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What Practices Need to Know about Transition Care Management Codes

The new Physician Fee Schedule includes transition care management (TCM) codes that allow for reimbursement of the non-face-to-face care provided when patients transition from an acute care setting back into the community.

Two new codes will be used to pay for all services that up until now were done but not reimbursed.

CPT Code 99495 covers communication with the patient or caregiver within two business days of discharge. This can be done by phone, e-mail, or in person. It involves medical decision making of at least **moderate** complexity and a face-to-face visit within **14** days of discharge. The location of the visit is not specified. The work RVU is 2.11.

CPT Code 99496 covers communication with the patient or caregiver within two business days of discharge. This can be done by phone, e-mail, or in person. It involves medical decision making of **high** complexity and a face-to-face visit within **seven** days of discharge. The location of the visit is not specified. The work RVU is 3.05.

Although the Centers for Medicare and Medicaid Services may fine-tune the expectations for the services provided during the TCM time period, in addition to the above, the following required non-face-to-face services differ for staff and for the physician.

Clinical staff (under the supervision of a physician or other qualified clinician) may include:

- communicate with the patient or caregiver (by phone, e-mail, or in person),
- communicate with a home health agency or other community service that the patient needs,
- educate the patient and/or caregiver to support self-management and activities of daily living,
- provide assessment and support for treatment adherence and medication management,
- identify available community and health resources, and
- facilitate access to services needed by the patient and/or caregivers.

The physician or other qualified clinician may include:

- obtain and review discharge information,
- review need of or follow-up on pending testing or treatment,
- interact with other clinicians who will assume or resume care of the patient's system-specific conditions,
- educate the patient and/or caregiver,
- establish or re-establish referrals for specialized care, and
- assist in scheduling follow-up with other health services.

Since there is some overlap, such as education, it is expected that CMS will clarify the documentation requirements for the use of these codes. Once the requirements are known, ACP will provide additional tools and resources, but since the codes are effective now, we encourage all practices to bill them.

Here are some additional tips regarding use of these new codes:

- Medication reconciliation and management should happen no later than the face-to-face visit.
- The codes can be used following "care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospitalization, observation status in a hospital, or skilled nursing facility/nursing facility." [*Current Procedural Terminology*, 2013. American Medical Association.]

- The codes cannot be used with G0181 (home health care plan oversight) or G0182 (hospice care plan oversight) because the services are duplicative.
- Billing should occur at the conclusion of the 30-day post discharge period.
- They are payable only once per patient in the 30 days following discharge, thus if the patient is readmitted TCM cannot be billed again.
- Only one individual can bill per patient, so it is important to establish the primary physician in charge of the coordination of care during this time period. If there is a question, then it might be important to contact the other physician's office to clarify. The discharging physician should tell the patient which clinician will be providing and billing for the TCM services.
- The codes apply to both new and established patients.

For more details on the new codes and any further guidance from CMS on how to use them, go to ACP's Running a Practice webpage.