CMS to Pay Physicians for Services Related to Care Transitions

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The 2013 physician fee schedule rate update rule includes a new policy to pay a patient's physician or practitioner to coordinate the patient's care in the 30 days following a hospital or skilled nursing facility (SNF) stay. CMS believes recognizing the work of community physicians and practitioners in treating a patient following discharge from a hospital or nursing facility will ensure better continuity of care for these patients and help reduce patient readmissions.

The rule added two new Current Procedural Terminology (CPT) codes - 99495 and 99496 - for transition care management (TCM). These codes allow physicians and non-physician practitioners to bill for non-face-to-face services provided by the physician or practitioner and their clinical staff during the thirty days following discharge from a hospital or SNF.

These services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting - including acute hospital, rehabilitation hospital, long-term acute care hospital, partial hospital, observation status in a hospital, or SNF/nursing facility - to the patient's community setting consisting of home, domiciliary, rest home, or assisted living facility.

TCM is comprised of one face-to-face visit within the specified time frames, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction.

For non-facility based physicians or practitioners, the payments are $164 or $231, subject to geographic adjustment. These payment rates are higher than level 5 office visits for either new or established patients. Physicians that bill these TCM codes cannot bill for care plan oversight – codes G0181 or G0182 - for those thirty days, but the payment rates for TCM codes are higher than CPO codes. Physicians may bill for certification and recertification for Medicare home health services -codes G0180 and G0179 - in conjunction with the TCM codes.

Below are summaries of the basic elements for codes 99495 and 99496:

Transition Care Management CPT Codes:

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

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