Compliance Alert
SIU SOM Office of Compliance and Ethics
Transitional Care Management

Transitional Care Management CPT Codes:

<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<td>99495</td>
<td>Transitional Care Management (TCM) Services with the following required elements: 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</td>
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<tr>
<td>99496</td>
<td>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, medical decision making of high complexity during the service period, face-to-face visit within 7 calendar days of discharge</td>
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What is transitional care management?
Transitional care management services are for a patient who’s medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting, partial hospital, observation status in a hospital, or a skilled nursing facility/nursing facility to the patient’s community setting.

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.
  - The date of service should be the date of the required face-to-face visit.

Health Care Professionals Who May Furnish TCM Services:
- Physicians (any specialty)
- The following non-physician practitioners (NPP) who are legally authorized to provide services within the State services are furnished:
  - Certified Nurse Midwives (CNM)
  - Clinical Nurse Specialists (CNS)
  - Nurse Practitioners (NP)
  - Physician Assistants (PA)
CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services “incident to” the services of a physician and other CNMs, CNSs, NPs, and PAs.

**Supervision:**
The required face-to-face visit must be furnished under a minimum of direct supervision and is subject to applicable State law, scope of practice, and the Medicare Physician Fee Schedule (PFS) “incident to” rules and regulations. The non-face-to-face services may be provided under general supervision. These services are also subject to applicable State law, scope of practice, and the PFS “incident to” rules and regulations. The practitioner must order services, maintain contact with auxiliary personnel, and retain professional responsibility for the service.

**Three TCM Components Must Be Furnished:**

1. **Interactive Contact**
   - Must be made with the beneficiary and/or caregiver within 2 business days following the beneficiary’s discharge to the community setting.
     - Contact may be via telephone, email, or face-to-face.
     - Can be provided by clinic staff under the direction of the physician or other qualified health care professional
   - Attempts to communicate should continue after the first two attempts in the required 2 business days until they are successful.
     - If two or more separate attempts are made in a timely manner and documented in the medical record but are unsuccessful, and if all other TCM criteria are met, the TCM service may be reported.

2. **Certain Non-face-to-face services**
   - Must furnish non-face-to-face services to the beneficiary, unless determined that they are not medically indicated or needed.
     - Clinical staff under direction may provide certain non-face-to-face services.

**Services Furnished by Physicians or NPPs**

- Obtain and review discharge information (ex: discharge summary or continuity of care documents)
- Review need for 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
- Assist in scheduling required follow-up with community providers and services

**Services Provided by Clinical Staff Under the Direction of a Physician or NPP**

- Communicate with agencies and community services the beneficiary uses
- Provide education to the beneficiary, family, guardian, and/or caregiver 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
• Assist the beneficiary and/or family in accessing needed care and services

3. A face-to-face visit
• Must furnish one face-to-face within certain timeframes as described by the Current Procedural Terminology (CPT) codes 99495 and 99496.
• The face-to-face visit is part of the TCM service and is not reported separately

Telehealth Services
• Effective 1/1/2014, TCM codes can be furnished through telehealth
• Medicare pays for a limited number of Part B services furnished by a physician or practitioner to an eligible beneficiary via a telecommunications system

Medication Reconciliation and Management
• Medication reconciliation and management must be furnished no later than the date of the face-to-face visit

Billing TCM Services:
• 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.
  o The required face-to-face visit may not take place on the same day you report discharge day management services.
    ▪ Following discharge, the beneficiary must be returned to his or her community setting (ex: his or her home, his or her domiciliary, a rest home or assisted living)
• Report reasonable and necessary E/M services (other than the required face-to-face visit) to manage the beneficiary’s clinical issues 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).

Codes that cannot be billed with TCM:
• Care plan oversight services;
• Home health or hospice supervision: G0181 and G0182;
• End-Stage Renal Disease services: 90951 – 90970;
• Chronic Care Management (CMM) services (CMM and TCM periods cannot overlap); and
• Prolonged E/M service without direct patient contact: 99358 and 99359.

Documentation Requirements:
Minimum documentation must include:
• Date the beneficiary was discharged;
- Date an interactive contact with the beneficiary and/or caregiver was made;
- Date the face-to-face visit was furnished; and
- The complexity of medical decision making (moderate or high).

**FQHC Transitional Care Management Guidelines:**
Transitional Care Management services can also be considered a RHC or FQHC visit. TCM services can be billed as a visit if it is the only medical service provided on that day with a RHC or FQHC practitioner, and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed. If it is the only medical service provided on that day with an RHC or FQHC practitioner, it is paid as a stand-alone billable visit.

RHCs and FQHCs can bill for qualified TCM services furnished by a RHC or FQHC practitioner.
- Must be furnished within 30 days of the date of the patient’s discharge from a hospital (including outpatient observation or partial hospitalization), SNF, or Community Mental Health Center (CMHC).
- Communication (direct contact, telephone, or electronic) with the patient or caregiver must commence within 2 business days of discharge, and a face-to-face visit must occur within 14 days of discharge for moderate complexity decision making (99495), or within 7 days of discharge for high complexity decision making (99496).
- The TCM visit is billed on the day that the TCM visit takes place, and only one TCM visit may be paid per beneficiary for services furnished during that 30 day post-discharge period. The TCM visit is subject to applicable copayments and deductibles. If the TCM visit occurs on the same day as another billable visit, only one visit may be billed.

**Sources:**
Current Procedural Terminology 2018
Transitional Care Management MLN Factsheet
Care Management Services in RHCs and FQHCs Frequently Asked Questions
Medicare Benefit Policy Manual – RHC and FQHC Update

Questions regarding this Compliance Alert can be directed to:
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<th>Author</th>
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<tr>
<td>February 7, 2018</td>
<td>Brooke Mullink</td>
<td>Initial Release</td>
<td>Mary A. Curry, Healthcare Compliance Officer</td>
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