



PAYMENT

Reimbursement Tips:

Transitional Care Management (TCM)



Overview

Transitional Care Management (TCM) are personalized and supportive services provided to patients who are being discharged from an inpatient hospital setting to a community setting.

This Tip Sheet provides FQHCs with simplified, easy-to-understand instructions for providing and billing CMS for TCM services. Also see NACHC resource: [CMS Billing Lingo, Defined!](#) for definitions of terms used throughout this document.



Initiating Visit Requirements

No initiating visit required prior to the start of TCM services. However, the face-to-face visit component of TCM qualifies as an initiating visit for other Medicare care management services (see NACHC resource: [Summary of Medicare Care Management Services Billed Using G0511](#)).



Eligible Patients

- ✓ Medicare Part B beneficiaries.
- ✓ Provide consent for services.
- ✓ At a moderate or high medical decision making (MDM) level.
- ✓ Are transitioning from an inpatient or partial hospitalization setting (i.e. acute, psychiatric, long-term care, skilled nursing, rehabilitation, observation, community mental health center) to a community setting (i.e. home, group home, rest home, assisted living, temporary or short-term settings such as a hotel, hostel, or homeless shelter).

Note: Utilize state or local Health Information Exchanges (HIEs) to review Admit, Discharge, Transfer (ADT) data and identify eligible patients.



Authorized Billing Providers

What they do:

- ✓ Determine medical necessity of TCM and order services.
- ✓ Obtain patient consent for services (verbal or written). If not obtained by billing provider, consent may also be obtained by auxiliary personnel under general supervision.
- ✓ Furnish services personally and/or via general supervision of auxiliary personnel as indicated by the service CPT code.

Note: During the consent process, the patient must be informed that coinsurance applies and that only one provider can deliver and bill for TCM services within the 30 days post-discharge. As TCM services are furnished by this same provider, consent must be obtained again if there is a change in the billing provider.

Who they are:

- Physicians (MD,DO)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Certified Nurse Midwife (CNM)

Note: TCM services are part of the Evaluation and Management services category, and TCM providers must therefore be qualified to perform and bill for E/M level services in the state where they practice.

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Auxiliary Personnel

What they may do (under general supervision):

- ✓ Obtain patient consent for services (verbal or written)
- ✓ Perform TCM interactive contact
- ✓ Perform certain non-face-to-face TCM services (see below)

Who they are (examples):

- ✓ Nurses (nurse care manager, clinical nurse specialist (CNS), RN, LPN)
- ✓ Social Workers
- ✓ Mental Health Counselor (MHC)

Services Elements, Coding & Billing

CODE	Service Elements	Service Provider	FQHC Medicare Billing Code & Rate
CPT® 99495	<ul style="list-style-type: none"> • Interactive contact with the patient/caregiver occurs within 2 business days of discharge • Moderate level medical decision making (MDM) • Face-to-face visit occurs within 14 calendar days of discharge 	Face-to-face visit: Authorized billing provider only Interactive contact and non-face-to-face services: Auxiliary personnel under general supervision, or the billing provider may choose to personally deliver these services.	G0467, PPS qualifying medical visit, established patient: \$195.99 The face-to-face component of TCM services may furnished via telehealth during the COVID-19 telehealth extension. The full TCM service would then be billed via G2025. The national 2024 rate for G2025 is \$95.27
CPT® 99496	<ul style="list-style-type: none"> • Interactive contact with the patient/caregiver occurs within 2 business days of discharge • High level medical decision making (MDM) • Face-to-face visit occurs within 7 calendar days of discharge 		

Activities of TCM

There are three components in a 30-day period, starting on the date the patient is discharged, required to bill Medicare for TCM services: Interactive Contact, Face-to-Face Visit, Non-Face-to-Face Services.

1. Interactive Contact

Within 2 business days of the discharge date, the billing provider or qualified auxiliary personnel (under the supervision of the billing provider) initiates direct and interactive communication with the patient or caregiver (phone, in-person, electronic) addressing:

- ✓ Type of services the patient had during admission
- ✓ The discharge diagnosis
- ✓ Patient status and follow-up services that may be needed
- ✓ Medication reconciliation (not required to be part of the interactive contact, but must occur no later than the date of the face-to-face visit)
- ✓ Scheduling a face-to-face visit with the provider

Note: 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.

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Activities of TCM *continued*

2. Face-to-Face Visit

Following discharge, and after the interactive contact, a face-to-face visit allows the billing provider to assess the patient and develop a plan to aid the patient's return to the community setting. Medication reconciliation must occur no later than the date of the face-to-face visit, with the billing provider reviewing and signing off on any medication reconciliation performed by auxiliary personnel. The required time frame for this visit is based upon the complexity of the medical decision making (MDM), either moderate or high, for the patient's condition (see CPT codes above for corresponding time frames).

Note: The MDM criteria may be found in the Evaluation and Management chapter of the CPT® codebook.

3. Non-Face-to-Face Services

Additional care coordination services may be performed, as needed by the patient or caregiver, throughout the 30-day post-discharge time period. Non-face-to-face services may be performed by the billing provider and/or auxiliary personnel. Although auxiliary personnel may not perform provider-only services, the provider may choose to personally perform any care coordination services. Non-face-to-face services include:

Billing Provider	Auxiliary Personnel
<ul style="list-style-type: none"> ✔ Obtain and review the discharge information ✔ Review the need for, or follow up on, pending diagnostic tests and treatments ✔ Interact with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems ✔ Educate patient, family, guardian, and/or caregiver(s) ✔ Establish or reestablish referrals and arrange for needed community resources ✔ Assist with the scheduling of follow-up with community providers and services 	<ul style="list-style-type: none"> ✔ Identify and facilitate access to, and communication 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 activities of daily living (ADLs) ✔ Communicate aspects of care with the patient and any individuals involved in the care or decision-making process

The reimbursement rate is based on the 2024 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. Code descriptions taken from the AMA's CPT 2024 Manual, Professional Edition.

Be sure to capture the following documentation elements when billing for chronic care management services:

- ✔ The medical necessity of the transitional care management services
- ✔ Patient consent
- ✔ Date the patient was discharged
- ✔ Date of interactive contact with patient/caregiver and mode of communication, including attempts at contact
- ✔ Date and details of medication reconciliation
- ✔ Date of the face-to-face visit and mode (telehealth or in-person)
- ✔ Level of medical decision making (moderate or high)
- ✔ Services performed during the face-to-face visit
- ✔ Non-face-to-face services, date performed and by whom (provider and/or auxiliary personnel)
- ✔ Any relevant social drivers of health (SDOH) and activities of daily living (ADLs)

Note: The documentation for the face-to-face visit is not required to meet the typical Evaluation and Management (E/M) documentation requirements. A typical E/M visit is meant to capture the complexity and intensity of services as a single picture on the date of services whereas TCM services cover a period of 30 days. The minimum documentation requirements for TCM correspond directly to the components of TCM services and are used to meet the criteria to bill. An E/M office visit has several more service components (i.e. comprehensive history, physical examination) that are required but time or the level medical decision making are used to select the appropriate service code. Please refer to the CPT® code book for more information.

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The billing practitioner is ultimately responsible for documentation, including that of any contracted community-based organizations (CBOs) or other contracted personnel who furnish chronic care management services under the clinical care and treatment of this same billing practitioner.

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 an authorized billing provider, 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.

The face-to-face visit component of the TCM services is not billed separately. All services code elements must be met in order to bill for TCM services. Any Evaluation and Management (E/M) services occurring after the TCM face-to-face visit may be billed separately.

In a situation where a patient is readmitted within the 30-day TCM service period, TCM may be billed if all the components of the services have been provided during that 30-day period, which may include services after the second discharge that are within the same 30-day period. If all of the components were not furnished for the first discharge by one provider but were completed for the second discharge in the 30-day window, then the billing provider can report the TCM services so long as another provider has not already billed for the first discharge. Only one provider can bill for TCM per patient per 30-day period, and this rule applies even in the case of readmission. If the patient dies prior to the end of the 30-day TCM period, TCM services cannot be reported; instead, any face-to-face visits can be reported as E/M codes.

Patients pay 20% coinsurance based upon the lesser of the submitted charges or the local payment rate for G0467.

As TCM activities do include a face-to-face service (see [CMS Billing Lingo, Defined!](#)), CMS does include the services in the Medicare telehealth services list. The non-face-to-face elements of TCM services may be provided in person or virtually (i.e., audio-visual or two-way audio technology), or a combination of both. Additionally, some activities may not directly involve the patient (for example, creating connections with local community-based resources on behalf of the patient).

Co-Occurring Care Management Services

The qualifying visit component of TCM qualifies as an initiating visit for Medicare care management services, and is reported separately from those services. 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 (see NACHC resource: [Summary of Medicare Care Management Services Billed Using G0511](#) and G0512).

References

- AMA. 2024 CPT 2024 Codebook
- AAPC. 2024 HCPCS Level II Codebook
- CMS. CY 2022 Physician Fee Schedule Final Rule. Section 65206-65207. <https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1751-f>
- CMS. CY 2024 Physician Fee Schedule Final Rule <https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f>
- CMS List of Telehealth Services <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
- CMS. Medicare Learning Network. Transitional Care Management Services. <https://www.cms.gov/files/document/mln908628-transitional-care-management-services.pdf>
- CMS. TCM FAQs 2016. <https://www.cms.gov/files/document/billing-faqs-transitional-care-management-2016.pdf>