Chronic and Transitional Care Management

Reimbursement Policy ID: RPC.0127.0900

Recent review date: 09/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This reimbursement policy serves as a guide for submission of claims for care management services.

Exceptions

Limited specialty physicians such as clinical psychologists, podiatrists and dentists may not bill chronic care management (CCM).

Reimbursement Guidelines

Chronic Care Management
Chronic care management patients have 2 or more chronic conditions that are expected to last at least 12 months, until death, or that place them at significant risk of death, acute exacerbation or decompensation, or functional decline. These services are not typically provided face-to-face. Eligible practitioners are allowed to bill at least 20 minutes or more of care coordination services per month.

Primary care providers typically provide CCM services most often, but some specialists may provide and bill them. Clinical staff (employees or people working under contract with the billing physician) may provide those services as directed by the billing physician and not personally provided by the physician. These services are billed as "incident to" services.
These non-physician practitioners may bill Chronic Care Management (CCM) services.

- Certified Nurse Midwives (CNMs)
- Certified Nurse Specialists (CNSs)
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)

An initiating visit is required with the billing practitioner when the patient has not been seen within the previous year. If the practitioner does not specifically address CCM, for example, during an annual wellness exam, the visit may not be billed as an initiating visit (G0506).

Concurrent Billing

- Complex CCM (99491) may not be reported in the calendar month as non-complex CCM (99487, 99489, or 99490)
- CCM will not be reimbursed during the same month by the same practitioner as HCPCS codes G0181 or G0182 (home health care supervision, hospice care supervision) or CPT codes 90951-90970 (certain ESRD services).
- CCM codes 99478, 99489, 99490, 99491 by the same practitioner for services during the 30
- transitional care management (TCM) services period (CPT code 99495, 99496) will not be reimbursed when billed together.
- Complex CCM and prolonged E/M services may not be reimbursed in the same calendar month.
- Rural Health Centers and Federally Qualified Health Centers can bill CCM and TCM for the same patient during the same time period.
- Consult CPT instructions for other codes that may not be reimbursed when billed concurrently with CCM.

Transitional Care Management
Transitional care services (TCM) may be covered during the 30-day period that begins when a physician discharges a patient from an inpatient stay and continues for the next 29 days. The goal of these services is to help eligible patients transition back to a community setting after a stay at certain facility types.
Facility types include:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Inpatient rehabilitation
- Long term care hospital
- Skilled nursing facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a community health center

The patient must return to their community setting which may include a home, domiciliary (group home or boarding house), nursing facility or assisted living facility.
Physicians and non-physician practitioners may bill transitional care management (TCM) services.

- Certified Nurse Midwives (CNMs)
- Certified Nurse Specialists (CNSs)
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)

Non-Physician Practitioners (NPPs) may provide non-face-to-face TMC services “incident to” services of a physician or other non-physician practitioners.

TCM codes are care management codes. Physicians or (NPP)staff must provide patients with medically reasonable non-face-to-face services within the 30-day TCM service period. One face-to-face visit if required during the TCM service period as described by CPT code 99495 or 99496. Refer to the AMA CPT Evaluation and Management (E/M) Service Guidelines for guidance for care management codes that may be billed concurrently.

Definitions

Chronic Care Management
A coordinated approach to care for individuals with two or more chronic conditions, aiming to improve health outcomes, enhance quality of life, and reduce healthcare costs. It involves ongoing care beyond the traditional office visit, including personalized care plans, access to healthcare professionals, and support in managing medications and appointments.

Transitional Care Management
A structured approach that helps patients smoothly transition from one healthcare setting to another, such as from a hospital back to their home. It focuses on coordinating care and providing support to ensure a patient's needs are met during this transition, particularly after a hospital stay.

Incident To
“Incident to” a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services during the course of diagnosis or treatment of an injury or illness.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. https://www.ruralhealthinfo.org/care-management/chronic-care-management
VII. https://www.cms.gov/files/document/mln908628-transitional-care-management-services.pdf
VIII. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf
IX. Applicable health plans manual reference.
X. Applicable Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0014.0900 Incident To

Policy History

09/2026	Reimbursement Policy Committee Approval
09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
03/2026	Annual review • No major changes
11/2025	Reimbursement Policy Committee Approval