



Transitional Care Management Services



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What's Changed?

CPT code 99439 replaced HCPCS code G2058 (page 10).

You'll find substantive content updates in dark red font.

This booklet outlines transitional care services during the **30-day period** which begins when a physician discharges a Medicare patient from an inpatient stay and continues for the next 29 days. Medicare may cover these services to help eligible patients transition back to a community setting after a stay at certain facility types.

In this booklet, **you** refers to physicians or health care professionals providing TCM services.

This booklet focuses on covered services, location, who may provide services, supervision, billing services, documenting services, and service benefits.

Transitional Care Management Services Requirements

Required patient transitional care management (TCM) services include:

- Supporting a patient's transition to a community setting
- Health care professionals who accept patients at the time of post-facility discharge, **without a service gap**
- Health care professionals taking responsibility for a patient's care
- Moderate or high complexity medical decision making for patients with medical or psychosocial problems

The 30-day TCM period begins on a patient's inpatient discharge date and continues for the next 29 days. TCM services begin the day of discharge from 1 of these inpatient or partial hospitalization settings:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Inpatient rehabilitation facility
- Long-term care hospital
- Skilled nursing facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a community mental health center

After inpatient discharge, the patient must return to their community setting. These could include:

- Home
- Domiciliary (such as a group home or boarding house)
- Nursing facility
- Assisted living facility

Who May Provide TCM Services?

TCM services include both a face-to-face visit and non-face-to-face services. These health care practitioners must provide services associated with face-to-face TCM services and can supervise auxiliary personnel (which includes clinical staff):

- Physicians (any specialty)
- Non-physician practitioners (NPPs) legally authorized and qualified to provide the services in the state where they practice:
 - Certified nurse-midwives (CNMs)
 - Clinical nurse specialists (CNSs)
 - Nurse practitioners (NPs)
 - Physician assistants (PAs)

CNMs, CNSs, NPs, and PAs may provide non-face-to-face TCM services incident to services of a physician and other CNMs, CNSs, NPs, and PAs.

Supervision

The TCM codes are care management codes. As care management codes, auxiliary personnel may provide the non-face-to-face services of TCM under the general supervision of the physician or NPP subject to applicable state law, scope of practice, and the Medicare Physician Fee Schedule (PFS) incident to rules and regulations.

CNMs, CNSs, NPs, and PAs may also provide the non-face-to-face TCM services incident to the services of a physician.

TCM Components

When a patient is discharged from an approved inpatient setting, you **must** provide at least these TCM components during the course of the 30-day service period:

Interactive Contact

Within 2 business days after the patient's discharge from the inpatient or partial hospitalization setting, you (or clinical staff under your direction) must contact the patient or their caregiver via phone, email, or face-to-face. "Clinical staff" means someone who works under the supervision of a physician or other qualified health care professional and is allowed by law, regulation, and facility policy to perform or assist in the performance of a specialized professional service, but who doesn't individually report that professional service). The interactive contact must be performed by clinical staff who can address patient status and needs beyond scheduling follow-up care.

You may report the service if you make 2 or more unsuccessful separate contact attempts in a timely manner (and if you meet the other requirements of the service, including a timely face-to-face visit). Document your attempts in the patient's medical record. Continue trying to contact the patient until you're successful. If the face-to-face visit isn't within the required timeframe, you can't bill TCM services (see the [face-to-face](#) section).

Non-Face-to-Face Services

You and your clinical staff (as appropriate) must provide patients medically reasonable and necessary non-face-to-face services within the 30-day TCM service period. Clinical staff under your direction may provide certain non-face-to-face services.

Physician or NPP Non-Face-to-Face Services

Physicians or NPPs may provide these non-face-to-face services:

- Review discharge information (for example, discharge summary or continuity-of-care documents)
- Review the patient's need for, or follow-up on, diagnostic tests and treatments
- Interact with other health care professionals who may assume or reassume care of the patient's system-specific problems
- Educate the patient, family, guardian, or caregiver
- Establish or re-establish referrals and arrange needed community resources
- Help schedule required community providers and services follow-up

Auxiliary Personnel Under Physician or NPP General Supervision Non-Face-to-Face Services

Auxiliary personnel may provide these non-face-to-face TCM services under general supervision:

- Communicate with the patient
- Communicate with agencies and community service providers the patient uses
- Educate the patient, family, guardian, or caregiver to support self-management, independent living, and activities of daily living
- Assess and support treatment adherence, including medication management
- Identify available community and health resources
- Help the patient and family access needed care and services

Face-to-Face Visit

You must provide 1 face-to-face visit within the timeframes described by these 2 CPT codes:

- **CPT Code 99495** — Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision making of at least moderate complexity during the service period; Face-to-face visit, within 14 calendar days of discharge
- **CPT Code 99496** — Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision making of high complexity during the service period; Face-to-face visit, within 7 calendar days of discharge

You shouldn't report the TCM face-to-face visit separately.

Telehealth Services

You may provide CPT codes 99495 and 99496 via telehealth. We pay for a limited number of Part B services you provide an eligible patient via a telecommunications system. Using eligible telehealth services substitutes for a face-to-face encounter. [Telehealth Services](#) fact sheet has more information.

Medication Reconciliation & Management

You must provide medication reconciliation and management on or before the face-to-face visit date.

TCM Concurrent Billing

The [2020 Medicare Physician Fee Schedule \(PFS\) Final Rule \(FR\)](#) and [2021 Medicare PFS FR](#) revised TCM billing requirements, allowing you to only bill certain additional codes concurrently with TCM codes. See Table 1 for commonly used codes.



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Table 1. HCPCS Codes That May be Billed Concurrently

HCPCS Code	Descriptor
90951	ESRD related services with 4 or more face-to-face visits per month; for patients <2 years of age
90954	ESRD related services with 4 or more face-to-face visits per month; for patients 2–11 years
90955	ESRD related services with 2–3 face-to-face visits per month; for patients 2–11 years
90956	ESRD related services with 1 face-to-face visit per month; for patients 2–11 years
90957	ESRD related services with 4 or more face-to-face visits per month; for patients 12–19 years
90958	ESRD related services with 2–3 face-to-face visits per month; for patients 12–19 years
90959	ESRD related services with 1 face-to-face service per month; for patients 12–19 years
90960	End Stage Renal Disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90961	ESRD related services monthly with 2–3 face-to-face visits, for patients 20 years of age and older, by a physician or other qualified health care professional per month
90962	ESRD related services monthly with 1 face-to-face visit for patients 20 years and older, by a physician or other qualified health care professional per month
90963	ESRD related services for home dialysis per full month; for patients <2 years of age
90964	ESRD related services for home dialysis per full month; for patients 2–11 years
90965	ESRD related services for home dialysis per full month; for patients 12–19 years
90966	ESRD related services for home dialysis per full month; for patients 20 years of age and older
90967	ESRD related services for home dialysis per full month; per day; for patients <2 years of age
90968	ESRD related services for home dialysis per full month; per day; for patients 2–11 years
90969	ESRD related services for home dialysis per full month; per day; for patients 12–19
90970	ESRD related services for dialysis less than a full month of service; per day; for patient 20 years of age and older

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Table 1. HCPCS Codes That May be Billed Concurrently (cont.)

HCPCS Code	Descriptor
93792	Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results
93793	Anticoagulant management for a patient taking warfarin; must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed) and scheduling of additional test(s) when performed
99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
99358	Prolonged Evaluation and Management (E/M) service before and/or after direct patient care; first hour, non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged services
99359	Prolonged E/M service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)
99487	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99489	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

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Table 1. HCPCS Codes That May be Billed Concurrently (cont.)

HCPCS Code	Descriptor
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month
99491	Chronic care management services provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored
99439*	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
G0181	Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more
G0182	Physician supervision of a patient under a medicare-covered hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

*CPT code 99439 replaced HCPCS code G2058.

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Medical Decision Making

Patients who receive TCM must require moderate medical decision making (if you're billing CPT code 99495) or high-level medical decision making (if you're billing CPT code 99496) for their medical and psychosocial needs. Medical decision making refers to the complexity of establishing a diagnosis and selecting a management option as measured by:

- The number of possible diagnoses and the number of management options that must be considered
- The amount and complexity of medical records, diagnostic tests, and other information that must be obtained, reviewed, and analyzed
- The risk of significant complications, morbidity, and mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and the possible management options

Table 2 shows each medical decision-making level's elements. Your service must meet or exceed 2 of the 3 elements to qualify as an established type of medical decision making.

Table 2. Elements for Medical Decision-Making

Type of Decision Making	Diagnoses & Management Options Possible	Data Amount & Complexity	Significant Complications, Morbidity, & Mortality Risk
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

[Evaluation and Management Services Guide](#) has more information about medical decision making.

Billing TCM Services

TCM services billing tips:

- Only 1 physician or NPP may report TCM services.
- Report services once per patient during the TCM period.
- The same health care professional may discharge the patient from the hospital, report hospital or observation discharge services, and bill TCM services. The required face-to-face visit **can't** take place on the same day you report discharge day management services.
- Report reasonable and necessary E/M services (except required face-to-face visit) to manage the patient's clinical issues separately.
- You **can't** bill TCM services within a post-operative global surgery period (we don't pay TCM services if any of the 30-day TCM period falls within a global surgery period for a procedure code billed by the same practitioner).
- At a minimum, document this information in the patient's medical record:
 - Patient discharge date
 - Patient or caregiver first interactive contact date
 - Face-to-face visit date
 - Medical complexity decision making (moderate or high)

Billing TCM Services FAQs

The [Care Management](#) webpage has more information on TCM billing.

Advance Health Equity

Resources are available to help you understand and identify disparities that may affect TCM:

- [Building an Organizational Response to Health Disparities](#) — Resources and concepts for improving equity and responding to disparities. Topics include data collection, data analysis, culture of equity, quality improvement, and interventions
- [Guide to Reducing Disparities in Readmissions](#) — Overview and case studies of key care coordination and readmission issues and strategies for racially and ethnically diverse Medicare patients

Resources

- [2013 Medicare Physician Fee Schedule Final Rule](#)
- [2015 Medicare Physician Fee Schedule Final Rule](#)
- [Evaluation & Management Visits](#)
- [Federally Qualified Health Center](#)
- [Rural Health Clinic](#)
- [Rural Health Information Hub: Transitional Care Management](#)
- [Telehealth Services](#)

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