Medical Coverage Policy

Transitional Care Management (CPT® 99495, 99496)

☐ Device/Equipment ☐ Drug ☐ Medical ☐ Surgery ☐ Test ☒ Other

Effective Date:	1/1/2013	Policy Last Updated:	12/18/2012

☐ **Prospective review is recommended/required. Please check the member agreement for preauthorization guidelines.**

☒ **Prospective review is not required.**

CPT® created codes effective 1/1/2013 for Transitional Care Management Services and Medicare has defined an additional policy regarding these services in the Physician Fee Schedule Final Rule.

This payment policy addresses items not specifically addressed by CPT and those items where CMS and CPT may appear to differ, otherwise all other CPT guidelines apply

Coding Guidelines:
New and Established Patients: Consistent with CMS, BCBSRI will allow these services to be reported for New Patients.

Eligible Providers: Only Primary Care Clinicians may report these services and only for those patients that are primary care patients of the practice. Physicians who are designated primary care (Family Medicine, Geriatrics, Internal Medicine and Pediatrics) and nurse practitioners (RNP) or physician's assistants (PA) who are designated primary care may report these services

Face to Face Service and E/M Coding Guidelines: The first and required face to face service must be an evaluation and management type service by a physician, RNP or PA.Therefore only these clinicians may report Transitional Care Management Services. However, only the medical decision making guidelines apply, including when a PCMH reports this service. All other E/M services reported must conform to the standard definitions for the service. The initial required face to face service may not be a discharge management service, even if performed by the primary care practice, consistent with the CMS restriction. It also may not be performed on the same date as discharge by the same physician or nonphysician who reports the discharge management service.

PCMH providers already receive payment for care management; therefore, they are not eligible for additional payments beyond the Evaluation and Management services that are the required face to face service. However, to track Transitional Care management services PCMH providers are encouraged to report transitional care management codes (99495 and 99496). Transitional care management codes 99495 will be priced the same as 99214 and 99496 will be priced the same as 99215. Therefore, clinicians may elect to report other E/M codes on the date of the initial face to face visit, if performed (e.g. a New Patient Office service).

Reporting Date (Date of Service): Practices may report the service at the date of the required initial face to face evaluation and management type service. It is felt that in most cases, the medical decision making will be apparent and the date of the visit will define the level of service. Therefore, the ease of reporting

on the date of the first visit will simplify tracking by the practice, be more easily understood by the patient when the patient reviews any explanation of benefits information and this method will indicate to BCBSRI when the initial face to face service occurred. However, if moderate decision making was selected and the patient ultimately has complex medical decision making within the service period and the initial face to face required service occurred within 7 days of discharge, an amended claim may be submitted using the standard methods to correct a claim. Practices may instead elect to report at the end of the service period, if the practice so elects. Transitional Care Management must continue for the 30 day period unless the patient expires regardless of methodology of reporting.

Required Contact at Two Business Days: This contact must be able to be interactive and may be with the patient or caregiver in the case of a patient who requires a surrogate. The contact must occur within two business days of discharge regardless of when the primary care clinician was notified of the hospital or nursing facility discharge. The primary care staff person who makes the contact must be either a licensed physician, Register Nurse Practitioner (RNP), Physician Assistant (PA), Registered Nurse (RN), Licensed Practical Nurse (LPN),social worker or pharmacist. A medical assistant contact does not meet the requirements to report the service. The contact may be part of the required initial face to face service, if that service occurs within 2 business days of discharge and is distinct from discharge services.

Policy:
Transitional Care management services are covered and separately reimbursed for all non Patient Centered Medical Home Providers (PCMH) Primary Care Clinicians according to the guidelines noted above. These services are considered a primary care office visit and take a PCP office visit co-pay.

For providers that are part of a Patient Centered Medical Home Practices (PCMH):
PCMH providers already receive payment for care management; therefore, they are not eligible for additional payments beyond the Evaluation and Management services that are the required face to face service. However, to track these services PCMH providers are encouraged to report these codes. 99495 will be priced the same as 99214 and 99496 will be priced the same as 99215. Therefore, clinicians may elect to report other E/M codes on the date of the initial face to face visit, if performed (e.g. a New Patient Office service). In addition, must adhere to additional coding guidelines noted above.

Coverage:
Benefits may vary between groups and contracts. Please refer to the appropriate Evidence of Coverage, Subscriber Agreement, or Benefit Booklet for applicable office visit coverage.

Coding:
99495, 99496

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changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice.