Billing for Transitional Care Management Services
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Hospital readmissions are common and costly. Within the Medicare population, 19.6% of patients are readmitted within 30 days of hospital discharge, leading to a potentially preventable annual cost of $17.4 billion.[1] In recent years, the Center for Medicare and Medicaid Services (CMS) has recognized the importance of primary care and care coordination in improving patient care and reducing healthcare costs. As part of their effort to contain costs, CMS developed the Transitional Care Management (TCM) codes. These codes were designed to reduce 30-day re-hospitalization through reimbursement for care management and care coordination services. The TCM codes, 99495 and 99496, became effective January 1, 2013.[2] The complex requirements for these billing codes have limited their implementation to date, despite the many benefits of utilizing the TCM codes. This resource is intended to provide pharmacists with an overview of the requirements and examples of successful pharmacist involvement.

1. What is required to bill Transitional Care Management codes?

There are two TCM codes that can be utilized, 99495 and 99496. The codes require that the patient be discharged from an inpatient setting to a community setting (Table 1). There are specific non-face-to-face and face-to-face requirements that must be completed to bill for each of the TCM codes.[2,3]

Table 1: Qualifying transitions of care for TCM codes

From: Inpatient Setting	To: Community Setting
▪ Inpatient Acute Care Hospital ▪ Inpatient Psychiatric Hospital ▪ Long Term Care Hospital ▪ Skilled Nursing Facility ▪ Inpatient Rehabilitation Facility ▪ Hospital Outpatient Observation or Partial Hospitalization ▪ Partial Hospitalization at a Community Mental Health Center	▪ Home ▪ Domiciliary ▪ Rest Home ▪ Assisted Living

Non-face-to-face Requirements

In order to bill for either code, you MUST have an interactive communication (bi-directional telephone call, emails, texts, etc.) with the patient or caregiver within 2 business days of discharge. This interactive communication is conducted by licensed clinical staff under general supervision. There is no exhaustive list of licensed clinical staff, but CMS has clarified that a pharmacist acting within their state's scope of practice would qualify as licensed clinical staff.[4] The general supervision qualification means that the licensed clinical staff member must meet all "incident to" billing requirements with the exception of direct supervision. This means that the supervising provider does not have to be "on-site" in the same suite or office as the person providing the interactive contact. This allows for the contact to be made after hours or while the provider is away from the office.[5] For a more detailed description of "incident to" billing requirements, please review the CMS Benefit Policy Manual: Chapter 15, Section 60.

The non-face-to-face services provided by clinical staff through the interactive contact may include obtaining and reviewing records, reviewing follow-up needs, interacting with other health care professionals, providing education to the patient or caregiver, referring to community resources, and assisting in scheduling follow-up.[3]

Face-to-Face Requirements

The patient must have a face-to-face visit with a physician or a qualified non-physician practitioner. Qualified non-physician practitioners are defined as certified nurse-midwives, clinical nurse specialists, nurse practitioners, or physician assistants. Assuming the non-face-to-face interactive contact requirement was met, the timing of the visit and the level of medical decision-making are then utilized to determine whether the provider should submit the 99495 or 99496 code. If the patient is seen within 14 calendar days of discharge and moderate complexity medical decision-making is documented, the 99495 code may be billed. If the patient is seen within 7 calendar days of discharge and high complexity medical decision-making is documented, the 99496 code may be billed (Table 2). While the level of medical decision making must be met by the billing provider, licensed clinical staff, including pharmacists, may contribute to the visit by furnishing specific components of the face-to-face visit (Table 3).[3]

Table 2. Medical Decision Making Complexity

Type of Decision Making	**Elements (2 of 3 must be met)**		
	Number of Possible Diagnoses and/or Management Options	**Amount and/or Complexity of Data to be Reviewed**	**Risk of Significant Complications, Morbidity, and/or Mortality**
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Table 3. Face-to-Face Licensed Clinical Staff Services

May furnish:
▪ Communication with agencies and community services ▪ Provide education to patient and caretakers to support self-management, independent living, and activities of daily living ▪ Assess and support treatment regimen adherence and medication management ▪ Identify community and health resources ▪ Assist patient and family in accessing needed care and services

2. When should TCM claims be submitted?

The TCM claim may be submitted on the date of the face-to-face visit.[6] TCM codes may only be paid once within a 30-day time frame. That means that only one provider can bill for the service, and if the patient is readmitted, a second TCM code may not be submitted within the same 30-day time frame.

3. Who is the billing provider on a TCM claim?

While pharmacists can furnish non-face-to-face services or portions of the face-to-face services, pharmacists cannot serve as the billing provider on the TCM claim. The billing provider must be a physician or a qualified non-physician practitioner. Qualified non-physician practitioners are defined as certified nurse-midwives, clinical nurse specialists, nurse practitioners, or physician assistants.

4. Can other services be billed during the 30-day TCM service window?

While most services can be billed during the 30-day TCM service window, there are some exclusions (Table 4).[3] Individual organizations may want to determine how to identify patients that would have one of these services in the same service period as TCM and develop a strategy for how to prioritize billing.

Table 4. Restricted concurrent billing codes

Code	Description of Service
G0181 and G0182	Home health or hospice supervision
90951 – 90970	End-Stage Renal Disease services
99490, 99487, 99489	Chronic Care Management (CCM) services
99358 and 99359	Prolonged E/M Services Without Direct Patient Contact

5. What are the potential benefits of utilizing TCM codes?

The TCM codes provide favorable reimbursement rates compared to traditional evaluation and management codes. In addition, the codes provide higher work relative value units (Table 5).[7] Many practices are able to justify the pharmacist's involvement through increased reimbursement compared to traditional evaluation and management codes.

Table 5. TCM Reimbursement

CPT Code	Non-Facility Price	Work Relative Value Units (RVUs)	Comparator Evaluation and Management Code
99496	$233.41	3.05	99215 $146.24 Work RVU 2.11
99495	$165.54	2.11	99214 $ 108.34 Work RVU 1.50

In addition to the potential for increased reimbursement, TCM services may be able to demonstrate cost-savings through measurement of other metrics. TCM services may contribute to reductions in 30-day readmission rates and/or emergency department utilization.

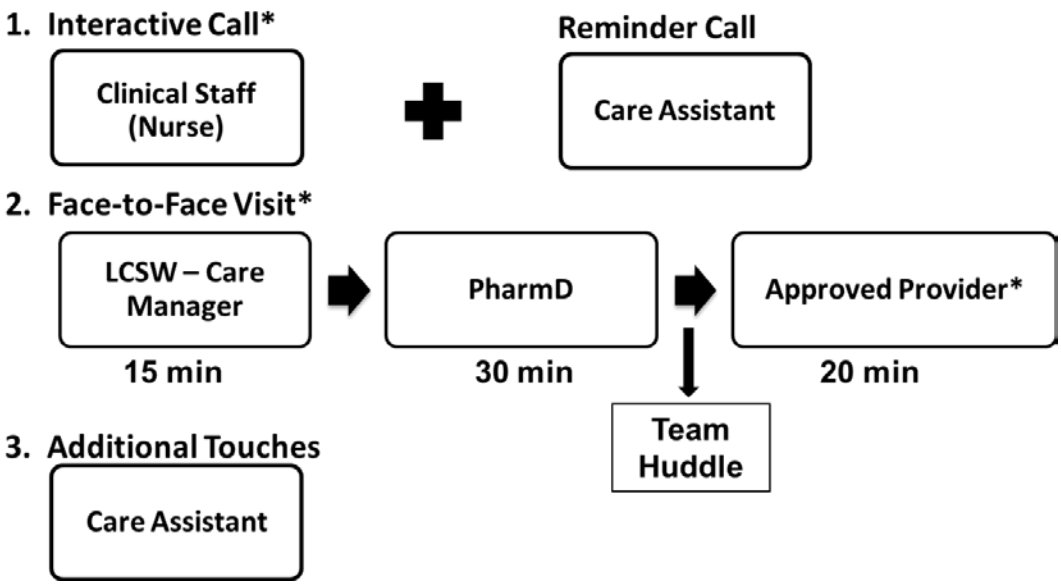
6. Are there any pharmacists doing this now?

Yes! Pharmacists are successfully engaging in care teams to help provide transitional care management services. Below are a few examples of clinics that have established transitional care management services with pharmacists integrated into the workflow.

North Carolina
UNC Internal Medicine Clinic

The University of North Carolina General Internal Medicine Clinic established a hospital follow-up, transition of care program in the winter of 2012. This program has been described elsewhere.[8,9] In brief, our program meets all of the TCM code requirements and is outlined in Figure 1. There are some components of our program that are not required for billing that we have found to be very useful, including reminder calls one business day prior to the visit.

Figure 1: Transitional Care Management Practice Example, University of North Carolina General Internal Medicine Clinic
*Required components for TCM claim



We started billing the TCM codes in January of 2013 and have successfully received reimbursement from Medicare and some private insurers. If the code is denied, we resubmit using the appropriate traditional evaluation and management code.

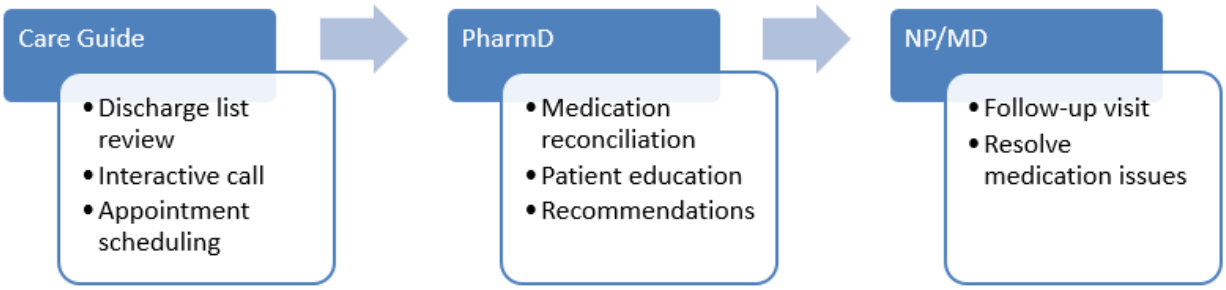
During the pilot phase, we measured the efficacy of our intervention through 30-day readmission rates. We demonstrated a reduction in 30-day readmission rates by approximately 65%.[8] This study was used to further justify the continuation of the program. In addition, the pharmacist involvement in the face-to-face visit was supported through a study comparing pharmacist involvement to no pharmacist involvement which demonstrated a 58% reduction in 30-day readmission rates.[9]

Beyond the pilot phase, we have established a monitoring program to facilitate continuous quality improvement. On a weekly basis, we monitor clinic access through number of appointments scheduled and our no-show rate weekly. On a monthly basis, we measure number of patients seen for a hospital follow-up visit within 7 days and within 14 days of hospital discharge and overall 30-day readmission rate.

Utah
Intermountain Healthcare Salt Lake Clinic
Internal Medicine/Family Medicine

The internal medicine and family medicine practices located at the Intermountain Salt Lake Clinic established a robust transitional care management service in 2013. The service involves a care guide, pharmacist and provider as outlined in Figure 2. The program meets the TCM codes requirements and successfully obtains reimbursement.

Figure 2: Transitional Care Management Practice Example, Intermountain Salt Lake Clinic

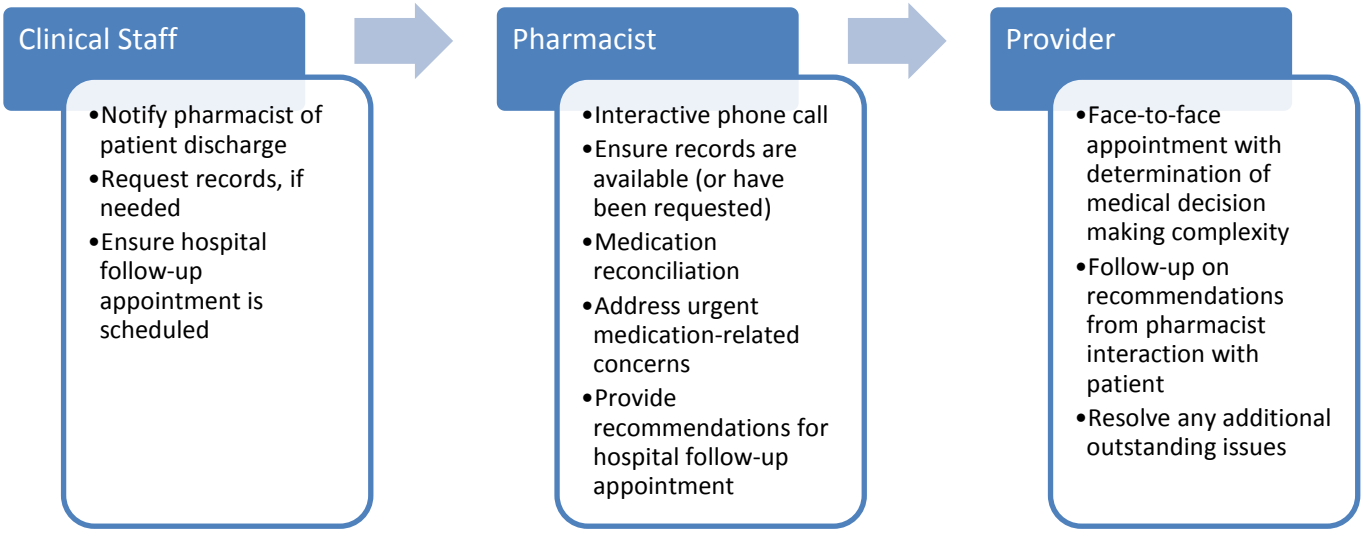


The pharmacist's interaction is primarily conducted via telephone communication, but can be completed in person, if preferred by the patient. The ability to interact with the patient while at home with their medications has been particularly beneficial to accurately reconcile the medication list and identify/resolve drug therapy problems and medication access issues in a timely fashion, even before the hospital follow-up appointment. With successful TCM billing since 2016, this service has proven valuable to the patients and clinicians at the Intermountain Salt Lake Clinic and serves as a model for similar implementations in other clinics within the system.

Ohio
W. W. Knight Family Medicine Center

The W. W. Knight Family Medicine Center established a transition of care program in June 2015. The program includes a pharmacist, clinical staff, and a provider. In an effort to streamline communication with the patient and decrease the number of calls patients receive post-discharge, the pharmacist performs all aspects of the interactive phone call. Figure 3 further describes the process and workflow.

Figure 3: Transitional Care Management Practice Example, W. W. Knight Family Medicine Center



Interaction between the patient and pharmacist primarily occurs via the telephone. When patients have extremely lengthy or complex medication regimens or if it is too difficult to perform medication reconciliation over the phone, the patient is asked to come into the clinic thirty minutes prior to their scheduled appointment and bring all of their medications. The phone follow-up with the pharmacist has allowed for the identification of medication-related problems that could result in readmission earlier.

Since process implementation, physicians have expressed hospital follow-up appointments run more smoothly when pharmacists are able to complete the TCM elements prior to the visit. In addition, the workflow implemented resulted in successful billing of the TCM service codes.

7. What are some tips for getting started?

Determine what resources in the clinic will be a part of the transitional care management team. Consider opportunities for collaboration with social work, care navigators, behavioral science or other disciplines at the site. Once the team has been established, define roles for each member of the team keeping in mind the required elements that have to be met for billing (see question #2). Create a workflow for the service, including how the team will be notified of patients who meet the criteria for the service, who will be the first point of contact, how handoffs will occur, and the standards for documentation processes. Again, ensure that the workflow developed allows for completion of the required elements. Establish metrics to evaluate during the development phase of your program. Metrics might include those listed in the examples provided above, including 30-day readmission rates, emergency room utilization, number of appointments and no-show rates. Assessing the number and type of medication-related interventions should also be considered. Demonstration of medication-related interventions may help to solidify the benefit of a pharmacist as a part of the transitional care management team.

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