



# 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 community setting (i.e., home, rest home, assisted living, including temporary or short-term settings such as hotel, hostel, or homeless shelter). 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 three TCM components include:

- Interactive Contact
- Face-to-Face Visit
- Non-Face-to-Face Services

## Interactive Contact

Within two (2) business days of discharge date, the physician, qualified health professional (QHP), or clinical staff have 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 (MDM) of high complexity during the service period (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 must occur no later than the date of the face-to-face visit. Refer to the 2023 MDM table for more information about medical decision making scoring.

During the COVID-19 Public Health Emergency (PHE), CMS allows TCM to be provided as an audio-visual telehealth service to a new or established patient. As it is on the [CMS list of telehealth services](#), it would be billed for using G2025 for the duration of the PHE when provided as an audio-visual telehealth service. Health centers must capture the actual CPT service code (e.g., 99495) for tracking purposes.

The PHE telehealth flexibilities for TCM will continue through December 31, 2024 after the PHE expires on May 11, 2023

## 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.

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### Initiating Visit

An initiating visit is not required for TCM.

Note: Transitional Care Management visits (CPT codes 99495 and 99496) are qualifying visits listed under PPS G0467 (FQHC visit, established patient) and are considered an Initiating Visit for other CMS general care management services.

### 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.

Under **Medicare**, a new patient is someone who has not received any Medicare-covered professional health service (medical or mental health) from any site within the FQHC organization, or from any practitioner within the FQHC organization, within the past 3 years from the date of service. Dental service would not count as dental is not covered by Medicare. This definition differs from the traditional CPT definition of a new patient. FQHCs are encouraged to educate staff of the variance and may choose to use a single definition.

**Face-to-face Visit.** A qualified FQHC practitioner must furnish the face-to-face portion of TCM services within the required time frame as determined by the MDM level. Any services qualifying as face-to-face, including during the interactive contact, which are provided by eligible clinical staff must be furnished under direct supervision of the billing practitioner. Direct supervision requires the supervising practitioner to be in the same building or immediately available.

**Non-face-to-face Services.** Non-face-to-face services may be furnished by the FQHC practitioner and/or licensed clinical staff, under the general supervision of the billing physician/practitioner. General supervision does not require the physical presence of the practitioner in the building, but it does require the services to be under the overall supervision and control of the practitioner. The non-face-to-face services eligible clinical staff may provide can be found under the Documentation section of this Reimbursement Tips.

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

TREATING (BILLING) PROVIDER				UNDER DIRECT OR GENERAL SUPERVISION
Physicians (MD or DO)	Non-Physician Practitioners			Licensed Clinical staff*
	NP	PA	CNM	CNS+, RN, LCSW, other licensed practitioner
X	X	X	X	X

*Physicians: Medical Doctor (MD) or Doctor of Osteopathy (DO)*

*Non-Physician Practitioners include: Nurse Practitioners (NP), Physician Assistants (PA), and Certified Nurse Midwives (CNM)*

*+Clinical Nurse Specialists (CNS) do not fit the Medicare definition of an FQHC practitioner.*

*++ Clinical staff, such as CNSs, RNs, LCSWs, and other licensed clinical staff, working under the direct supervision of a physician or NP, may complete specific tasks according to State licensure and scope of practice parameters. Direct supervision is required for face-to-face services and general supervision for non-face-to-face services.*

### 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

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### Non-Face-to-Face Services Documentation Requirements

Non-face-to-face services by the provider 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

Non-face-to-face services which may be provided by the clinical staff, under the direction of the provider:

- Identify and facilitate access to, and communicate with, community and health resources, including home health agencies, available to support patient and/or family service needs
- Provide assessment to support adherence and management of medication treatment regimen
- Educate patient and/or family/caretaker to support self-management, independent living, and ADLs
- Communicate aspects of care with the patient and any individuals involved in the care or decision making process

### 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.

TCM is billed with **CPT code 99495 or 99496, either alone or with other payable services.** TCM is the only care management service that is not paid separately from the PPS payment methodology. CPT codes 99495 and 99496 are qualifying visit services listed under PPS G0467 (FQHC visit, established patient). 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. Providers must use the medical decision making level and the date of the first face-to-face visit to select the appropriate TCM code.

### Within the COVID-19 PHE (Telehealth)

WHAT PROVIDER CODES	Services	What FQHC bills to CMS	What CMS pays (Physician Fee Schedule)
99495	At least moderate level of medical decision making during the service period. Face-to-face visit, within <u>14</u> calendar days of discharge.	G2025	\$98.27
99496	High level of medical decision making during the service period. Face-to-face visit, within 7 calendar days of discharge.		

*Notes: Rates here are based on the 2023 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 (Non-Telehealth)

WHAT PROVIDER CODES	Services	What FQHC bills to CMS	What CMS pays (Physician Fee Schedule)
99495	At least moderate level of medical decision making during the service period. Face-to-face visit, within <u>14</u> calendar days of discharge.	G0467	\$187.19
99496	High level of medical decision making during the service period. Face-to-face visit, within <u>7</u> days of discharge.	G0467	\$187.19

*Notes: Rates here are based on the 2023 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. Although the AMA CPT manual describes both new and established patients as eligible for TCM, G0467 is defined as an FQHC visit for established patients. Health center will need to acknowledge this discrepancy with their MACs or limit TCM services to established FQHC patients.*

Effective January 1, 2022, CMS began allowing FQHCs to bill for TCM and care management services furnished for the same beneficiary during the same service period, provided all requirements for each medically necessary service are separately met. The care management services include those billable by FQHCs using HCPCS code G0511 and G0512, which consider a service period as once in a calendar month. TCM services may be provided once within a 30 day period post-discharge. CMS specifically notes in the Final Rule that care management services are comprehensive and helpful in supporting patients with chronic medical or mental health conditions and

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illnesses during and beyond that 30 day post-discharge TCM period ([Federal Register, Section 65206-65207](https://www.federalregister.gov/documents/2022/01/01/65206-65207)).

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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