Coding and Documentation of Transitional and Chronic Care Management Services

Since 2013, Medicare has reimbursed physicians and non-physician practitioners for transitional care management (TCM) under two CPT codes: 99495 and 99496. TCM involves a range of specified services to support a beneficiary for 30 days following his or her discharge from a facility setting.

As of January 1, 2015, Medicare now reimburses the same providers for chronic care management (CCM) under CPT code 99490. CCM supports a beneficiary with two or more chronic conditions through non-face-to-face care management services.

There are two additional CPT codes for care management services: 99487 and 99489. These services are described as complex chronic care management. Presently, Medicare does not reimburse for these services, although some commercial payers do.

Coding for care management services presents new challenges. The regulatory requirements for billing TCM and CCM are significantly different from the rules for other services furnished by physicians and non-physician practitioners, i.e., evaluation and management (E&M) services and procedures.

From a coder’s perspective, the medical record documentation must be sufficient to demonstrate beneficiary eligibility and delivery of the required services by a qualified provider. The following summarizes the necessary documentation for each.

Transitional Care Management

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary eligibility: post-discharge</td>
<td>Documentation that beneficiary was discharged to domicile or community setting from inpatient acute care hospitals (inpatient, observation, and outpatient partial hospitalization); rehabilitation hospitals; long-term acute care hospitals; skilled nursing facilities; and community mental health center partial hospitalization programs. <strong>Note:</strong> Discharge to a skilled nursing facility or community mental health center partial hospitalization program does not qualify.</td>
</tr>
<tr>
<td>Beneficiary eligibility: required level of medical decision-making</td>
<td>Documentation to support the following: Moderate complexity (99495): 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 (99496): 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.</td>
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<td>Communication by interactive means with beneficiary or caregiver within two business days of discharge (or two separate, unsuccessful attempts at communication during same time period)</td>
<td>Documentation of date of communication (or two failed attempts) and name and credentials of person making or attempting communication. <strong>Note:</strong> Such person may be a physician/non-physician practitioner (NPP) or clinical staff under general supervision.</td>
</tr>
<tr>
<td>Medication reconciliation performed no later than date of face-to-face visit</td>
<td>Documentation to support such services was provided; no specific documentation requirements identified.</td>
</tr>
<tr>
<td>Face-to-face E/M visit with physician/NPP within 7 (99496) or 14 (99495) calendar days following discharge</td>
<td>Documentation of date of visit. No specific elements required, but should at least be sufficient to bill Level 1 E/M visit. <strong>Note:</strong> Any subsequent E/M during 30-day period is separately billable.</td>
</tr>
<tr>
<td>Non-face-to-face care management services during 30-day post-discharge period furnished by physician/NPP or clinical staff under general supervision (no specific amount of time required)</td>
<td>Documentation to support such services was provided; no specific documentation requirements identified.</td>
</tr>
</tbody>
</table>

**Notes on TCM claim submission:**

- A claim should be submitted no earlier than the 30th day following discharge. The date of service listed on the claim should be the 30th day following discharge.
- A claim should be submitted under the National Provider Identifier (NPI) of the physician/NPP who performed the face-to-face visit.
- The site of service listed on the claim should be the site at which the face-to-face visit is performed.
- A physician/NPP cannot submit multiple claims for TCM covering overlapping time periods if beneficiary is admitted more than once during 30-day period. If patient is admitted during the 30-day period, the physician/NPP can bill an E/M that appropriately reflects the level of documented care provided during the face-to-face visit.
A physician/NPP who reports a global procedure cannot bill for TCM services for the same time period.
A physician/NPP who bills for TCM services cannot bill for the following services during the 30-day period:

- Care plan oversight services (99339, 99340, 99374-99380)
- Prolonged services without direct patient contact (99358, 99359)
- Anticoagulant management (99363, 99364)
- Medical team conferences (99366-99368)
- Education and training (98960-98962, 99071, 99078)
- Telephone services (98966-98968, 99441-99443)
- End-stage renal disease services (90951-90970)
- Online medical evaluation services (98969, 99444)
- Preparation of special reports (99080)
- Analysis of data (99090, 99091)
- Complex chronic care coordination services (99487, 99489)
- Chronic care management (99490)
- Medication therapy management services (99605-99607)

### Chronic Care Management

To be eligible to bill for CCM, a provider must satisfy certain scope-of-service requirements specified by regulation, including: (1) appropriate use of a certified electronic health record to compile relevant health information; (2) maintenance of an electronic care plan for each beneficiary receiving CCM; (3) processes to ensure beneficiary access to care; (4) facilitation of care transitions; and (5) performance of care coordination activities. Each of these requirements is discussed in detail in our white paper, [Providing and Billing Medicare for Chronic Care Management](#).

Typically, a coder will not be expected to confirm the provider’s compliance with these requirements; instead, this responsibility will likely fall to the practice administrator or billing practitioner. Therefore, the following focuses exclusively on the medical record documentation necessary to demonstrate beneficiary eligibility and delivery of the required services by a qualified provider.

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<tbody>
<tr>
<td>Beneficiary eligibility</td>
<td>Documentation that beneficiary has two or more chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. <strong>Note:</strong> There is no definitive list of chronic conditions, nor is there specific criteria that must be met to satisfy the specified acuity level.</td>
</tr>
<tr>
<td>Beneficiary’s written consent to receive CCM (document must be maintained in practice’s electronic health record)</td>
<td>Beneficiary’s written acknowledgment that the provider has explained the following: (1) the nature of CCM; (2) how CCM may be accessed; (3) that only one provider at a time can furnish CCM for the beneficiary; (4) the beneficiary’s health information will be shared with other providers for care coordination purposes; (5) the beneficiary may stop CCM at any time by revoking consent, effective at end of then-current calendar month; and (6) the beneficiary will be responsible for any associated copayment or deductible. <strong>Notes:</strong> According to the Centers for Medicare &amp; Medicaid Services’ (CMS) guidance, consent should be obtained and CCM services should commence following a face-to-face patient encounter (e.g., annual wellness visit, initial preventive physical exam, E/M service); also, CMS guidance indicates there is no requirement to periodically obtain an updated consent as long as the patient remains under the consenting provider’s care for CCM services.</td>
</tr>
</tbody>
</table>
| 20 minutes of non-face-to-face care management services furnished during calendar month by licensed clinical staff under physician’s/NPP’s general supervision | CMS does not list explicit documentation requirements for non-face-to-face services; however, the following would be sufficient to demonstrate compliance with this requirement: date and amount of time spent providing non-face-to-face services (preferably start/stop time); clinical staff furnishing services (with credentials); and brief description of services. **The following rules apply for counting the 20 minutes:**
• Time spent providing services on different days or by different clinical staff members in same month may be aggregated to total 20 minutes.
• If two staff members are furnishing services at the same time, only the time spent by one individual may be counted.
• Time of less than 20 minutes during a calendar month cannot be rounded up to meet this requirement; nor may time be carried over from a prior month.
• Time spent while the beneficiary is an inpatient at a facility cannot be counted.
• Time spent on the same day the patient receives an E/M service from the provider billing for CCM cannot be counted.
**Notes:** Licensed clinical staff includes individuals with state-issued licenses and certified medical assistants; CMS representatives indicated that documentation of time should be similar to those requirements imposed by Medicare Administrative Contractor (MAC) for other time-based services; CMS representatives indicated that creation of the electronic care plan is a qualifying service toward the 20-minutes requirement.
**Notes:** Qualifying services include (but are not limited to): (1) performing medication reconciliation and overseeing beneficiary’s self-management of medications; (2) ensuring receipt of all recommended preventive services; (3) monitoring beneficiary’s condition (physical, mental, social); (4) providing education and addressing questions from patient, family, guardian and/or caregiver; (5) identifying and arranging for needed community resources; and (6) communicating with home health agencies and other community service providers. |

**Notes on CCM claim submission:**

- CMS will pay only one CCM claim per beneficiary per calendar month.
- Check with commercial payers before submitting CCM code 99490 to identify payment rules.
- A claim should be submitted under the name of practitioner or practice identified on the written consent form.
- A claim for CCM may be submitted each month as soon as 20 minutes of non-face-to-face care management services have been provided. CMS has not yet offered guidance regarding the date of service or the site of service to be listed on the claim.
- A physician/NPP who bills for TCM services cannot bill for the following services during the same calendar month as CCM:
  
  Transitional care management (99495 and 99496)
  
  Home healthcare supervision (G0181)
  
  Hospice care supervision (G0182)
  
  End-stage renal disease services (90951-90970)

**Complex Chronic Care Management**

While not recognized by CMS or paid under the Medicare Physician Fee Schedule (MPFS), complex chronic care management (Complex CCM) services are payable by certain commercial payers. Similar to CCM, Complex CCM captures non-face-to-face care, although there are different time requirements for this code as noted below.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Patient eligibility: required level of medical decision-making</td>
<td>Documentation to support the following: Moderate complexity: 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: 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.</td>
</tr>
<tr>
<td>60 minutes of non-face-to-face care management services furnished during calendar month by licensed clinical staff under physician’s/NPP’s general supervision (99487)</td>
<td>Date and amount of time spent providing non-face-to-face services (preferably start/stop time); clinical staff furnishing services (with credentials); and brief description of services.</td>
</tr>
</tbody>
</table>
>89 minutes of non-face-to-face care management services furnished during calendar month by licensed clinical staff under physician’s/NPP’s general supervision, per 30-minute increment (+99489)

Documentation to support time requirement as described above.

Notes on Complex CCM claim submission:

- Face-to-face visits may be billed separately.
- The same provider may not bill TCM concurrently with Complex CCM.
- If a commercial carrier reimburses both CCM (99490) and Complex CCM (99487 and add-on code 99489), coders should work with practice management and providers to determine which codes are most appropriate for their services.

Other Considerations

Coders and billers working for organizations where operations are decentralized among locations may find instances where multiple providers are attempting to bill TCM or CCM services for a single patient. For example, in a multispecialty group setting, it is possible that an oncologist, a cardiologist and a primary care physician may wish to provide and bill for these services. In these instances, coders/billers should bring the issue to the attention of management so that it can be addressed prior to claims submittal. (Organizations may wish to proactively address this issue with its providers and establish policies, where appropriate, to prevent conflict.)

For information on PYA’s TCM and CCM coding and documentation training services, or assistance in operationalizing the care management model (gap analysis, staff training on processes and protocols, etc.), contact the experts listed below at PYA, (888) 420-9876.

Additional PYA resources on the requirements of billing TCM and CCM:

Providing and Billing Medicare for Chronic Care Management—2015 Medicare Physician Fee Schedule Final Rule white paper

Providing and Billing Medicare for Transitional Care Management white paper

PYA’s four-part educational series: Physician Value-Based Payments—What You Don’t Know Can Hurt You