Commercial Reimbursement Policy

Subject: **Transitional Care Management – Professional**	
Policy Number: **C-22002**	Policy Section: **Evaluation and Management**
Last Approval Date: **05/22/2024**	Effective Date: **04/27/2022**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem allows reimbursement for Transitional Care Management services, upon discharge from the below locations to the member's community setting, unless provider, state, or federal contracts and/or requirements indicate otherwise.

When a member requires a transition to a community setting, the Transitional Care Management services period begins upon the member's discharge and continues for 29 days.

Reimbursable

Transition discharge from:

- Inpatient Hospital
- Acute Hospital
- Rehabilitation Hospital
- Long-Term Acute Care Hospital
- Partial Hospital
- Observation status in a hospital
- Skilled Nursing Facility
- Nursing Facility
- Emergency Room

Transition to member community setting:

- Member's home
- Domiciliary
- Rest Home
- Assisted Living Facility

Related Coding

Code	Description	Comments
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.	

Policy History

05/22/2024	Review approved: no changes
04/27/2022	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- AMA CPT 2024 Professional Edition
- CMS
- Optum EncoderPro 2024

Definitions

Transitional Care Management	Management and coordination of services as needed for all medical conditions, psychosocial needs, and activity of daily living support for the full 30-day post discharge as patient transitions back into community setting.
General Reimbursement Policy Definitions	

Related Policies and Materials

Scope of License

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.