

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Transitional Care Management Services

This publication provides the following information:

- Transitional Care Management (TCM) services;
- Health care professionals who may furnish TCM services;
- TCM services settings;
- Components included in TCM;
- Billing TCM services;
- Frequently Asked Questions; and
- Resources.

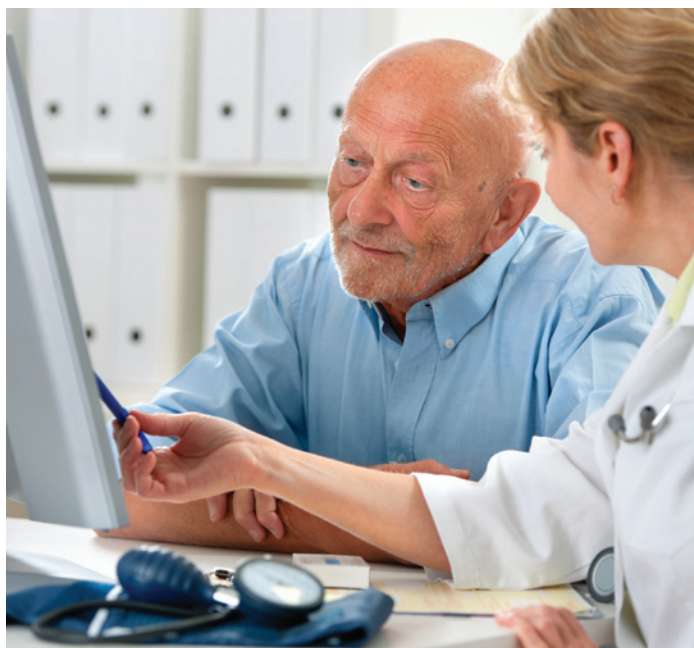
TCM SERVICES

The requirements for TCM services include:

- The services are required during the beneficiary's transition to the community setting following particular kinds of discharges;
- The health care professional accepts care of the beneficiary post-discharge from the facility setting without a gap;
- The health care professional takes responsibility for the beneficiary's care; and
- The beneficiary has medical and/or psychosocial problems that require moderate or high complexity medical decision making.

The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days.

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HEALTH CARE PROFESSIONALS WHO MAY FURNISH TCM SERVICES

The following health care professionals may furnish TCM services:

- Physicians (any specialty); and
- 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; and
 - Physician assistants.

When “you” is used in this publication, we are referring to these health care professionals.

TCM SERVICES SETTINGS

TCM services are furnished following the beneficiary’s discharge from one of the following inpatient 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; and
- Partial hospitalization at a Community Mental Health Center.

Following discharge from one of the above settings, the beneficiary must be returned to his or her community setting, such as:

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



COMPONENTS INCLUDED IN TCM

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:

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

Each component is discussed in more detail on pages 3 and 4.



AN INTERACTIVE CONTACT

You must make an interactive contact 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 and not merely receipt of a voicemail or e-mail without response from the beneficiary and/or caregiver. You may not bill the TCM 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.

CERTAIN NON-FACE-TO-FACE SERVICES

You must furnish non-face-to-face services to the beneficiary, unless you determine that they are not medically indicated or needed. Certain non-face-to-face services may be furnished by licensed clinical staff under your direction.

Services Furnished by Physicians or NPPs

You may furnish the following non-face-to-face services:

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

Services Furnished by Licensed Clinical Staff Under the Direction of a Physician or NPP

Licensed clinical staff under your direction may furnish the following face-to-face services:

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

A FACE-TO-FACE VISIT

One face-to-face visit must be furnished within certain timeframes as described by the following two new Current Procedural Terminology (CPT) codes (effective for services furnished on or after January 1, 2013):

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

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

The face-to-face visit is part of the TCM service and is not reported separately.

Medical Decision Making

Medical decision making is determined by considering the following factors:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient’s presenting problem(s), selecting the diagnostic procedure(s), and/or selecting the possible management options.

The table below shows the elements for each level of medical decision making. Note that to qualify for a given type of medical decision making, two of the three elements must be either met or exceeded.

Elements for Each Level of Medical Decision Making

Type of Decision Making	Number of Possible Diagnoses and/or Management Options	Amount and/or Complexity of Data to Be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

For more information about medical decision making, please refer to the “1995 Documentation Guidelines for Evaluation and Management Services” located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf> or the “1997 Documentation Guidelines for Evaluation and Management Services” located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Medication Reconciliation and Management

Medication reconciliation and management must be furnished no later than the date you furnish the face-to-face visit.

BILLING TCM SERVICES

Information about billing TCM services is provided below:

- Only one health care professional may report TCM services;
- Report services once per beneficiary during the TCM period;

- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day discharge day management services are reported;
- Reasonable and necessary evaluation and management (E/M) services (other than the required face-to-face visit) to manage the beneficiary’s clinical issues should be reported separately;
- You may not bill TCM services and services that are within a post-operative global period (TCM services cannot be paid if any of the 30-day TCM period falls within a global period for a procedure code billed by the same practitioner);
- When you report CPT codes 99495 and 99496 for Medicare payment, you may not also report the following codes during the TCM period:
 - Care plan oversight services: Healthcare Common Procedure Coding System (HCPCS) codes G0181 and G0182; and
 - End-Stage Renal Disease services: CPT codes 90951 – 90970; and
- You must 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).



FREQUENTLY ASKED QUESTIONS

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.

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.

If the codes became effective on January 1, 2013, and, in general, cannot be billed until 29 days past discharge, will claims submitted before January 29, 2013, with the TCM codes be denied?

Because the TCM codes describe 30 days of services and because the TCM codes are new codes beginning on January 1, 2013, only 30-day periods beginning on or after January 1, 2013, are payable. Thus, the first payable date of service for TCM services is January 30, 2013.

The CPT book describes services by the physician’s staff as “and/or licensed clinical staff under his or her direction.” Does this mean only registered nurses and licensed practical nurses or may medical assistants also provide some parts of the TCM services?

Medicare encourages practitioners to follow CPT guidance in reporting TCM services. Medicare requires that when a practitioner bills Medicare for services and supplies commonly furnished in physician offices, the practitioner must meet the “incident to” requirements described in Chapter 15, Section 60, of the “Medicare Benefit Policy Manual” (Publication 100-02) located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf> on the CMS website.

Can the services be provided in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)?

While FQHCs and RHCs are not paid separately by Medicare under the Medicare Physician Fee Schedule (PFS), the face-to-face visit component of TCM services could qualify as a billable visit in a FQHC or RHC. Additionally, physicians or other qualified providers who have a separate Fee-For-Service practice when not working at the RHC or FQHC may bill the CPT TCM codes, subject to the other existing requirements for billing under the PFS.

If the beneficiary is readmitted within 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. Alternatively, the practitioner can bill for TCM services following the second discharge for a full 30-day period as long as no other provider bills the service for the first discharge. CPT guidance for TCM services states that only one individual may report TCM services and only once per beneficiary within 30 days of discharge. Another TCM may not be reported by any practitioner 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 E/M code.

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.

Can TCM services be reported under the primary care exception? Can the services be reported with the -GC modifier?

TCM services are not on the primary care exception list, so the general teaching physician policy applies as it would for E/M services not on the list. When a physician (or other appropriate billing provider) places the -GC modifier on the claim, he or she is certifying that the teaching physician has complied with the requirements in Chapter 12, Sections 100.1 through 100.1.6, of the "Medicare Claims Processing Manual" (Publication 100-04) located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> on the CMS website.

Can practitioners under contract to the physician billing for the TCM service furnish the non-face-to-face component of the TCM?

Physician offices should follow "incident to" requirements for Medicare billing. "Incident to" recognizes numerous employment arrangements, including contractual arrangements, when there is direct physician supervision of auxiliary personnel. This issue is addressed in greater detail in Chapter 15, Section 60, of the "Medicare Benefit Policy Manual" (Publication 100-02) located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf> on the CMS website.

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.

If a beneficiary is discharged on Monday at 4:30 p.m., 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 beneficiary by the end of the day on Wednesday, the second business day following the day of discharge.


Can TCM services be reported when furnished in the outpatient setting?

Yes. CMS has established both a facility and non-facility payment for this service. Practitioners should report TCM services with the place of service appropriate for the face-to-face visit.

RESOURCES

The table below provides TCM resource information.

Transitional Care Management Resources

For More Information About...	Resource
Transitional Care Management Services	Calendar Year 2013 Medicare Physician Fee Schedule Final Rule http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf on the U.S. Government Printing Office website
Evaluation and Management Services	Medicare Learning Network® (MLN) publication titled “Evaluation and Management Services Guide” http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval_mgmt_serv_guide-ICN006764.pdf on the CMS website
All Available MLN Products	“Medicare Learning Network® Catalog of Products” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right 
Provider-Specific Medicare Information	MLN publication titled “MLN Guided Pathways to Medicare Resources Provider Specific Curriculum for Health Care Professionals, Suppliers, and Providers” booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Beneficiaries	http://www.medicare.gov on the CMS website



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