mln Booklet
KNOWLEDGE • RESOURCES • TRAINING

Transitional Care Management Services

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
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What's Changed?

- No substantive content updates.

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

Medicare may cover transitional care services during the **30-day period** that begins when a physician discharges a Medicare patient from an inpatient stay and continues for the next 29 days. These services help eligible patients transition back to a community setting after a stay at certain facility types.

Transitional Care Management Services Requirements

Required patient transitional care management (TCM) services include:

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

The 30-day TCM period begins the day the patient is discharged from 1 of these inpatient or partial hospitalization settings and continues for the next 29 days:

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

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

- Home
- Domiciliary (like a group home or boarding house)
- Nursing facility
- Assisted living facility

Who Can Provide TCM Services?

TCM services include both face-to-face visits and non-face-to-face services. These health care practitioners can provide services associated with face-to-face TCM services and can supervise auxiliary personnel (including 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

TCM codes are care management codes. Auxiliary personnel may assign them for TCM non-face-to-face services under the general supervision of the physician or NPP subject to applicable state law, scope of practice, and the Medicare Physician Fee Schedule incident to rules and regulations.

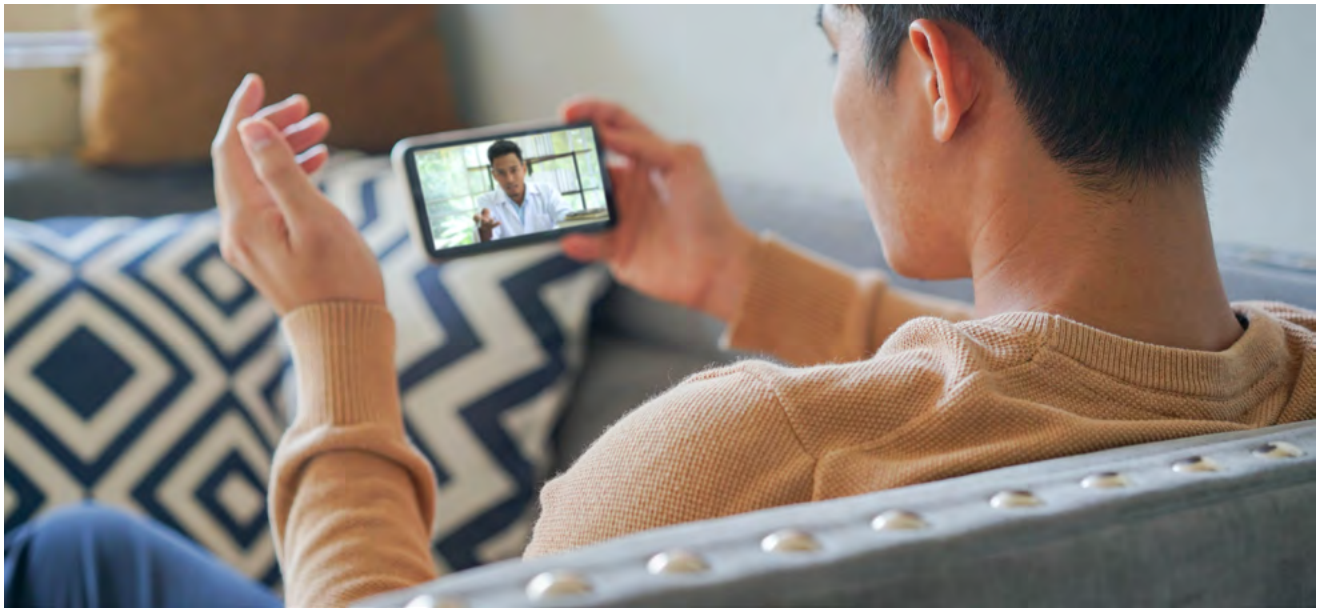
CNMs, CNSs, NPs, and PAs may also provide the non-face-to-face TCM services incident to the physician's services.

TCM Components

When a patient discharges from an approved inpatient setting, provide at least these TCM components during the 30-day service period:

Interactive Contact

- You (or clinical staff under your direction) must contact the patient or their caregiver by phone, by email, or face-to-face within 2 business days after the patient's discharge from the inpatient or partial hospitalization setting
  - "Clinical staff" means someone who's supervised by a physician or other qualified health care professional and is allowed by law, regulation, and facility policy to perform or assist in a specialized professional service but doesn't individually report that professional service
- The interactive contact must be performed by clinical staff who can address patient status and needs beyond scheduling follow-up care
- You may report the service if you make 2 or more unsuccessful separate contact attempts in a timely manner (and if you meet the other service requirements, including a timely face-to-face visit)
- Document your attempts in the patient's medical record
- Continue trying to contact the patient until you're successful
- If the face-to-face visit isn't within the required timeframe, you can't bill TCM services (see the face-to-face section)



Non-Face-to-Face Services

- You and your clinical staff (as appropriate) must provide patients with medically reasonable and necessary non-face-to-face services within the 30-day TCM service period
- Clinical staff under your direction may provide certain non-face-to-face services

Physician or NPP Non-Face-to-Face Services

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, 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 reestablish referrals and arrange needed community resources
- Help schedule required community providers and services follow-up

Auxiliary Personnel Under Physician or NPP General Supervision Non-Face-to-Face Services

Auxiliary personnel may provide these non-face-to-face TCM services under general supervision:

- Communicate with the patient
- Communicate with agencies and community service providers 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:

- **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 At least moderate level of medical decision making 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 High level of medical decision making during the service period Face-to-face visit, within 7 calendar days of discharge

Don't report the TCM face-to-face visit separately.

Telehealth Services

You can provide CPT codes 99495 and 99496 through telehealth. We pay for a limited number of Part B services that you provide to an eligible patient using a telecommunications system.

Medication Reconciliation & Management

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

TCM Concurrent Billing

You can bill certain other care management services concurrently with TCM services when medically reasonable and necessary and if time and effort aren't counted more than once. See the following table for commonly used codes.

Table: HCPCS Codes You Can Bill Concurrently

HCPCS Code	Descriptor
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month

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HCPCS Code	Descriptor
90953	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90955	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90956	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month

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HCPCS Code	Descriptor
90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
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	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older
90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age

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HCPCS Code	Descriptor
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 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
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment
98976	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
98977	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days

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HCPCS Code	Descriptor
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)
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 service before and/or after direct patient care; first hour
99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes

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HCPCS Code	Descriptor
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)
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 that 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 that 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 that 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

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HCPCS Code	Descriptor
99491	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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99439	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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 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)
G0181	Physician or allowed practitioner 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 or allowed practitioner development and/or revision of care plans
G0182	Physician supervision of a patient under a Medicare-approved 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

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Medical Decision Making

Patients who get TCM must need moderate medical decision making (if you're billing CPT code 99495) or high-level medical decision making (if you're billing CPT code 99496). The levels of medical decision making are defined in the 2023 CPT E/M Guidelines. Medical decision making, which refers to establishing diagnoses, assessing the status of a condition, and selecting a management option, is defined by 3 elements:

- **Problems:** The number and complexity of problems addressed during the encounter
- **Data:** The amount and complexity of data to be reviewed and analyzed, like medical records, diagnostic tests, and other information
- **Risk:** The risk of complications and morbidity or mortality of patient management

Billing TCM Services

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 E/M services (except the required face-to-face visit) to manage the patient's clinical issues separately.
- You **can't** bill TCM services within a post-operative global surgery period (we don't pay for 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 decision making (moderate or high)

Advance Health Equity

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. Topics include data collection, data analysis, culture of equity, quality improvement, and interventions.
- Guide for Reducing Disparities in Readmissions — Overview and case studies of key care coordination and readmission issues and strategies for racially and ethnically diverse Medicare patients.

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Resources

- 2013 Medicare Physician Fee Schedule Final Rule
- Care Management
- Evaluation & Management Visits
- Federally Qualified Health Center
- Information for Rural Health Clinics
- Rural Health Information Hub: Transitional Care Management

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