



HCCITM
HOME CENTERED CARE
INSTITUTE

Exploring Service Solutions in Managing Complex Illness for Palliative Care

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Agenda

1. Introductions
2. Objectives
3. Transitional Care Management (TCM)
4. General Behavioral Health Integration (BHI)
5. Social Determinants of Health (SDOH)
6. Caregiver Training
7. Q&A | Next Steps

Objectives

- Identify CMS-aligned metrics and billing codes for Transitional Care Management (TCM), Behavioral Health Integration (BHI), Social Determinants of Health (SDOH), and Caregiver Training to ensure accurate documentation and reimbursement.
- Evaluate care team roles and responsibilities in delivering integrated, patient-centered services across complex care domains, including TCM, BHI, SDOH, and caregiver training.
- Recognize implementation challenges and apply quality improvement strategies to enhance patient engagement, satisfaction, and program performance in home-based primary and palliative care settings.



Opening Discussion

Does your organization currently offer any of the following services?

- Transitional Care Management (TCM)
- Behavioral Health Integration (BHI)
- Support for Social Determinants of Health (SDOH)
- Caregiver Training

If so, what have been some of your successes or challenges in implementing these services?



Transitional Care Management (TCM)

Transitional Care Management (TCM)

- Transitional Care Management (TCM) is a structured, patient-centered approach to managing care transitions from inpatient facilities to community settings. It is designed for individuals with moderate to high medical complexity who require coordinated follow-up to prevent readmissions and ensure continuity of care. TCM supports patients during the critical 30-day post-discharge period through timely communication, medication reconciliation, and comprehensive care planning.
- CMS introduced dedicated billing codes (99495 and 99496) to reimburse providers offering these transitional services, including those in home-based primary care (HBPC) settings.

Eligibility Criteria

- **Recent discharge:** Patients who have been discharged from an inpatient/acute care setting within the past 2 business days and transitioned to a community care setting.
- **Discharge location:** Eligibility includes being discharged to home, domiciliary, rest home, or assisted living facility from specific types of facilities such as inpatient acute care hospitals, psychiatric hospitals, long-term care hospitals, skilled nursing facilities, or inpatient rehabilitation facilities.
- **Patient and caregiver education:** TCM candidates often need extensive education about their condition, medications, or self-care.

Key Components of TCM

Interactive Contact:

- Must occur within 2 business days of discharge.
- Can be via phone, email, or in-person

Face-to-Face Visit:

- Required within 7 days (high complexity) or 14 days (moderate complexity)

Non-Face-to-Face Services:

Medication reconciliation

- Coordination with community services
- Patient/caregiver education
- Review of discharge information

HCCI Resource

[Transitional Care Management Interactive Contact Requirements](#)
[Transitional Care Management \(TCM\) Face-To-Face Visit Requirements](#)

TCM Billing and Coding Requirements

Eligible Providers:

- Physicians (MDs and DOs, any specialty)
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Clinical Nurse Specialists (CNSs)

Additional Notes

- Providers may deliver both face-to-face and non-face-to-face components of TCM.
- Clinical staff under general supervision may assist with non-face-to-face services
- Only one provider may bill for TCM per patient per discharge
- TCM does not require prior patient consent to bill
- The billing provider does not need to have an established relationship with the patient prior to discharge

TCM Coding

CPT Code	Description and Requirements	2025 Medicare National Fee Schedule Payment	85% of MC allowable (NP/PA)
99495	Transitional Care Mgmt. (Moderate MDM/Complexity, seen within 14 days of discharge)	\$201.20	\$171.02
99496	Transitional Care Mgmt. (High MDM/Complexity, seen within 7 days of discharge)	\$272.68	\$231.78

HCCI Resource
[Home Based Medical Care Advanced Coding Opportunities - 2025](#)



General Behavioral Health Integration (BHI)

General Behavioral Health Integration (BHI)

- General Behavioral Health Integration (BHI) is a structured, team-based care management service designed to support patients with mental, behavioral, or psychiatric conditions within primary care settings. It promotes whole-person care by integrating behavioral health into routine medical care, improving access, outcomes, and continuity.
- CMS reimburses BHI services under CPT code 99484, which covers monthly care coordination activities performed by clinical staff under the supervision of a physician or qualified healthcare professional

Eligibility Criteria

- A patient qualifies for General BHI services if they have at least one mental, behavioral health, or psychiatric condition, including substance use disorders.
- The condition is either pre-existing or diagnosed by the billing practitioner, and in the clinical judgment of the practitioner, it warrants BHI services

Key Components of BHI

- **Initial Assessment and Monitoring:** Using validated tools to assess behavioral health needs and track progress over time.
- **Personalized Care Planning:** Collaborating with the patient to create and revise a tailored treatment plan.
- **Ongoing Care Management:** Maintaining a continuous relationship with the care team for support and follow-up.
- **Behavioral Health Coordination:** Facilitating access to appropriate behavioral health services and specialists.
- **Team-Based Collaboration:** Engaging a multidisciplinary team to deliver integrated, patient-centered care.
- **Patient and Family Engagement:** Involving patients and caregivers in decision-making and care planning.
- **Quality Improvement:** Measuring outcomes and using data to enhance care delivery and effectiveness.

BHI Billing and Coding Requirements

Eligible Providers:

- Physicians
- Clinical Psychologists (CPs)
- Clinical Social Workers (CSWs)
- Nurse Practitioners, and Physician Assistants

Additional Notes

- Initial assessment using validated rating scales
- Development and revision of care plans
- Coordination of treatment (e.g., psychotherapy, pharmacotherapy)
- Ongoing communication with the care team
- Patient consent must be documented
- Services can be provided outside of face-to-face encounters

BHI Coding

CPT Code	Description and Requirements	2025 Medicare National Fee Schedule Payment	85% of MC allowable (NP/PA)
99484	General Behavioral Health Integration Services; 20 minutes per calendar month	\$53.05	\$45.09

HCCI Resource
[Home Based Medical Care Advanced Coding Opportunities - 2025](#)

Benefits to Incorporating BHI Services

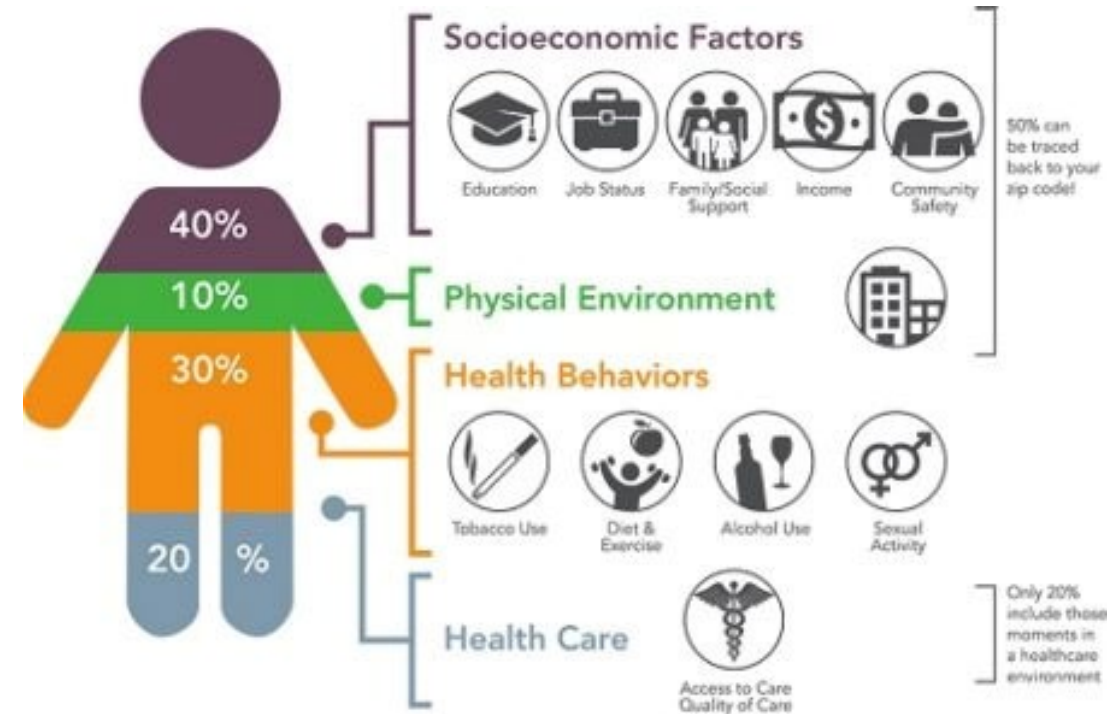
- Promotes overall health
- Closes treatment gaps
- Reduces stigma
- Reduces risk for self-harm and suicide
- Improves patient satisfaction



Social Determinants of Health (SDOH)

What are Social Drivers of Health?

- “The conditions in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life”
- Shaped by money, power, and resources



Process of SDOH Intervention in HBPC

1. **Identify** patients who are likely to have multiple health and social needs
2. **Screen** patients for SDOH needs and determine appropriate organizations with the resources and knowledge to address their specific needs
3. **Connect** patients with these community organizations to help address their health-related social needs
4. **Follow up** to ensure patients are connected and facilitate completion of the SDOH intervention or activity
5. **Track** outcomes of patients receiving community-based services

SDOH Risk Assessment

- Per CMS, Calendar Year 2024 coding and payment has been finalized for the administration of SDOH risk assessments.
- The risk assessment must be provided in conjunction with a qualifying visit, including an E/M visit, some behavioral health visits, or the Annual Wellness Visit (AWV).
- The SDOH risk assessment used by providers and practices must be standardized and evidence-based covering, at minimum, the following domains:
 1. Housing security
 2. Food insecurity
 3. Transportation needs
 4. Utility difficulty

SDOH Resources

CMS has listed the following resources that can be utilized when performing the SDoH Risk Assessment. These tools are simply resources that can be used as an example or guide when customizing a template for your practice or utilized to perform the assessment when providing care for patients.

- Accountable Health Communities Health-Related Social Needs Screening Tool
- American Academy of Family Physicians Social Needs Screening Tool
- HealthBegins
- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- Virginia Commonwealth University Health System: Social Needs Assessment

Stakeholder Partnerships

Internal

- Transitional and Supportive Care/House Calls
- Population health teams
- FaithHealth
- Pharmacy residents
- Care coordination
- Nurse navigators

External

- Community resource agencies
- Mental health
- Acute rehab and skilled nursing facilities
- Home health and DME
- Hospice and palliative care
- Community volunteers/nonprofits
- Congregational partners

SDOH Coding

HCPCS Code	Description and Requirements	2025 Medicare National Fee Schedule Payment
G0136	Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, no more than every 6 months.	\$18.97

HCCI Resource
Social Determinants of Health (SDoH) Screening and Coding Requirements
Home Based Medical Care Advanced Coding Opportunities - 2025

A healthcare professional, likely a nurse or doctor, is shown in a clinical setting, possibly a hospital room. They are wearing a stethoscope and are focused on attending to a patient who is lying in a hospital bed. The image is overlaid with a semi-transparent blue filter. The text 'Caregiver Training' is prominently displayed in the center-left area.

Caregiver Training

Introduction to Caregiver Training

- CMS recognizes caregiver training as **reimbursable care**
- Training may occur **without the patient present**
- Supports patients with conditions like **dementia, mobility limitations, and chronic illness**
- Can be delivered **in-person or via telehealth**

Billing & Compliance Essentials

Reimbursement Requirements

- Consent from patient or representative is mandatory
- Training must align with the individualized treatment plan
- Frequency should reflect:
 - Changes in patient condition
 - New diagnoses
 - Transition to new caregivers
- Services must be **reasonable and necessary** under Medicare.

CPT & HCPCS Codes for Caregiver Training

Behavioral & Functional Training:

- CPT 96202: Group behavior management training (initial 60 min)
- CPT 96203: Add-on (15 min)
- CPT 97550: Functional performance training (initial 30 min)
- CPT 97551: Add-on (15 min)
- CPT 97552: Group functional training

HCPCS Codes:

- G0539–G0540: Behavior management training
- G0541–G0543: Direct care strategies (e.g., wound care, infection control)

Survey Insights – Caregiver Experience

Patient-Caregiver Satisfaction Survey Highlights:

- Measures caregiver support and provider compassion
- Key metrics:
 - Level of support to caregivers
 - Provider's time and attentiveness
 - Trustworthiness and communication
- Encourages feedback to improve care delivery

HCCI Resource
[Patient Caregiver Satisfaction Survey Form](#)

Integrating Caregiver Training into Practice

Best Practices for Providers:

- Identify caregiver needs during patient visits
- Offer training proactively during care transitions
- Document training sessions thoroughly
- Use surveys to assess caregiver satisfaction and adjust support
- Leverage community resources and refer caregivers as needed



Questions or Comments?

Tell us how we did!

Please complete the short evaluation
that will appear after you close the
Zoom window

Takes 1–2 minutes

Thank you for your time and insights!

HCCI Courses Included in Innovation Award

1. Telehealth in Home-Based Primary Care
2. Management of Mental Health Conditions in Homebound Patients
3. Managing Multicomplexity in the Homebound Patient
4. Medication Management in Home-Based Primary Care
5. Patient Assessment in Home-Based Primary Care
6. Risk Adjustment and HCC Coding for House Calls
7. House Calls 101: Introduction to Home-Based Primary Care
8. Foundations of Coding & Billing for House Calls
9. Optimizing Revenue for House Calls: Coding, Billing, and Documentation
10. Intersection of Home-Based Primary Care and Palliative Care

HCCI Learning Hub™

HCCIntelligence™ Premier Resources Included in Innovation Award

General HBMC

- [HBPC: An Essential Lifeline for Caregivers](#)
- [HBPC: A Powerful Solution for Home-Limited, Medically Complex Patients](#)
- [Media Toolkit & Marketing Toolkit](#)
- [Interdisciplinary Team \(IDT\) Meeting Guide](#)
- [Patient Caregiver Satisfaction Survey Form](#)

Remote Patient Monitoring

- [Remote Patient Monitoring](#)

SDOH

- [Social Determinants of Health \(SDoH\) Screening and Coding Requirements](#)

TCM

- [Transitional Care Management Interactive Contact Requirements](#)
- [Transitional Care Management \(TCM\) Face-To-Face Visit Requirements](#)

HBPC Coding/Billing-Specific

- [Risk Adjustment Factors \(RAF\) for House Calls: Hierarchical Condition Categories \(HCC\) Coding Guide](#)
- [Home Based Medical Care Advanced Coding Opportunities](#)
- [Home-Based Medical Care Evaluation and Management \(E/M\) Guidelines](#)
- [Home-Based Medical Care: Superbill Worksheet](#)

CCM

- [CCM Toolkit](#)
- [Chronic Care Management \(CCM\) Care Plan Requirements](#)
- [Chronic Care Management \(CCM\) Provider Checklist](#)
- [Chronic Care Management \(CCM\) Care Plan Template](#)

[HCCI Learning Hub™](#)



Next Steps

- ☐ Attend October Monthly Consult Meeting
- ☐ Reschedule and/or attend November Monthly Consult Meeting
- ☐ Submit Innovation Award Progress Report by December 15th (see next slide)
- ☐ Complete Innovation Award Learning Evaluation Survey by December 15

Innovation Award Progress Report

Key Performance Indicator (KPI) Description	Time Period	Practice KPI
# CCM consented patients by month	April 2025	
	May 2025	
	June 2025	
	July 2025	
	August 2025	
	September 2025	
	October 2025	
	November 2025	
# Patients billed for CCM services by month	April 2025	
	May 2025	
	June 2025	
	July 2025	
	August 2025	
	September 2025	
	October 2025	
	November 2025	
# CCM consented patients who received a virtual or face-to-face medication reconciliation	April – November 2025	
# CCM consented patients who were hospitalized	April – November 2025	
CCM-specific codes billed for CCM consented patients	April – November 2025	

Due December 15th!