Transitional Care Management Coding

Rev. January 2019

99495 Transitional Care Management Services requires: ✓ FTF visit within 14 calendar days post discharge ✓ Decision-Making of **Moderate** complexity	
99496 Transitional Care Management Services requires: ✓ FTF visit within 7 calendar days post discharge ✓ Decision-Making of **High** complexity	
Effective Jan 2016, the date of service for TCM should be the first day of care (face to face visit)	
Both codes REQUIRE communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post discharge. This communication may be provided by ancillary staff under the supervision of the physician.	
Documentation Must Include	✓ Timing of initial post-discharge communication with patient/caregiver ✓ Date of face to face visit ✓ Complexity of Medical Decision Making (evidenced by # of diagnoses, data complexity and patient Risk).
Reporting Criteria	✓ TCM commences on date of discharge for the next 29 days ✓ TCM may be rendered by physician or NPP ✓ Includes Face to Face visit (not reported separately) within code specified time-frames ✓ Includes non-face to face services performed by staff under MD supervision ✓ Contact with patient must be made within 2 business days of discharge ✓ Medication reconciliation and management must occur no later than the date of the first face to face visit
Non-Face to Face services provided by clinical staff under the direction of physician or NPP include	☐ Communication with Home Health Agencies and other community services utilized by patient ☐ Patient and family/caretaker education to support self-management, independent living, and ADLs ☐ Identification of available community and health resources ☐ Facilitating access to care and services needed by patient and/or family
Non-Face to Face services provided by the physician or NPP include	☐ Obtaining and reviewing the discharge information or continuity of care documents ☐ Reviewing need for or follow up on pending diagnostic tests and treatments ☐ Interaction with other health care professionals who will assume or reassume care of the patient's system-specific problems ☐ Education of patient, family, guardian and/or caregiver ☐ Assistance in scheduling follow up with community providers and services
Code Frequency	**Once per patient per thirty days (*see re-admissions)**
Re-Admission during initial TCM period	There are two Options: 1 – Bill for TCM using first discharge date or 2 – Wait for next discharge date to start 30-day TCM period
Code Limitations	Surgeons in 90-day global period cannot use these codes Initial face-to-face E/M service bundled into TCM codes
Additional OV needed during TCM period	Any medically necessary encounter provided during the 30-day TCM period may be billed using the appropriate E/M code
Context **(Allowable discharge and transition sites of service)**	Transition of Care occurs when patient is discharged from these places of service: Inpatient, acute, rehab, long term acute care, partial hospitalization, observation, SNF, or NF (NOTE: EMERGENCY DEPT DISCHARGE DOES NOT QUALIFY FOR TCM) The TCM codes cover discharge from those places of service to patient's home. **DO NOT BILL TCM CODE IF THE PATIENT DOES NOT TRANSITION TO HIS HOME.**
Providing Specialty	Primarily used by PCPs, however any provider (or specialty other than hospitalist) who is managing the post-discharge care may bill these codes.