Providing and Billing Medicare for Transitional Care Management

Updated February 2025

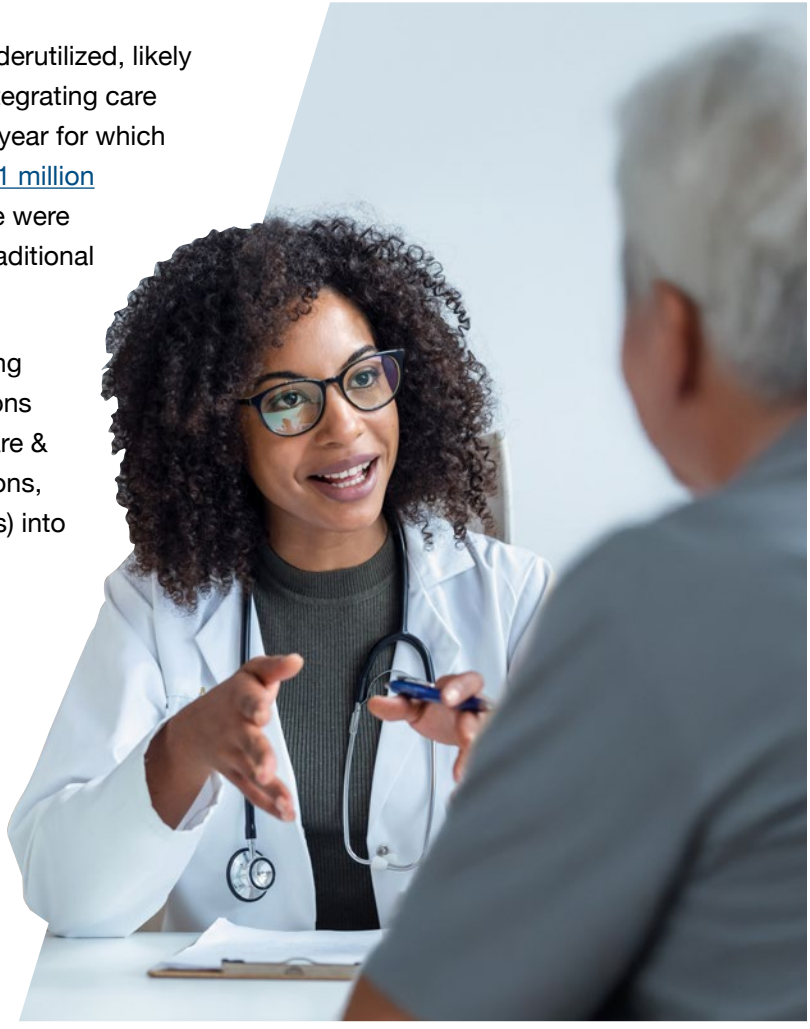
Background

Medicare began reimbursing physicians and non-physician practitioners for transitional care management (TCM) in 2013 with the goals of reducing readmissions and improving outcomes.

CPT Code	Descriptor
99495	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; at least moderate level of medical decision-making during the service period; face-to-face visit within 14 calendar days of discharge
99496	Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; high level of medical decision-making during the service period; face-to-face visit within seven calendar days of discharge

Despite these potential benefits, TCM remains underutilized, likely due to administrative burden and challenges in integrating care coordination processes. In 2022 (the most recent year for which data is available), Medicare paid approximately 1.1 million claims for TCM. For the sake of comparison, there were approximately 5 million inpatient discharges for traditional Medicare beneficiaries that same year.

To help providers understand the rules for providing and billing TCM, we have condensed the regulations and related guidance from the Centers for Medicare & Medicaid Services (CMS) (i.e., webinar presentations, FAQs, and Medicare Learning Network fact sheets) into the following summary.



Q: Who is eligible to receive TCM?

Beneficiaries discharged to their community setting (e.g., home, nursing home) from one of the following facilities are eligible to receive TCM: acute care hospitals (including inpatient, observation, and outpatient partial hospitalization discharges, but not discharges from the emergency department); rehabilitation hospitals, long-term acute care hospitals; skilled nursing facilities (Part A stay); and community mental health center partial hospitalization. A beneficiary discharged from one of these settings to another one of these settings (e.g., discharge from an acute care hospital to a skilled nursing facility) is not eligible for TCM.

Q: What is the time period for TCM?

A provider may bill for one unit of CPT 99495 or 99496 for specified services furnished during a 30-day period beginning with the date of discharge and continuing for 29 days.

Q: Who is eligible to bill for TCM?

MDs and DOs (regardless of specialty), physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives are eligible to bill for TCM.

Q: Must the beneficiary be an established patient of the billing practitioner?

Unlike other care management services, TCM does not require a previously established relationship with the beneficiary.

Q: Must the billing practitioner obtain the beneficiary's consent to bill for TCM?

Unlike other care management services, CMS does not require documentation of the beneficiary's consent to receive the service as a prerequisite to billing for TCM.

Q: What are the five required elements of TCM?

1. Initial communication with the beneficiary or caregiver within two business days of discharge (or two separate, unsuccessful attempts at communication). If, for example, the beneficiary is discharged on Friday, the initial communication (or two unsuccessful attempts) must be made by the end of the day on Tuesday (unless Monday or Tuesday is a legal holiday, then end of the day on Wednesday).
2. Face-to-face visit within seven days (99496) or 14 days (99495) of discharge.
3. Medication reconciliation and management performed on or before the date of face-to-face visit.
4. Non-face-to-face care management services furnished throughout the 30-day period.
5. Medical decision-making of moderate complexity (99495) or high complexity (99496) during the service period.

Q: What are the requirements for the initial communication?

1. Such communication may occur face-to-face, by telephone, or by interactive electronic means. Communication may occur after the patient has been discharged, when interactive contact is on the same day.
2. The communication may be made by the billing practitioner or clinical staff under the billing practitioner's general supervision. Such clinical staff must be capable of addressing the beneficiary's status and needs beyond scheduling follow-up care. Communication with administrative staff does not satisfy this requirement.
3. The date of the communication (or the two failed attempts) and the name and credential of the person making the communication (or the failed attempts) must be documented.

Q: What are the requirements for the face-to-face visit?

1. The face-to-face visit must be performed by the billing practitioner.
2. CMS describes the face-to-face visit as an evaluation and management (E/M) service but does not specify the level or elements of such visit.
3. The billing practitioner cannot perform the face-to-face visit on the same day as discharge management services.
4. The E/M service may be performed at any appropriate location, including the facility from which the beneficiary was discharged. The service may be performed before the beneficiary physically leaves the facility but only following discharge (and only if the billing practitioner did not provide discharge management services on that day).
5. Any additional E/M services furnished by the billing practitioner (or any E/M service performed by another practitioner) during the 30-day period is separately payable.

Q: Can a telehealth visit qualify as the face-to-face visit?

Yes, but only if the face-to-face visit meets all Medicare telehealth coverage requirements. To the extent the telehealth geographic or originating site coverage requirements apply in a specific case, these requirements would have to be satisfied for the telehealth visit to qualify as the TCM face-to-face visit.

Q: What constitutes medical decision-making of moderate or high complexity?

Moderate complexity requires multiple possible diagnoses and/or management of options; moderate complexity of medical data (e.g., tests) to be reviewed; and moderate risk of significant complications, morbidity, and/or mortality, as well as co-morbidities.

High complexity requires an extensive number of possible diagnoses and/or management of options; extensive complexity of medical data (e.g., tests) to be reviewed; and high risk of significant complications, morbidity, and/or mortality, as well as co-morbidities.

The beneficiary's medical record should reflect the required level of medical decision-making for the selected level of service.

Q: What non-face-to-face services must be performed during the 30-day period?

The billing practitioner must provide the beneficiary with all medically reasonable and necessary non-face-to-face services within the 30-day period. Based on the specific circumstances, the billing practitioner is to determine whether a specific service must be personally performed by the practitioner or whether it may be performed by clinical staff under the practitioner's general supervision. CMS does not require a specific number of minutes of non-face-to-face services be furnished in the 30-day period to bill for TCM. The services provided, however, must be properly documented. The following are the types of non-face-to-face services CMS expects to be provided unless the circumstances indicate otherwise:

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

Q: What is the date of service for TCM?

According to CMS' March 2016 FAQs regarding TCM, "[t]he date of service you report should be the date of the required face-to-face visit. You may submit the claim once the face-to-face visit is furnished and need not hold the claim until the end of the service period."

Q: Can multiple practitioners bill for TCM for the same beneficiary for the same time period?

Medicare will pay only the first eligible claim submitted for TCM following a beneficiary's discharge from a facility. Other practitioners may continue to report other reasonable and necessary services, including other E/M services, furnished to the beneficiary during the 30-day period. If a billing practitioner's claim for TCM is denied because another practitioner submitted a claim for TCM, the billing practitioner may then submit a claim for the face-to-face visit under the appropriate E/M code.

Q: What if the beneficiary is readmitted during the 30-day period?

The billing practitioner still can bill for TCM based on the original discharge as long as the services are furnished by the practitioner during the 30-day period, including the time following the second discharge. Alternatively, the practitioner can bill for TCM following the second discharge for a full 30-day period as long as no other practitioner bills the service for the first discharge. Also, if the face-to-face visit occurred prior to the readmission, the billing practitioner may bill for that visit under the appropriate E/M code rather than billing for TCM.

Q: What if the beneficiary dies prior to the 30th day?

The billing practitioner may submit a claim for the face-to-face visit under the appropriate E/M code but not for TCM.

Q: Can the billing practitioner provide and bill for other care management services (e.g., chronic care management, remote physiologic monitoring) during the TCM 30-day period?

Yes, a billing practitioner can bill other care management services concurrently with TCM when medically reasonable and necessary and if time and effort aren't counted more than once. Read a complete list of the care management codes that may be billed concurrently.

Q: What services cannot be billed during the 30-day period for TCM?

Medicare will not pay for TCM if any of the 30-day TCM period falls within a global surgery period for a procedure code billed by the same practitioner.

The billing practitioner (and any other practitioner in the same specialty and in the same practice) cannot bill for any of the following services furnished to the TCM beneficiary during the 30-day period:

- Care plan oversight services (CPT 99339, 99340, 99374-99380)
- Medical team conferences (CPT 99366-99368)
- Education and training (CPT 98960-98962, 99071, 99078)
- Telephone services (CPT 98966-98968, 99441-99443)
- Online medical evaluation services (CPT 98970-98972)
- Preparation of special reports (CPT 99080)
- Medication therapy management services (CPT 99605-99607)

Q: What is the place of service for TCM?

The place of service reported on the claim should correspond to the place of service of the required face-to-face visit.

Q: What are the 2025 reimbursement rates for TCM furnished in a non-facility setting?

The following reflects the 2025 Medicare Physician Fee Schedule (MPFS) national payment amounts; actual reimbursement will vary by geographic area.

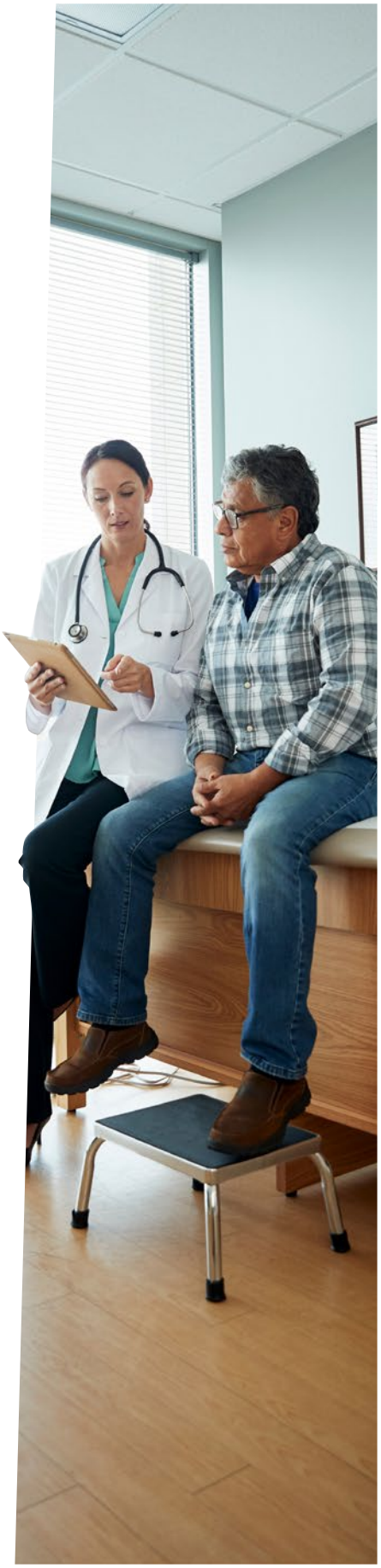
Code	Descriptor	2025 MPFS Non-Facility Payment Rate
99495	TCM services, moderate complexity, face-to-face visit within 14 calendar days of discharge	$201.20
99496	TCM services, high complexity, face-to-face visit within seven calendar days of discharge	$272.68

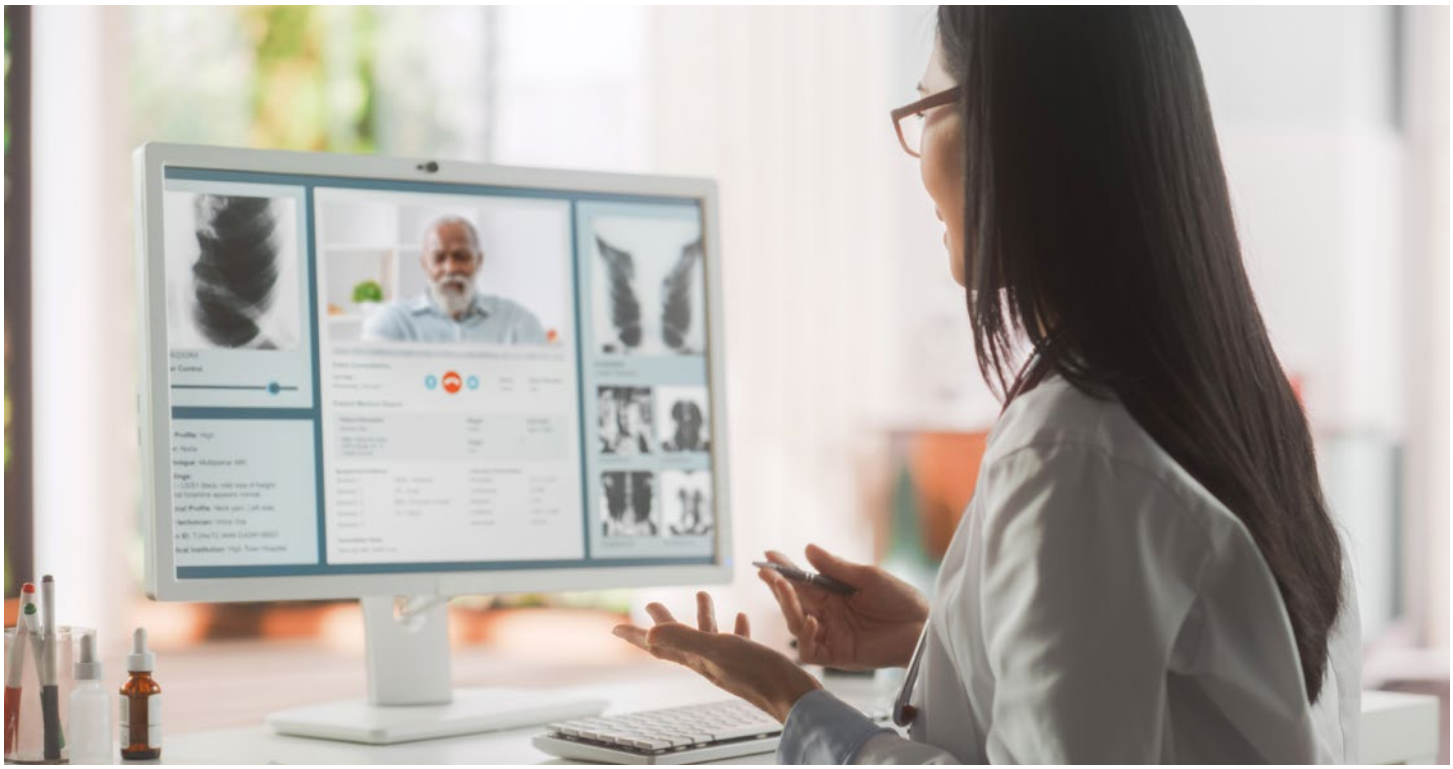
Q: What are the 2025 reimbursement rates for TCM services furnished in a facility setting?

The following reflects the 2025 Medicare national payment amounts; again, actual reimbursement will vary by geographic area.

Code	Descriptor	2025 MPFS Facility Payment Rate
99495	TCM services, moderate complexity, face-to-face visit within 14 calendar days of discharge	$134.24
99496	TCM services, high complexity, face-to-face visit within seven calendar days of discharge	$182.43

For TCM furnished in a hospital outpatient department, CMS has assigned CPT 99495 and 99496 to APC 5012 (clinic visit and related services). The national payment amount for this APC is $128.87 (not adjusted for labor costs). CPT 99495 and 99496 have been assigned status indicator “V,” which means they are paid under OPPS and will receive a separate APC payment.





Q: Can rural health clinics (RHCs) and federally qualified health centers (FQHC) provide and bill for TCM?

Effective January 1, 2025, RHCs and FQHCs may provide and bill Medicare for TCM under CPT 99495 and 99496. The RHC or FQHC will be reimbursed at the non-facility national payment amounts listed above, as opposed to the RHC all-inclusive rate (AIR) or the FQHC prospective payment system (PPS) rate. Thus, if the RHC's AIR or the FQHC's PPS rate is higher than these amounts, the RHC or FQHC should bill for the face-to-face visit, even if the RHC or FQHC performs the additional TCM services. If the RHC or FQHC performs the face-to-face visit via telehealth, however, TCM reimbursement will be higher than the 2025 rate for telehealth services furnished by an RHC or FQHC ($94.45).

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