FAQ: Billing for Transitional Care Management (TCM) Services in Ambulatory Clinics

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Purpose

Hospital readmissions are common and costly. In an effort to contain costs, The Center for Medicare and Medicaid Services (CMS) developed the Transitional Care Management (TCM) codes. These codes were designed to reduce 30-day re-hospitalization through reimbursement for care management and care coordination services. The TCM codes, 99495 and 99496, became effective January 1, 2013.[1] The complex requirements for these billing codes initially limited their implementation, but CMS has since relaxed some of the requirements. This resource is intended to provide pharmacists with an overview of the requirements and examples of successful pharmacist involvement.

1. What is required to bill Transitional Care Management (TCM) codes?

The 30-day TCM period begins the day the patient is discharged from an inpatient setting and continues for the next 29 days. There are two TCM codes that can be utilized, 99495 and 99496. The codes require that the patient be discharged from an inpatient setting to a community setting (Table 1). There are specific non-face-to-face and face-to-face requirements that must be completed to bill for each of the TCM codes.[1,2]

Table 1: Qualifying transitions of care for TCM codes

From: Inpatient Setting	To: Community Setting
▪ 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	▪ Home ▪ Domiciliary (such as a group home or boarding house) ▪ Nursing Facility ▪ Assisted Living Facility

Non-face-to-face Requirements

A) Interactive Contact:

- To bill for either code, the provider or clinical staff MUST have an interactive communication (bi-directional telephone call, emails, texts, etc.) with the patient or caregiver within 2 business days of discharge. A minimum of 2 documented unsuccessful attempts also meets the criteria of completion of this requirement.

- This interactive communication may be conducted by licensed clinical staff under general supervision who can address patient status and needs beyond scheduling follow-up care. There is no exhaustive list of licensed clinical staff, but CMS has clarified that a pharmacist acting within their state's scope of practice would qualify as licensed clinical staff.[3]

B) The non-face-to-face services provided by clinical staff/clinical pharmacist through the interactive contact may include:

- Communication with the patient;
- Communication with agencies and community service providers;
- Education to the patient, family, guardian, or caregiver to support self-management, independent living, and activities of daily living;
- Assessment and support for treatment adherence, including medication management;
- Identification of available community and health resources;
- Helping the patient and family access needed care and services.[2]

Face-to-Face Requirements

- The patient must have a face-to-face visit with a physician or a qualified non-physician practitioner. Assuming the non-face-to-face interactive contact requirement was met, the timing of the visit and the level of medical decision-making are then utilized to determine whether the provider should submit the 99495 or 99496 code.

    - If the patient is seen within 14 calendar days of discharge and moderate complexity medical decision-making is documented, the 99495 CPT code may be billed.

    - If the patient is seen within 7 calendar days of discharge and high complexity medical decision-making is documented, the 99496 CPT code may be billed (Table 2).[2]

    - Medication reconciliation and management must be provided on or before the face-to-face visit date.

- The face-to-face portion of this service can be performed via telehealth as of the date of publication. For current telehealth eligible services, please check the CMS Telehealth Services List here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Table 2. Medical Decision-Making Complexity

Type of Decision Making	Elements (2 of 3 must be met)		
	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
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

2. When should TCM claims be submitted?

The TCM claim may be submitted on the date of the face-to-face visit.[2] TCM codes may only be paid once within a 30-day time frame. That means that only one provider can bill for the service, and if the patient is readmitted, a second TCM code may not be submitted within the same 30-day time frame. Also, the required face-to-face visit can't take place on the same day that the patient is reported as discharged.

3. Who is the billing provider on a TCM claim?

While pharmacists can furnish non-face-to-face services or portions of the face-to-face services as auxiliary personnel, pharmacists cannot serve as the billing provider on the TCM claim. The billing provider must be a physician or a qualified non-physician practitioner. Qualified non-physician practitioners are defined as certified nurse-midwives, clinical nurse specialists, nurse practitioners, or physician assistants.

4. Can other services be billed during the 30-day TCM service window?

Yes! The Medicare Physician Fee Schedules revised TCM billing requirements allowing additional codes to be billed concurrently.[2] The one limitation that remains is that TCM codes may not be billed within a post-operative global surgery period for a procedure code billed by the same practitioner. This does not apply if TCM services are provided by a different practitioner, such as a primary care provider.

Table 3. Previously Restricted Concurrent Billing Codes That Are Now Permitted

Code	Description of Service
G0181 and G0182	Home health or hospice supervision
90951-90970	End-Stage Renal Disease services
93792, 93793	Remote INR Monitoring
98975-98981	Remote Therapeutic Monitoring services
99453, 99454, 99457, 99458; 99091	Remote Physiologic Monitoring (RPM) services
99490, 99487, 99489, 99491, 99439	Chronic Care Management (CCM) services
99358 and 99359	Prolonged E/M Services Without Direct Patient Contact

5. What are the potential benefits of utilizing TCM codes?

The TCM codes provide favorable reimbursement rates compared to traditional evaluation and management codes. In addition, the codes provide higher work relative value units (Table 5).[4] Many practices can justify the pharmacist's involvement through increased reimbursement compared to traditional evaluation and management codes.

Table 4. TCM Reimbursement*

CPT Code	Non-Facility Price	Transitioned Non-FAC PE RVU	Comparator Evaluation and Management Code
99496	$272.68	4.40	99215 - $175.64 (Work RVU 3.79)
99495	$201.20	3.27	99214 - $125.18 (Work RVU 2.78)

***Based on the 2025 Physician Fee Schedule National Payment Amount**

In addition to the potential for increased reimbursement, TCM services may be able to demonstrate cost-savings through measurement of other metrics. TCM services may contribute to reductions in 30-day readmission rates and/or emergency department utilization.

6. Are there any pharmacists doing this now?

Yes! Pharmacists are successfully engaging in care teams to help provide transitional care management services. Below are a few examples of clinics that have established transitional care management services with pharmacists integrated into the workflow.

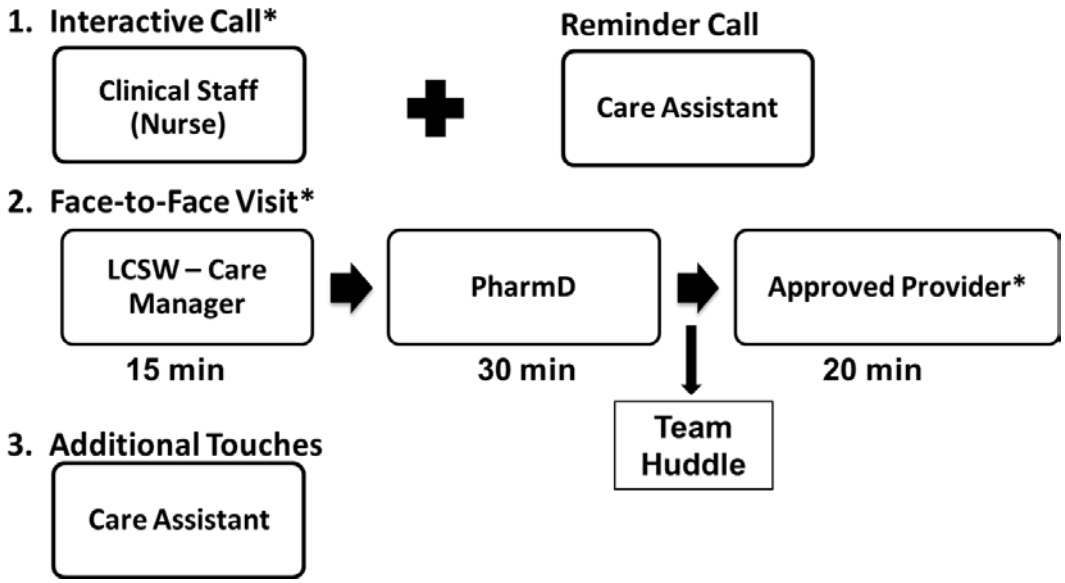
Example #1 - North Carolina UNC Internal Medicine Clinic

The University of North Carolina General Internal Medicine Clinic established a hospital follow-up, transition of care program in the winter of 2012. This program has been described elsewhere.[5,6] In brief, our program meets all of the TCM code requirements and is outlined in Figure 1. There are some components of our program that are not required for billing that we have found to be very useful, including reminder calls one business day prior to the visit.

We started billing the TCM codes in January of 2013 and have successfully received reimbursement from Medicare and some private insurers. If the code is denied, we resubmit using the appropriate traditional evaluation and management code.

Figure 1: Transitional Care Management Practice Example, University of North Carolina General Internal Medicine Clinic

*Required components for TCM claim



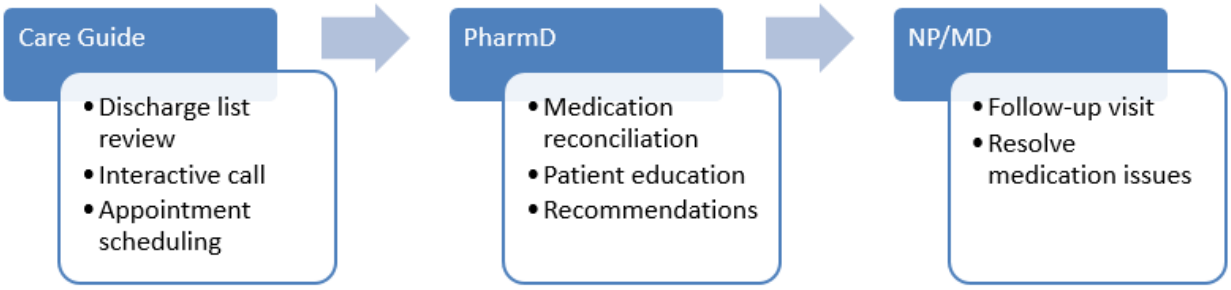
During the pilot phase, we measured the efficacy of our intervention through 30-day readmission rates. We demonstrated a reduction in 30-day readmission rates by approximately 65%.[5] This study was used to further justify the continuation of the program. In addition, the pharmacist involvement in the face-to-face visit was supported through a study comparing pharmacist involvement to no pharmacist involvement which demonstrated a 58% reduction in 30-day readmission rates.[6]

Beyond the pilot phase, we have established a monitoring program to facilitate continuous quality improvement. On a weekly basis, we monitor clinic access through the number of appointments scheduled and our no-show rate weekly. On a monthly basis, we measure the number of patients seen for a hospital follow-up visit within 7 days and within 14 days of hospital discharge and overall, 30-day readmission rate.

Example #2 – Utah Intermountain Healthcare Salt Lake Clinic Internal Medicine/Family Medicine

The internal medicine and family medicine practices located at the Intermountain Salt Lake Clinic established a robust transitional care management service in 2013. The service involves a care guide, pharmacist and provider as outlined in Figure 2. The program meets the TCM codes requirements and successfully obtains reimbursement.

Figure 2: Transitional Care Management Practice Example, Intermountain Salt Lake Clinic



The pharmacist's interaction is primarily conducted via telephone communication, but can be completed in person, if preferred by the patient. The ability to interact with the patient while at home with their medications has been particularly beneficial to accurately reconcile the medication list and identify/resolve drug therapy problems and medication access issues in a timely fashion, even before the hospital follow-up appointment.

With successful TCM billing since 2016, this service has proven valuable to the patients and clinicians at the Intermountain Salt Lake Clinic and serves as a model for similar implementations in other clinics within the system.

7. What are some tips for getting started?

- Determine what resources in the clinic will be a part of the transitional care management team.
- Consider opportunities for collaboration with social work, care navigators, behavioral science or other disciplines at the site.
- Once the team has been established, define roles for each member of the team keeping in mind the required elements that must be met for billing (see questions #1 and #2).

- Create a workflow for the service, including how the team will be notified of patients who meet the criteria for the service, who will be the first point of contact, how handoffs will occur, and the standards for documentation processes. Again, ensure that the workflow developed allows for completion of the required elements.

- Establish metrics to evaluate during the development phase of your program. Metrics might include those listed in the examples provided above, including 30-day readmission rates, emergency room utilization, number of appointments and no-show rates. Assessing the number and type of medication-related interventions should also be considered. Demonstration of medication-related interventions may help to solidify the benefit of a pharmacist as a part of the transitional care management team.

References

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