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Transitional Care Management Interactive Contact Requirements – 2026

Purpose

This resource for home-based primary care (HBPC) providers and practice staff defines the requirements for the interactive contact required of clinical staff during the Transitional Care Management (TCM) period and is intended to serve as a reference when creating workflows or templates for outreach. This resource was developed utilizing Centers for Medicare & Medicaid Services (CMS) guidelines and requirements and can be referenced for further details.

Interactive contact (TCM call) is the required non-face-to-face element of a TCM visit. Contact must be made with the beneficiary and/or caregiver/responsible party within two business days of discharge. Accepted methods of contact can be via telephone, email, or a face-to-face performed by the provider or licensed clinical staff. This contact must address the patient's medical status and needs, and go beyond scheduling follow-up care. If the first attempt to communicate with the patient is unsuccessful, CMS requires documentation of at least two failed attempts and expects communication attempts to continue until contact is made. However, if at least two documented attempts are recorded in the medical record before the face-to-face TCM visit, the provider can proceed with billing the Transitional Care Management CPT code.

Below is a list of required elements the clinical staff must include when documenting the interactive contact:

- The discharge date and date of the TCM call with the patient/caregiver.
- How is the patient handling their transition home? Do they feel their condition is stable enough to be safe at home?
- Review of discharge medications.
- Review of hospital discharge instructions. This could include diagnostic tests or treatments that were recommended and/or scheduled, and any other health care professionals to whom the patient was referred.
- Does the patient or caregiver have any questions regarding discharge instructions or medications?
- Does the patient have all necessary medications, or are refills or new prescriptions needed?
- Does the patient or caregiver require any assistance arranging follow-up doctor visits, testing, therapy, and/or in-home needs?
- Does the patient or caregiver have all the necessary durable medical equipment (DME)? If not, what additional orders are needed?
- Confirm the appointment date on which the provider is scheduled to see the patient for the face-to-face visit.

The provider should verify the interactive contact communication was completed and documented when seeing the patient for the post-discharge face-to-face visit. In order to ensure documentation is complete and clearly reflects all of the non-face-to-face work required by CMS during the TCM service period, the provider may consider utilizing the following MACRO/template within their post-discharge visit.

Transitional Care Management EHR Example Face-to-Face Progress Note Template:

- Date of Discharge:
- Hospital Records Received & Reviewed/ Summary:
- Date of Interactive Contact:
- Medication Reconciliation:
- Follow-up Pending Diagnostic Tests or Treatments:
- Other Health Care Professional Care Partners:
- Patient/Caregiver Education Provided:
- Referrals & Community Resources Needed:
- Appointment or Scheduling Needs:

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