



National Hospice and Palliative Care Organization
Palliative Care Resource Series

TRANSITIONAL CARE MANAGEMENT

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The Centers for Medicare and Medicaid Services established new codes and a new Medicare benefit for transitional care management (TCM) in 2013. Its intent is to help prevent hospital readmissions, and covers the day of discharge from an inpatient admission through the next 29 days. Only one physician can bill, and two CPT codes are provided. The details are described below.

WHO CAN PROVIDE TCM?

1. Physicians (any specialty)
2. The following non-physician practitioners (NPP) who are legally authorized and qualified to provide the services in the State in which they are furnished:
 - Certified nurse-midwives
 - Clinical nurse specialists
 - Nurse practitioners
 - Physician assistants

TCM MAY BE PROVIDED AFTER DISCHARGE FROM:

- 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

BENEFICIARY MUST BE RETURNED TO A COMMUNITY SETTING SUCH AS:

- His or her home
- His or her domiciliary
- A rest home or
- Assisted living

TCM COMPONENTS

During the 30 days beginning on the date the beneficiary is discharged from a hospital inpatient setting, the following three TCM components must be furnished:

1. An interactive contact;
2. Certain non-face-to-face services; and
3. A face-to-face visit

COMPONENT #1: INTERACTIVE CONTACT

- An interactive contact must be made with the beneficiary and/or caregiver, as appropriate, within 2 business days following the beneficiary's discharge to the community setting.
- The contact may be via telephone, e-mail, or face-to-face.
- For Medicare purposes, attempts to communicate should continue after the first two attempts in the required **2 business days** until they are successful. A successful attempt requires a direct exchange of information and appropriate medical direction by clinical staff with the beneficiary and/or caregiver.
 - ◆ not merely receipt of a voicemail or e-mail without response from the beneficiary and/or caregiver.
 - ◆ TCM may not be billed if there was no successful communication within the 30-day period between the facility discharge and the date of service for the post-discharge TCM code.

COMPONENT #2: NON-F2F SERVICE, PHYSICIAN OR NPP MAY PROVIDE

1. Obtain and review discharge information (for example, discharge summary or continuity of care documents).
2. Review need for or follow-up on pending diagnostic tests and treatments.
3. Interact with other health care professionals who will assume or reassume care of the beneficiary's system-specific problems.
4. Provide education to the beneficiary, family, guardian, and/or caregiver.
5. Establish or re-establish referrals and arrange for needed community resources.
6. Assist in scheduling required follow-up with community providers and services.

COMPONENT #2: NON-F2F SERVICE, LICENSED CLINICAL STAFF* MAY PROVIDE

1. Communicate with agencies and community services used by the beneficiary.
2. Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living.
3. Assess and support treatment regimen adherence and medication management.
4. Identify available community and health resources.
5. Assist the beneficiary and/or family in accessing needed care and services.

*Beginning 1/1/15, general supervision is acceptable for the non-F2F services; all other incident-to criteria must be met

COMPONENT #3: FACE-TO-FACE ENCOUNTER

CPT Code 99495 – Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge).

- \$175.46 Medicare allowable

CPT Code 99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)

- \$242.30 Medicare allowable

TCM DOCUMENTATION

Document the following information, **at a minimum**, in the beneficiary's medical record:

- Date the beneficiary was discharged;
- Date you made an interactive contact with the beneficiary and/or caregiver;
- Date you furnished the face-to-face visit; and
- The complexity of medical decision making (moderate or high).

TCM FAQs

1. What date of service should be used on the claim?

The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The reported date of service should be the 30th day.

2. What place of service should be used on the claim?

The place of service reported on the claim should correspond to the place of service of the required face-to-face visit.

3. During the 30 day period of TCM, can other medically necessary billable services be reported?

Yes, other reasonable and necessary Medicare services may be reported during the 30 day period, with the exception of those services that cannot be reported according to CPT guidance and Medicare HCPCS codes G0181 and G0182.

CODING TCM

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

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

Resources and Links

- [Transitional-Care-Management-Services-Fact-Sheet-ICN908628](#)
- [Calendar Year 2013 Medicare Physician Fee Schedule Final Rule](#)

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