoms, admissions, medication changes, missed appointments, and incomplete referrals.
- [ ] Review discharge instructions, available test results, and pending tests that need follow-up.
- [ ] Determine whether the visits reflect a temporary increase in need or a persistent pattern.
- [ ] Escalate immediate clinical, behavioral health, or safety risks.

Understand Why the Patient Is Returning

- [ ] Ask the patient what brought them back and what made the current care plan difficult to follow.
- [ ] Review access to primary care, specialty care, and clinical guidance outside regular office hours.
- [ ] Assess medication affordability, availability, side effects, and understanding; reconcile changes with the current medication list.
- [ ] Identify behavioral health, substance use, transportation, housing, food, caregiver, or health literacy needs.
- [ ] Confirm preferred language, communication needs, and a reliable way to reach the patient.
- [ ] Ask what would make care easier for the patient to access and manage.

Coaching Tip — Use Your Care Team

A nurse, social worker, or care manager can gather visit records, explore barriers, help arrange services, and track follow-through within their role. The treating clinician evaluates symptoms, reconciles treatment decisions, and guides the clinical response. Give every unresolved action an owner and a due date.

Create a Coordinated Response

- [ ] Assign one person or team to lead the response and give the patient a clear contact.
- [ ] Create one concise plan with the patient's needs, barriers, warning signs, next steps, accountable owners, and due dates.
- [ ] Identify realistic alternatives when emergency care is not required, including same-day care and after-hours clinical guidance.
- [ ] Schedule appointments based on clinical need and discharge instructions; use warm handoffs instead of providing contact information alone.
- [ ] Make the current plan available to ED, primary care, specialty, behavioral health, and care management teams through approved information-sharing channels.
- [ ] Use teach-back: ask the patient to explain whom they will contact, what they will do next, and when they should seek emergency care.

Confirm and Improve the Connection

- [ ] Verify that medications were obtained and priority appointments or services occurred.
- [ ] Confirm that pending test results were reviewed and communicated, with next steps assigned.
- [ ] Bring incomplete actions back into outreach, care management, or the next care team huddle.
- [ ] If the patient returns, reassess clinical needs and identify what the plan did not address; update the response with the patient.
- [ ] Track completed follow-up, medication access, service connections, admissions, and ED use over a consistent review period.
- [ ] Continue review until the patient knows the next step, an accountable team member is identified, and priority connections are completed; maintain ongoing support when needed.

Rules of the Play

Preserve access to emergency care. A history of frequent visits does not replace evaluation of new or worsening symptoms. Explain when to seek emergency help; care plans must not delay appropriate emergency screening and treatment.

The goal is not simply to prevent another emergency department visit. It is to make sure the emergency department is not the patient's only reliable path to care.

Practice references

AHRQ — Re-Engineered Discharge Toolkit, Tool 5
https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool5.html

Washington ACEP — Seven Best Practice Resources
https://www.washingtonacep.org/resources/seven-best-practice-resources/

CMS — Emergency Room Rights under EMTALA
https://www.cms.gov/priorities/your-patient-rights/emergency-room-rights

Practice guidance reviewed October 15, 2026. Apply clinical judgment, applicable privacy requirements, and organizational protocols. This workflow is not a standalone billing service.

Play 07

Transition of Care

The Play for a Safe Return Home

Know what changed. Confirm what the patient needs. Make sure the next step happens.

Receive and Review

- [ ] Confirm the discharge date, setting, and patient status.
- [ ] Obtain diagnoses, medication changes, pending results, follow-up instructions, and ordered services.
- [ ] Assign one person or team to coordinate the transition.

Connect With the Patient

- [ ] For qualifying TCM, complete interactive clinical contact within two business days after discharge.
- [ ] Ask about symptoms, medications, instructions, and barriers to recovery.
- [ ] Compare the discharge medication list with what the patient is actually taking; resolve or escalate discrepancies.
- [ ] Confirm the patient knows whom to call and when to seek emergency care.



Coaching Tip — Use Your Care Team

Clinical staff can conduct outreach under the treating practitioner's direction. Nurses, social workers, and care managers can help identify barriers and connect services within their roles. The physician or qualified practitioner completes the required visit and medical decision making. Scheduling alone does not satisfy interactive clinical contact.

Make the Connections

- [ ] Arrange follow-up based on clinical need and the applicable TCM deadline.
- [ ] Confirm medications, equipment, home health, transportation, and referrals are accessible.
- [ ] Assign a reviewer for pending tests and results.
- [ ] Give every unresolved issue an owner, a next action, and a due date.

Verify and Follow Through

- [ ] Confirm medications were obtained, services arrived, and follow-up care occurred.
- [ ] Confirm results were reviewed, communicated, and addressed.
- [ ] Return missed appointments and incomplete actions to an active work queue.
- [ ] By the end of the 30-day transition, close remaining issues or transfer them to an ongoing care team that accepts responsibility.

Escalate promptly: Worsening symptoms, high-risk medication problems, missing essential services, urgent results, or an unsafe home care situation. Document the response and reassessment plan.

A scheduled appointment is a step. A verified connection is the result.

Medicare Rules of the Play

Transitional Care Management Billing

TCM covers 30 days—discharge day and the next 29 days. The required visit is one part of that service.

Confirm a Qualifying Discharge

Qualifying settings include:

- Inpatient acute care, psychiatric, rehabilitation, and long-term care hospitals.
- Skilled nursing facilities.
- Hospital outpatient observation or partial hospitalization.
- Community mental health center partial hospitalization.

The patient must transition to a community setting, such as home, assisted living, a group home, or a nursing facility.

ED-only discharge: The patient should still receive clinically appropriate follow-up. Bill the appropriate E/M service when its requirements are met. An ED visit alone does not qualify for TCM. A formal observation or inpatient stay may qualify.

Select the Supported Code

Requirement	99495	99496
Medical decision making	At least moderate	High
Required face-to-face visit	Within 14 calendar days	Within 7 calendar days

Both codes also require:

- [ ] Interactive clinical contact within two business days after discharge.
- [ ] Medication reconciliation and management on or before the required visit.
- [ ] Medically necessary non-face-to-face transition services during the service period.

If the patient cannot be reached: Document at least two separate attempts within the two-business-day window and continue outreach until successful. TCM may still be reported if all other requirements are met.

Check Before Billing

- [ ] Confirm one billing physician or eligible practitioner is reporting TCM once for the service period.
- [ ] Document discharge details, contact or attempt dates, visit date, medication reconciliation, medical decision making, and transition services.
- [ ] Do not separately bill the required TCM visit as an E/M service.
- [ ] Check global surgery and concurrent-service restrictions; do not count time or effort twice.
- [ ] If TCM requirements are not met, evaluate the appropriate E/M service and continue needed care.

CMS Reference:

Transitional Care Management Services, MLN908628
https://www.cms.gov/files/document/mln908628-transitional-care-management-services.pdf

Confirm current Medicare, payer, and organizational requirements before billing.

Put Your Next Play Into Action

Choose up to three improvements to bring back to your team.

Organization or team: _____

Team lead: _____ Review date: _____

Priority 1

Play and change to make: _____

Accountable owner: _____

Next action and due date: _____

How we will verify completion: _____

Priority 2

Play and change to make: _____

Accountable owner: _____

Next action and due date: _____

How we will verify completion: _____

Priority 3

Play and change to make: _____

Accountable owner: _____

Next action and due date: _____

How we will verify completion: _____

At your next huddle, ask what happened because of the plan.

Make the next step clear.

For the patient.
For the care team.
For the person responsible for follow-through.

AaNeel

Follow Us

Corporate Office

6650 gunn Hwy,
Tampa, FL 33625

Support

+1 (813) 200-5604

techsupport@aaneel.com

Sales

+1 (813) 909-9555

Sales@aaneel.com