Frequently Asked Questions about Transitional Care Management (TCM)

What is transitional care management (TCM)?

Transitional care management (TCM) includes services provided to a patient with medical and/or psychosocial problems requiring moderate or high-complexity medical decision making. TCM services involve a transition of care from one of the following hospital settings:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care hospital
- Skilled nursing facility
- Inpatient rehabilitation facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a community mental health center

What current procedural terminology (CPT) codes do I use to report TCM?

There are two CPT codes that may be used to report TCM:

- 99495 Transitional Care Management Services with the following required elements:
    - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge
    - Medical decision making of at least moderate complexity during the service period
    - Face-to-face visit within 14 calendar days of discharge
- 99496 Transitional Care Management Services with the following required elements:
    - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge
    - Medical decision making of high complexity during the service period
    - Face-to-face visit within seven calendar days of discharge

How much do these services pay?

Payment allowances will vary by payer, and Medicare's allowance will vary geographically. Also, Medicare's allowance depends on the conversion factor in force at the time claims are paid.

Based on these relative value units (RVUs) and the current (2017) conversion factor, the Medicare allowance for code 99495 performed in a non-facility setting (e.g., a physician's office) would be approximately $165.45. In a facility setting, the corresponding allowance is approximately $112.

For code 99496 performed in a non-facility setting, the Medicare payment allowance would be approximately $233.99. In a facility setting, it is approximately $162.

Is TCM reportable for new and established patients?

Effective February 2013, TCM codes can be utilized on new or established patients.

I understand that TCM also includes non-face-to-face care provided by the physician and his or her clinical staff. What are some examples?

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge
- Communication with home health agencies and other community services utilized by the patient
- Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living
- Assessment and support for treatment regimen adherence and medication management
- Identification of available community and health resources
- Facilitating access to care and services needed by the patient and/or family

Non-face-to-face services provided by the physician or other qualified health care provider may include:

- Obtaining and reviewing the discharge information (e.g., discharge summary, as available, or continuity of care documents)
- Reviewing need for, or follow up on pending diagnostic tests and treatments
- Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems
- Education of patient, family, guardian, and/or caregiver
- Establishment or re-establishment of referrals and arrangement of needed community resources
- Assistance in scheduling any required follow up with community providers and services

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Why shouldn't I just bill an office visit (e.g., CPT code 99214) instead?

Transitional care management accounts for all the services you and your team deliver during the 30-day post-discharge period. This includes the 7- or 14-day face-to-face visit. This visit does not have to meet a documentation level of service such as a 99214 or 99215 other than the medical decision making component. You can bill it as an office visit if documentation requirements for history, exam, and medical decision making are met should the patient die or be re-admitted.

If the patient needs another visit during the 30 days, can I bill for this?

Yes, for an evaluation and management (E/M) visit you can bill additional visits other than the one bundled E/M visit in the TCM. There are some restrictions on what you can bill (such as anticoagulation management, home health care certification, and other miscellaneous forms).

May I report a discharge management code and a TCM code?

A physician or non-physician practitioner (NPP) may report both the discharge code and appropriate TCM code if he or she provided both services. However, Medicare prohibits billing a discharge day management service on the same day that a required E/M visit is furnished under the CPT TCM codes for the same patient. Thus, you cannot count an E/M service as both a discharge day service and the first E/M under the TCM codes.

Does the discharge visit count as the post-discharge contact?

No, the discharge visit does not count. The initial contact must be made after the patient leaves the hospital. This is to make sure the patient has the support necessary until they have a face-to-face visit within the 7 or 14 days, as prescribed. The initial contact can be phone, e-mail, text, or direct face-to-face. It can be with the patient or his/her caregiver.

How is a "business day" defined, and what happens if I can't reach the patient and/or caregiver in that time frame?

For the purposes of TCM, business days are Monday through Friday, except holidays, without respect to normal practice hours or date of notification of discharge.

If two or more separate attempts are made in a timely manner, but are unsuccessful and other TCM criteria are met, the service may be reported. Medicare, however, expects attempts to communicate to continue until they are successful.

Attempts to communicate should continue after the first two attempts in the required two business days until you are successful. If you make two or more separate attempts in a timely manner and document them in the medical record, but are unsuccessful in making contact and if all other TCM criteria are met, you may report the service. CMS does expect attempts to make contact to continue until successful.

May more than one physician report TCM services for the same patient during the 30-day post-discharge period?

No. TCM services may be billed by only one individual during the post-discharge period. If more than one physician or NPP submits a claim for TCM services provided to a patient in a given 30-day period following discharge, Medicare will pay the first claim it receives that otherwise meets its coverage requirements.

If I provide a 10- or 90-day global surgical service that results in TCM post-discharge, may I report both the global surgical service and a TCM code?

No. Both CPT and Medicare prohibit a physician who reports a service with a global period of 10 or 90 days from also reporting the TCM service.

CPT and Medicare preclude a physician from reporting certain other services with TCM. Please consult 2017 CPT codes for a complete list of these services.

Who can complete the medication reconciliation for TCM?

Transitional care management medication reconciliation requires the medications on discharge to be reconciled with the medications the patient was taking previously. The nurse can obtain these medications, but the physician needs to order any changes, additions, or deletions to the medication. Medicine reconciliation and management must be furnished no later than the date of the face-to-face visit.

Does the required face-to-face visit have to be in the office?

No. While the visit will typically be in the office, it may also be in the patient's home or another location where the patient resides.

Effective January 1, 2014, you may furnish CPT codes 99495 and 99496 through telehealth. Medicare will pay for a limited number of Part B services furnished by a physician or practitioner to an eligible beneficiary via a telecommunication system. For the eligible telehealth services, the use of telecommunication systems substitutes for an in-person encounter.

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What happens if the patient is re-admitted before the 30 days expire?

The face-to-face visit would become the appropriate level E/M code for the service that was provided. You would start over your 30 days of service on the TCM once the patient was discharged.

Do you have to be a primary care physician to bill TCM services?

No. Neither CPT nor Medicare restricts use of the TCM codes to specific specialties. Likewise, qualified NPPs may also bill these services.

What time period does a TCM code cover?

The 30-day TCM service period begins on the day of discharge and continues for the next 29 days.

What diagnosis code(s) do I use when reporting TCM?

Report the diagnosis code(s) for the conditions that require TCM services. Typically, these will be the conditions the patient had at the time of discharge, which represents the start of TCM.

When do I bill for TCM?

You should submit your bill on the 30th day post-discharge. TCM covers 30 days of management services with one evaluation service bundled in to the code. The date of service on the claim would be the 30th day post-discharge.

Will these services be subject to co-insurance and deductible under Medicare?

Yes.

What are the coding limitations associated with TCM?

A physician or other qualified health care professional who reports codes 99495 or 99496 may not report the following codes during the time period covered by the TCM services codes:

- Care plan oversight services (99339, 99340, 99374-99380)
- Home health or hospice supervision: HCPCS codes G0181 and G0182
- Prolonged services without direct patient contact (99358, 99359)
- Anticoagulant management (99363, 99364)
- Medical team conferences (99366-99368)
- Education and training (98960-98962, 99071, 99078)
- Telephone services (98966-98968, 99441-99443)
- End stage renal disease services (90951-90970)
- Online medical evaluation services (98969, 99444)
- Preparation of special reports (99080)
- Analysis of data (99090, 99091)
- Complex chronic care coordination services (99487, 99489)
- Medication therapy management services (99605-99607)
- Chronic care management (CCM) services unless (a) the TCM service period ends before the end of a given calendar month, and (b) the time requirements for CCM services are subsequently met during that month (99490)

What is required to document in the beneficiary's medical record?

At a minimum, the following is required to document in the beneficiary's medical record:

- Date the beneficiary was discharged
- Date you made interactive contact with the beneficiary and/or caregiver
- Date you provided the face-to-face visit
- Complexity of medical decision making (moderate to high)