



Transitional Care Management

Carly Hudelson, MD, MSc and Leah M. Marcotte, MD

VSSL Briefs are a series of documents written and led by trainees and learners with the goal of providing background information about policies and programs related to focus areas for the Lab. Please see the bottom of this document for additional disclaimers.

In 2013, the Centers for Medicare and Medicaid Services (CMS) introduced new Transitional Care Management (TCM) billing codes (99495, 99496) as a way to better compensate outpatient primary care providers (PCPs) and their teams for managing care transitions after patients are discharged from hospitals.¹ Early analysis of TCM has been favorable. In the first three years these codes were available, patients who received TCM services had significantly lower mortality, readmissions, and healthcare costs compared to those who did not, although uptake was low.² Since the creation of these codes, CMS has worked to remove barriers to use. However, there remains confusion about what specifically is required to bill for TCM services. This issue brief provides guidance for PCPs and other ambulatory care providers interested in incorporating these codes into their practice.

What is Transitional Care Management?

The intent of TCM is to increase payment for a package of ambulatory services within a 30-day period after discharge. The TCM codes, 99495 and 99496 are reimbursed at a substantially higher rate than traditional evaluation and management (E&M) outpatient visit codes. The difference between 99495 and 99496 relates to documentation of decision-making complexity and timing after discharge. In order for a PCP to bill for a TCM visit when they see a recently discharged patient, the following components must be present:

1. **Direct, telephone or electronic contact** between the patient and a qualified member of the outpatient care team within 2 business days of discharge. Licensed clinical staff can perform this service incident to general supervision of a physician or qualified healthcare professional. This contact can serve to address medical and/or psychosocial concerns post-discharge, care coordination, and review discharge information.
2. **A face-to-face appointment** (office, home-based or telehealth) with at least moderate complexity medical decision making within 14 calendar days of

discharge (99495) or high complexity within 7 days (99496) focused in review of hospitalization and management of care post-discharge.

3. Medication reconciliation must be completed by date of face-to-face visit.

TCM Service Eligibility

	Eligible for TCM Services	Ineligible for TCM Services
Discharge from	Inpatient acute care, psychiatric hospital, observation stay, partial hospitalization, long term care hospital, skilled nursing facility (SNF), inpatient rehabilitation facility	Emergency department
Discharge to	Home, adult family home, assisted living facility	SNF
Healthcare utilization	No hospital readmission within 30 days of initial discharge	Hospital readmission within 30 days of initial discharge
Payer	Medicare, some commercial insurance	Washington state Medicaid, some commercial insurance

CY 2020 Policy Updates

TCM was designed to reimburse for the longitudinal clinical activities that support patients discharging from the hospital. Since the initiation of TCM codes in 2013, CMS has continued to iterate policy based on health system and provider feedback. The CY2020 Physician Fee Schedule increases reimbursement rates for both 99495 and 99496 to 2.36 and 3.11 work relative value units (wRVUs), respectively. Additionally, TCM codes now may be used with fourteen additional Healthcare Common Procedure Coding System (HCPCS) codes that previously were felt to be overlapping services, including hospice care (G0182) and home care with care plan oversight (G0181). The final rule also allows for TCM to be billed in concurrent periods as CCM codes 99490 and 99491.

More research is needed to understand how the TCM codes affect patient care and to understand barriers to implementation, in order to both improve patient care and ensure primary care and other ambulatory care teams are receiving reimbursement for the important cognitive and administrative work they do when a patient is discharged.

cite as: Hudelson C, Marcotte LM. Transitional Care Management. VSSL Briefs. 2019; 1:1.

References

1. CY2013 Physician Fee Schedule Final Rule. Centers for Medicare and Medicaid Services. 11/01/2012. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1590-FC.html> Accessed 11/6/19.

December 2019

2. Bindman AB, Cox DF. Changes in Health Care Costs and Mortality Associated With Transitional Care Management Services After a Discharge Among Medicare Beneficiaries. *JAMA Intern Med.* 2018 Sep 1;178(9):1165-1171.
3. CY2020 Physician Fee Schedule Final Rule. Centers for Medicare and Medicaid Services. 11/01/2019. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F.html>. Accessed 11/6/19.

Disclaimers: The goal of this brief is to provide background information about policies related to Lab activities, not to provide operational or legal guidance for implementing such policies. The content in this issue brief is provided “as is,” and VSSL and the issue brief authors disclaim any and all warranties, express or implied, including any warranties as to accuracy, comprehensiveness, or currency of the content of this work. This work is no substitute for individual patient assessment based upon healthcare professionals’ and health care organizations’ examination of each patient and consideration of, among other things, age, current or prior medical conditions, applicability for the policies discussed in this work, and other factors unique to the patient. VSSL does not provide advice or guidance and this work is merely a reference tool. Healthcare professionals, and not VSSL, are solely responsible for the use of this work including all medical and policy judgments and for any resulting diagnosis and treatments. Given continuous, rapid advances in policy and health information, independent professional verification of medical diagnoses, policy and service indications, and treatment options should be made, and healthcare professionals should consult a variety of sources. When applying policies and services to patients, healthcare professionals are advised to consult policy documents directly to verify, among other things, conditions of use, particularly if the policies or services being applied to patients are new, infrequently used, and involve multiple requirements. To the maximum extent permitted under applicable law, no responsibility is assumed by VSSL or its authors for any injury and/or damage to persons or property, as a matter of products liability, negligence law or otherwise, or from any reference to or use by any person of this work.