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1500 Spring Garden Street
Suite 501 | Philadelphia, PA 19130
P: 800-843-3360 | F: 267-702-2690
www.hospitalmedicine.org

FAQ: New CPT Transitional Care Management (TCM) Codes 99495-6

The primary driver in creating two new CPT Transitional Care Management (TCM) codes has been to improve care coordination and to provide better incentives to ensure patients are seen in a physician's office, rather than be at risk for readmission. CMS' adoption of codes for TCM services is part of a broader multi-year strategy to recognize and support primary care and care management.

These services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living). Transitional care management commences upon the date of discharge and continues for the next 29 days.

Will this document describe everything I need to know about these new codes?

Keep in mind that the final rule implementing these new codes is the only information currently available. CMS has stated they will provide further guidance regarding the billing of the new CPT TCM codes. The usual process with new codes is further guidance from Medicare transmittals and MedLearn Matters articles, which answer a lot of operational questions. We hope to start seeing this information soon, but there is sometimes a wait until the first quarter to get clear definition. SHM will provide further information as it becomes available.

Are hospitalists eligible to bill these new codes?

No, although there may be rare exceptions for atypical hospital medicine practices. CMS has made it clear that the physician billing for TCM services should have an ongoing relationship with the beneficiary and the intent is for community based primary care physicians. Further, it is unlikely that most hospitalists will have the post-discharge relationship with a patient necessary to fulfill the required services (ex: communication within 2 days post-discharge and a face to face visit within 14 days). With that said, assuming they can fulfill the requirements; use of the codes does not preclude use by hospitalists.

Are non-physician practitioners eligible to bill the new codes?

The non-physicians who may bill TCM codes are NPs, PAs, CNSs, and CNMs, unless they are otherwise limited by their state scope of practice. However, like their physician counterparts, NPP hospitalists are unlikely to meet the requirements.

I'm still curious, what are the new TCM codes and how can hospitalists help?

Transitional care management (TCM) is comprised of one face-to-face visit within the specified time frames, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction. Below are the two new CPT TCM codes and their related requirements:

- **99495** Transitional Care Management Services (Moderate Complexity):
    - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post-discharge.
    - Medical decision making of at least moderate complexity during the service period.
    - Face-to-face visit, within 14 calendar days post-discharge.

- **99496** Transitional Care Management Services (High Complexity):
    - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post-discharge.
    - Medical decision making of high complexity during the service period.
    - Face-to-face visit, within 7 calendar days post-discharge.

Will hospitalists, as discharging physicians, have any formal communication requirements placed on them as a result of these new codes?

There are no added formal requirements for communication between the accepting primary care/community physician and the discharging inpatient physician. The accepting community physician is responsible for reviewing the discharge summary, and the community physician can decide whether standard clinical practice indicates the need for further communication with the discharging physician. However, the discharging physician should continue to communicate with the community physician as necessary as part of billing for discharge day management services.

How can hospitalists support efforts surrounding TCM services and help PCP colleagues get paid for work they already perform, or would like to perform?

CMS expects the discharging hospitalist to help coordinate care by discussing ongoing care requirements with the patient as part of discharge day services (99238-9) and to identify a community provider (i.e. PCP) for follow up whenever possible. Specifically, hospitalists should tell patients that transition care management services should be provided by their PCP after discharge, and that Medicare will pay for those services. If the patient does not have a pre-identified PCP for follow up care, the hospitalist should suggest a PCP to the patient. This information should be recorded in the discharge summary

As a hospitalist, I already perform many transitional services at discharge. Why can't I bill the new codes as part of a discharge?

There is a distinction between the discharge day management and TCM services. CMS has specifically sought to avoid any implication that the E/M services furnished on the day of discharge as part of discharge management services could be considered to meet the requirement for the TCM service that must be conducted within 7 or 14 days of discharge.

Therefore, the E/M service required for the CPT TCM codes cannot be furnished by the same physician or nonphysician practitioner on the same day as the discharge management service.

There are physicians and group practices billing for discharge day management who are also regularly responsible for the patient's primary care. Are they able to bill for TCM services?

Yes. The physician billing discharge day management could also be the physician who is regularly responsible for the beneficiary's primary care (this may be especially the case in rural communities).

However, CMS intends to guard against overlap in the actual work involved in providing these two services and will not allow both discharge and TCM to be billed on the same day.

How often can TCM services be billed for the same patient?

The codes can be billed only once per patient within 30 days after the original discharge for which a TCM code has been billed.

Can more than one physician bill the TCM codes if they are caring for the same patient?

No, these services may be billed by only one individual during the 30 day period after discharge.

Are hospitalists working in SNFs eligible to bill the TCM codes when a patient is discharged to a SNF?

No. The TCM codes may not be billed when patients are discharged to a SNF. For patients in SNFs there are E/M codes for initial, subsequent, discharge care, and the visit for the annual facility assessment, specifically CPT codes 99304-99318. These codes may be billed for SNF beneficiaries for the care management services they receive in the period after discharge from an acute care hospital.

However, when SNF patients are discharged from the SNF to the community or to a nursing facility, the physician or practitioner who furnishes TCM services can use the CPT TCM codes to bill for those services.

How much will the compensation be for providing TCM services?

The AMA estimates the higher-level billing code requiring a face-to-face visit with the patient within a week of discharge and would pay roughly $230. The lower-level code includes a face-to-face visit within two weeks and would pay about $160.