Transitional Care Management (TCM)

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The purpose of this memo is to clarify the requirements for billing and documentation to be followed that support the use of these codes.

Effective Jan 1, 2013, the AMA has established 2 new CPT codes, 99495 and 99496, for Transitional Care Management (TCM). These services are for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care **from an inpatient hospital setting** (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital or skilled nursing facility/nursing facility, **to the patient's community setting** (home, domiciliary, rest home or assisted living).

The primary driver in creating two new CPT Transitional Care Management (TCM) codes has been to improve care coordination and to prevent emergency department visits and re-hospitalizations during the first 30 days after discharge.

99495 – Transitional Care Management Services with the following requirements;

- 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 requirements;

- 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

What does this mean to you?

- TCM commences upon date of discharge and continues for the next 29 days.
- Interactive contact with the patient or caregiver within 2 business days of discharge, which may be direct (face-to-face), telephonic or by electronic means.
- A face-to-face visit within one of the specified time frames as stated above. This face-to-face visit is included in the TCM and not reported separately. Additional E/M services after the first face-to-face visit may be reported separately.
- Medical Necessity complexity (MDM) is based on E/M guidelines definitions, which refer to number of diagnoses and management options, amount of date to be reviewed, complexity of that data and risk of significant complications.
- Medical reconciliation and management must occur no later than the date of the face-to-face visit.
- Reported only once per patient within 30 days of discharge.
- May only be reported by one individual.
    - Apart from primary care physicians who would be billing for most of these services, specialists who provide necessary services can also bill these CPT codes.
- The physician who reports a global procedure is not permitted to use these codes.

On August 21, 2013, CMS issued FAQs for physicians interested in billing the Transitional Care Management (TCM) codes. For a full list of FAQ's – access the tip sheet on the CMS.gov website.

FAQ

- **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.

- **If the patient is readmitted in the 30-day period, can TCM still be reported?**
  - Yes, TCM services can still be reported as long as the services described by the code are furnished by the practitioner during the 30-day period, including the time following the second discharge. Example, the practitioner can bill for TCM services following the second discharge for a 30-day period as long as no other provider bills the service for the first discharge. CPT guidance for TCM services state that that only one individual may report TCM services and only one per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within 30 days.

- **Can TCM services be reported if the beneficiary dies prior to the 30th day following discharge?**
  - Because the TCM codes describe 30 days of care, in cases when the beneficiary dies prior to the 30th day, practitioners should not report TCM services but may report any face-to-face visits that occurred under the appropriate evaluation and management (E/M) code.

- **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. (reference CPT book or Encoder for detailed list)

- **If a patient is discharged on Monday at 4:30, does Monday count as the first business day and then Tuesday as the second business day, meaning that the communication must occur by close of business on Tuesday? Or, would the provider have until the end of the day on Wednesday?**
  - In the scenario described, the practitioner must communicate with the patient by the end of the day on Wednesday, the second business day following the day of discharge.

- **Medicare will only pay one physician or qualified practitioner for TCM services per beneficiary per 30 day period following a discharge. If more than one practitioner reports TCM services for a beneficiary, how will Medicare determine which practitioner to pay.**
  - Medicare will only pay the first eligible claim submitted during the 30 day period that commences with the day of discharge. Other practitioners may continue to report other reasonable and necessary services, including other E/M services, to beneficiaries during those 30 days.

Resources:
www.cms.gov/Medicare/Medicare-Fee-for-Service.../FAQ-TCMS.pdf
http://codingpro.decisionhealth.com (April 2013/Volume 19/ No 4) (May 2013 Tip Sheet)