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KNOWLEDGE • RESOURCES • TRAINING

Transitional Care Management Services

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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What's Changed?

- Added codes health care professionals can bill concurrently with Transitional Care Management services
- Added language about auxiliary personnel providing services under supervision

You'll find substantive content updates in dark red font.

Introduction

This booklet outlines transitional care services during the "30-day period," which begins when a physician discharges the patient from an inpatient stay and continues for the next 29 days. Medicare may cover these services to help a patient transition back to a community setting after a stay at certain facility types.

This booklet focuses on covered services, location, who may provide services, supervision, billing services, documenting services, and service benefits.

In this booklet, **you** refers to physicians or health care professionals providing TCM services.

TCM Services Requirements

Required patient TCM services include:

- Supporting the patient's transition to the community setting
- Health care professionals who accept patient care at post-facility discharge without a service gap
- Health care professionals taking responsibility for patient's care
- Moderate or high complexity medical decision making for patients who have medical or psychosocial problems

The 30-day TCM period begins on a patient's inpatient discharge date and continues for the next 29 days. TCM services begin the day of discharge from 1 of these inpatient or partial hospitalization 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

After inpatient discharge, the patient must return to their community setting. These could include:

- Home
- Domiciliary
- Nursing home
- Assisted living facility

Health Care Professionals Who May Provide TCM Services

The following list of health care practitioners must provide the services associated with the TCM face-to-face visit and can supervise auxiliary personnel, which includes clinical staff:

- Physicians (any specialty)
- Non-Physician Practitioners (NPPs) legally authorized and qualified to provide the services in the state where they practice:
  - Certified Nurse-Midwives (CNMs)
  - Clinical Nurse Specialists (CNSs)
  - Nurse Practitioners (NPs)
  - Physician Assistants (PAs)

CNMs, CNSs, NPs, and PAs may provide non-face-to-face TCM services incident to services of a physician and other CNMs, CNSs, NPs, and PAs.

Supervision

The TCM codes are care management codes. As care management codes, auxiliary personnel may provide the non-face-to-face services of TCM under the general supervision of the physician or NPP subject to applicable state law, scope of practice, and the Medicare Physician Fee Schedule (PFS) "incident to" rules and regulations.

CNMs, CNSs, NPs, and PAs may also provide the non-face-to-face services of TCM incident to the services of a physician.

TCM Components

When a patient is discharged from an approved inpatient setting, you **must** provide at least these TCM components over the course of the 30-day service period:

An Interactive Contact

Within 2 business days following the patient's discharge, you must contact the patient or their caregiver via phone, email, or face-to-face. You or your "clinical staff" (A person who works under the supervision of a physician or other qualified health care professional and is allowed by law, regulation, and facility policy to perform or assist in the performance of a specialized professional service, but who doesn't individually report that professional service) can address patient status and needs beyond scheduling follow-up care. Get more information about interactive contacts in the CPT Codebook at the American Medical Association Store.

Report the service if you make 2 or more unsuccessful separate attempts in a timely manner. Document your attempts in the medical record if you meet all other TCM criteria. Continue trying

to communicate with the patient until successful. If the face-to-face visit isn't within the required timeframe, you can't bill TCM services (see the Face-to-Face Visit section).

More resources are available to help you understand and identify disparities that may affect TCM:

- Building an Organizational Response to Health Disparities — Resources and concepts for improving equity and responding to disparities. Concepts include data collection, data analysis, culture of equity, quality improvement, and interventions
- Guide to Reducing Disparities in Readmissions — An overview and case studies of key care coordination and readmission issues and strategies for racially and ethnically diverse Medicare patients

Certain Non-Face-to-Face Services

You must provide patient non-face-to-face services, unless you determine they aren't medically indicated or needed. Clinical staff under your direction may provide certain non-face-to-face services.

Services Provided by Physicians or NPPs

Physicians or NPPs may provide these non-face-to-face services:

- Review discharge information (for example, discharge summary or continuity-of-care documents)
- Review the patient's need for, or follow-up on, pending diagnostic tests and treatments
- Interact with other health care professionals who may assume or reassume care of the patient's system-specific problems
- Educate the patient, family, guardian, or caregiver
- Establish or re-establish referrals and arrange needed community resources
- Help schedule required community providers and services follow-up

TCM Services Provided By Auxiliary Personnel Under Physician or NPP General Supervision

Auxiliary personnel may provide the following non-face-to-face TCM services under general supervision at any time during the 30-day TCM service period:

- Communicate with the patient
- Communicate with agencies and community service providers that the patient uses
- Educate the patient, family, guardian, or caregiver to support self-management, independent living, and activities of daily living
- Assess and support treatment adherence including medication management
- Identify available community and health resources
- Help the patient and family access needed care and services

Face-to-Face Visit

You must provide 1 face-to-face visit within the timeframes described by these 2 CPT codes:

- **CPT Code 99495** — Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 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
- **CPT Code 99496** — Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision making of high complexity during the service period; Face-to-face visit, within 7 calendar days of discharge

You shouldn't report the TCM face-to-face visit separately.

The 2021 Medicare Physician Fee Schedule Final Rule revised TCM billing requirements, allowing you to bill additional codes concurrently with TCM codes. See Table 1 for details.

Table 1. HCPCS Codes That Can be Billed Concurrently

HCPCS Code	Descriptor
90951	ESRD related services with 4 or more face-to-face visits per month; for patients <2 years of age
90954	ESRD related services with 4 or more face-to-face visits per month; for patients 2–11 years
90955	ESRD related services with 2–3 face-to-face visits per month; for patients 2–11 years
90956	ESRD related services with 1 face-to-face visit per month; for patients 2–11 years
90957	ESRD related services with 4 or more face-to-face visits per month; for patients 12–19 years
90958	ESRD related services with 2–3 face-to-face visits per month; for patients 12–19 years
90959	ESRD related services with 1 face-to-face service per month; for patients 12–19 years
90960	End Stage Renal Disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90961	ESRD related services monthly with 2–3 face-to-face visits, for patients 20 years of age and older, by a physician or other qualified health care professional per month

Table 1. HCPCS Codes That Can be Billed Concurrently (cont.)

HCPCS Code	Descriptor
90962	ESRD related services monthly with 1 face-to-face visit for patients 20 years and older, by a physician or other qualified health care professional per month
90963	ESRD related services for home dialysis per full month; for patients <2 years of age
90964	ESRD related services for home dialysis per full month; for patients 2–11 years
90965	ESRD related services for home dialysis per full month; for patients 12–19 years
90966	ESRD related services for home dialysis per full month; for patients 20 years of age and older
90967	ESRD related services for home dialysis per full month; per day; for patients <2 years of age
90968	ESRD related services for home dialysis per full month; per day; for patients 2–11 years
90969	ESRD related services for home dialysis per full month; per day; for patients 12–19
90970	ESRD related services for dialysis less than a full month of service; per day; for patient 20 years of age and older
93792	Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results
93793	Anticoagulant management for a patient taking warfarin; must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed) and scheduling of additional test(s) when performed
99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
99358	Prolonged Evaluation and Management (E/M) service before and/or after direct patient care; first hour, non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged services

Table 1. HCPCS Codes That Can be Billed Concurrently (cont.)

HCPCS Code	Descriptor
99359	Prolonged E/M service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)
99487	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99489	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month
99491	Chronic care management services provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored

Table 1. HCPCS Codes That Can be Billed Concurrently (cont.)

HCPCS Code	Descriptor
G0181	Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more
G0182	Physician supervision of a patient under a medicare-covered hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more
G2058	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

Telehealth Services

You may provide CPT codes 99495 and 99496 via telehealth. Medicare pays for a limited number of Part B services you provide an eligible patient via a telecommunications system. Using eligible telehealth services substitutes for an in-person encounter. Find more information about eligible services in the Telehealth Services booklet.

Medical Decision Making

Medical decision making refers to a complex diagnosis and selecting a management option by considering these factors:

- Number of possible diagnoses and management options
- Amount and complexity of medical records, diagnostic tests, and other information you must get, review, and analyze
- Risk of significant complications, morbidity, and mortality as well as comorbidities associated with the patient's problem(s), the diagnostic procedure(s), and the possible management options

Table 2 shows the elements for each medical decision-making level. Your service must meet or exceed 2 of the 3 elements to qualify for a given type of medical decision making.

Table 2. Elements for Each Medical Decision-Making Level

Decision Type	Diagnoses & Management Options Possible	Data Amount & Complexity	Significant Complications, Morbidity, & Mortality Risk
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Find more information about medical decision making on the Evaluation and Management: Billing Correct Level of Service webpage.

Medication Reconciliation & Management

You must provide medication reconciliation and management on or before the face-to-face visit date.

Billing TCM Services

This list offers TCM services billing tips:

- Only 1 physician or NPP may report TCM services.
- Report services once per patient during the TCM period.
- The same health care professional may discharge the patient from the hospital, report hospital or observation discharge services, and bill TCM services. The required face-to-face visit can't take place on the same day you report discharge day management services.
- Report reasonable and necessary Evaluation and Management (E/M) services (except required face-to-face visit) to manage the patient's clinical issues separately.
- You can't bill TCM services and services within a post-operative global surgery period (Medicare doesn't pay TCM services if any of the 30-day TCM period falls within a global surgery period for a procedure code billed by the same practitioner).
- At a minimum, document this information in the patient's medical record:
  - Patient discharge date
  - Patient or caregiver first interactive contact date
  - Face-to-face visit date
  - Medical complexity decision making (moderate or high)

Billing TCM Services FAQs

Find more information on billing in the FAQs about Billing the PFS for TCM Services.

Resources

- Evaluation & Management Visits
- Telehealth Services Webpage