PAYMENT

Reimbursement Tips:

FQHC Requirements for Medicare Transitional Care Management (TCM)

Transitional Care Management (TCM) supports the transition and coordination of services from an inpatient/acute care setting to a community setting by establishing a coordinated plan with the patient's primary care provider(s).

Program Requirements

Transitional Care Management (TCM) refers to the coordination of a Medicare patient's transition to a community setting after discharge from an acute care setting. As part of TCM, a practitioner provides or oversees the management and/or coordination of a patient's medical, psychological, and daily living needs following discharge from one of the following:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long-Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center

Patient Eligibility & Consent

Eligible patients are those transitioning from an inpatient hospital setting (i.e., acute, psychiatric, long-term care, skilled nursing, rehabilitation, or observation status) to their home, rest home, community mental health center, or assisted living facility. A practitioner must obtain consent before furnishing or billing for TCM. Consent may be verbal or written but must be documented in the medical record.

Timeframe & Services

TCM services may be offered within the 30-day period starting on the date when the beneficiary is discharged from inpatient care, continuing for the next 29 days. The components of TCM include:

Interactive Contact

Within two (2) days of discharge date, the provider initiates direct and interactive communication with the patient (i.e., phone, in person, electronic). Contact must be more than simply scheduling a follow-up appointment and it would typically address the type(s) of services the patient had during admission, what the discharge diagnosis was, and what follow-up services they may need.

If two or more reasonable but unsuccessful attempts are made to reach the patient within two days after discharge, and all other TCM criteria are met, the service may be reported (billed). Document all contact attempts. Continue attempts to communicate until successful.

Face-to-face Visit

Within either seven (7) or fourteen (14) days following discharge, a face-to-face visit is required. A patient whose condition warrants medical decision making of high complexity (99496) must be seen within seven days of discharge while one whose condition warrants moderately complex decision making (99495) must be seen within fourteen days. Medication reconciliation is required for patients on or before the date of the face-to-face TCM visit. Refer to either the 1995 Documentation Guidelines for Evaluation and Management Services or 1997 Documentation Guidelines for Evaluation and Management Services for more information about medical decision making scoring. Eligible telehealth services may be used in place of an in-person encounter for either of these services.

During the COVID-19 Public Health Emergency (PHE), CMS allows TCM to be provided as an audio-visual telehealth service. As it is on the CMS list of telehealth services, the current guidance is that it would be billed for using G2025 for the duration of the PHE when provided as an audio-visual telehealth service. It is recommended that health centers capture the actual CPT service code (e.g., 99495) for tracking purposes.

Note: Prior to the COVID-19 PHE, CMS allowed for TCM to be provided via telehealth and it was payable at a much higher rate, even if offered via telehealth. Since TCM codes are on the CMS list of approved telehealth services, it appears that they would need to be billed using G2025 thereby reducing the payment rate considerably. Unlike AWV, there is no statement from CMS that TCM will be paid at the current non-PHE Telehealth rate.

Non-Face-to-Face Services

Throughout the 30-day post-discharge time period, non-face-to-face services refer to the provider's activity to assess and inform the patient, other providers, caregivers and involved community services about the patient's health, care coordination needs, and education needs.

Non-face-to-face services must be provided unless determined not medically indicated or needed.

Initiating Visit

The three Transitional Care Management components (interactive contact, face-to-face visit, and non-face-to-face services) comprise the set of services that may be provided beginning on the day of discharge through day 30.

Authorized Provider/Staff

Only one qualified clinical provider may report TCM services for each patient following a discharge. The same provider who discharged the patient may report TCM services, but the required face-to-face visit cannot take place on the same day as the actual discharge. TCM codes are for new or established patients.

In **Medicare**, a new patient is one that has not been seen within the past three years by a FQHC provider covered by Medicare (dentists would not count as they are non-covered). This definition differs from the traditional CPT definition of a new patient. FQHCs may choose to use a single definition.

Face-to-face Visit. Required face-to-face time must be furnished under minimum direct supervision (supervision of auxiliary staff by billing practitioner).

Non-face-to-face Services. Non-face-to-face time may be furnished under general supervision (the billing practitioner provides overall direction and control, but their direct physical presence is not required during provision of services).

TREATING (BILLING) PROVIDER				
Physicians (MD or DO)	Non-Physician Practictioners			
	NP	PA	CNM	CNS
x	x	x	x	x

Medical Doctor (MD) and Doctor of Osteopathy (DO)

Non-Physician Practitioners include: Nurse Practitioners (NP), Physician Assistants (PA), Certified Nurse Midwives (CNM), Clinical Nurse Specialists (CNS).

All supervision requirements (regardless of CMS/ Medicare policy) are subject to applicable State law, licensure, and scope of practice definitions.

Documentation

TCM accounts for all services delivered and documented during the 30-day post-discharge period. For TCM visits conducted via audio-visual telehealth during the COVID-19 PHE, the provider would document in the medical chart that the visit was conducted in this manner. All other documentation requirements remain the same as before the COVID-19 PHE.

TCM Documentation Requirements

1. Date the beneficiary was discharged
2. Date of interactive contact with the beneficiary and/or caregiver
3. Date of the face-to-face visit
4. Complexity of medical decision making (moderate to high)

Face-to-Face Visit Documentation Requirements

The face-to-face visit does not have to meet typical Evaluation and Management (i.e., 99213) documentation requirements. In addition to minimum documentation requirements, clinical notes may include:

- Referrals made to other providers
- Identification of community resources available to the patient
- Any contacts made with other providers to coordinate care
- Continuing care instructions for family members who may be present
- Patient education materials given to the patient
- Labs and/or diagnostic tests performed (code separately)
- DME ordered or discontinued

Non-Face-to-Face Services Documentation Requirements

Non-face-to-face services may include:

- Obtaining and reviewing the discharge information (i.e. discharge summaries as available, or any continuity of care documents)
- Reviewing the need for, or following up on, pending diagnostic tests and treatments
- Interacting with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems
- Educating patient, family, guardian, and/or caregiver(s)
- Establishing or reestablishing referrals and arranging for needed community resources
- Assisting with the scheduling of follow-up with community providers and services

Coding & Billing

Claims for TCM services may be submitted when the requirements to bill for the services have been met, or any time after that within the timely filing requirement period, which is one year from the date of service.

Reimbursement Tips: FQHC Requirements for Medicare TCM

TCM is billed with **CPT code 99495 or 99496, either alone or with other payable services**. If it is the only service rendered by a FQHC practitioner, it is paid as a stand-alone billable service. If it is furnished on the same day as another Medicare PPS G code eligible service, only one service is paid.

Within the COVID-19 PHE *(Telehealth)*

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*What CMS pays (Physician Fee Schedule)*
99495	Moderate complexity medical decision making during the service period. Face-to-face visit, within *14* calendar days of discharge.	G2025	$99.45
99496	High complexity medical decision making during the service period.		

Notes: Rates here are based on the 2021 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI.

NOT Within the COVID-19 PHE *(Telehealth or Non-Telehealth)*

WHAT PROVIDER CODES	*Services*	*What FQHC bills to CMS*	*What CMS pays (Physician Fee Schedule)*
99495	Moderate complexity medical decision making during the service period. Face-to-face visit, within *14* calendar days of discharge.	99495	$207.96
99496	High complexity medical decision making during the service period.	99496	$281.59

Notes: Rates here are based on the 2021 Medicare Physician Fee Schedule (PFS); no Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied. FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI.

When reporting CPT codes 99495 and 99496 for Medicare payment, do not report:

- 93792: Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring
- 93793: Anticoagulant management
- 99487-99489/G0511: Any Chronic Care Management during the TCM period

If a FQHC provider performed surgery at a facility and that procedure had a global surgical period, a FQHC could not bill for TCM for transition from the facility.

Other commercial payers and Medicare Advantage plans may pay for TCM. Commercial payers may have different payment rates for each code. TCM services rendered by a FQHC for a Medicare beneficiary are subject to co-insurance.

References

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