COLORADO
Department of Health Care Policy & Financing
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# Transitions of Care Codes Fact Sheet

December 2026

The Department of Health Care Policy and Financing (HCPF) is **opening the traditional Transitional Care Management codes 99495 and 99496, referred to collectively as Transitions of Care (TOC) codes, effective January 1, 2026.**

## What Does This Mean?

As of January 1, 2026, providers can begin billing codes 99495 and 99496 in place of the Evaluation and Management (E/M) codes 99214 and 99215 for eligible TOC visits. The TOC codes will be reimbursed at an equivalent rate to the E/M codes (e.g., 99495 will be reimbursed at the same rate as 99214 and 99496 will be reimbursed at the same rate as 99215). Providers must complete the following activities to successfully bill the TOC codes:

1. **Initial Contact:** Within 2 business days of the discharge date, the billing provider or qualified auxiliary personnel (under the supervision of the billing provider) makes two attempts to initiate direct and interactive communication with the patient or caregiver (phone, in-person, electronic) addressing: type of services the patient had during admission, discharge diagnosis, patient status and follow-up services that may be needed, medication reconciliation (not required to be part of the interactive contact, but must occur no later than the date of the face-to-face visit/virtual visit), and scheduling a face-to-face visit or virtual visit with the provider based on the required timeframes for each code, as outlined in the billing guidance.
2. **Follow-Up Appointment (Face-to-Face or Virtual Visit):** Following discharge, and after the interactive contact, a face-to-face or virtual visit allows the billing provider to assess the patient and develop a plan to aid the patient's return to the community setting. Medication reconciliation must occur no later than the date of the face-to-face/virtual visit, with the billing provider reviewing and signing off on any medication reconciliation performed by auxiliary personnel. The required time frame for this visit is based upon the complexity of the medical decision making, either moderate or high, for the patient's condition, as outlined in the billing guidance.
3. **Non-Face-to-Face Services:** Additional care coordination services may be performed, as needed by the patient or caregiver, throughout the 30-day post-discharge time period. Non-face-to-face services may be performed by the billing provider and/or auxiliary personnel. Although auxiliary personnel may not perform provider-only services, the provider may choose to personally perform any care coordination services.

Providers cannot bill the following E/M codes on the same date of service for members:

- Office or other outpatient E/M visits: 99202–99205 (new patient) and 99211–99215 (established patient)
- Home visit E/M codes: 99341–99345 (new patient home visits) and 99347–99350 (established patient home visits)
- Domiciliary / rest home / custodial care E/M codes: 99324–99328 (new patient) and 99334–99337 (established patient)

## Which providers can bill these codes?

All primary care and specialty care providers seeing Health First Colorado members can use the TOC codes, as well as the following providers:

- Federally Qualified Health Centers (FQHCs)*
- Psychiatrists and Psychiatric Advanced Practice Providers (APPs) part of Provider Type 16 (Clinic – Practitioner) or Provider Type 25 (Non-Physician Practitioner – Group)
- Rural Health Centers (RHCs)*
- Indian Health Service (IHS) providers*

*See additional billing guidance in the Frequently Asked Questions.

## Why is HCPF opening these codes?

TOC services play a critical role in reducing preventable readmissions and improving continuity of care for members following hospital or facility discharge.

### Benefits for Members

- **Reduced readmission risk:** TOC visits address clinical needs early, such as medication reconciliation, and close gaps in care by providing structured follow-up within 7 to 14 days after discharge.
- **Improved overall outcomes:** Early post-discharge engagement supports member stability, adherence and long-term health.

### Benefits for Providers

- **Standardized workflows across payers:** Many payers, including commercial and Medicare, already reimburse for TOC services. Aligning with these existing practices allows providers to use the same standardized workflow and documentation processes for all patients, without having to implement a different process for Health First Colorado members.
- **Shared savings opportunity:** Lower readmission rates and improved medication adherence that result from consistent TOC engagement contribute to improved member outcomes and can enhance providers' ability to earn shared savings. More information is available on the Alternative Payment Model webpage.
- **Strengthened care coordination:** TOC services formalize timely post-discharge follow-up workflows that benefit both providers and members.

## Questions?

Contact Morgan Anderson at Morgan.Anderson@state.co.us with questions about billing or reimbursement for these codes. For general questions contact HCPF_ACC@state.co.us.

Thank you for your ongoing collaboration to improve outcomes and advance high-quality, coordinated care for Health First Colorado members.

# Transitions of Care Codes Tip Sheet

## Step 1:Type of Admission

Determine from where the patient is discharged:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital Outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center

**Important:** A follow-up appointment after an Emergency Department (ED) visit is not a candidate for a TOC visit.

## Step 2: Discharge Location

Determine the discharge location of the patient:

- Patient home
- Patient domiciliary
- Rest home
- Assisted living

## Step 3: Initial Contact

You must make **at least two attempts to contact** the patient **within two business days of discharge** and schedule a follow-up face-to-face or virtual visit within 14 days after discharge.

**Important:** If you make two or more separate attempts to contact the patient in a timely manner and document the attempts in the medical record and if all other TOC visit criteria are met, you may report this service even if you were unsuccessful in reaching the patient.

## Step 4: Documentation

Document the TOC critical factors at first contact (either during the initial phone outreach or during the subsequent follow-up visit) which include:

- Discharge date
- Discharge summary reviewed
- Pending Diagnostic Tests and Treatments
- Pending Consultant Follow-Up
- Home Health Care
- Home Physical or Occupational Therapy
- Durable Medical Equipment
- Community Resources Needed
- Education Needed
- Patient Current Location

**Important:** During the face-to-face or virtual visit, document as you would for an E/M visit.

## Step 5: Medication Reconciliation

Medication reconciliation must be completed no later than the date of the follow-up face-to-face or virtual visit.

**Important:** It is best practice is to perform medication reconciliation during the two-day contact to identify any prescribing errors early during the patient's transition.

## Step 6: Current Procedural Terminology (CPT) Codes

| TOC Code | Use | Reimbursement |
|---|---|---|
| 99496 | • 7-day TOC follow-up for **high medical complexity.**<br>• Medical complexity is determined as two established problems are worse or one new problem with further work-up is identified. | Same as 99215 E/M code. |
| 99495 | • 14-day TOC follow-up for **both moderate and high complexity.** | Same as 99214 E/M code. |

## Frequently Asked Questions

**Q: Can Child Health Plan *Plus* (CHP+) providers bill these codes?**
**A:** Not at this time. HCPF is exploring opening these codes for CHP+ and will provide additional details when available.

**Q: Do virtual visits fulfill billing requirements?**
**A:** Yes.

**Q: Will providers receive higher reimbursement when using the TOC codes?**
**A:** No, TOC code 99496 is reimbursed at the same rate as E/M code 99215. TOC code 99495 is reimbursed at the same rate as E/M code 99214.

**Q: The member I see is enrolled in one of the two Managed Care Organizations (MCOs). Can I still bill for these codes?**
**A:** Yes, however each MCO may have different implementation dates for these codes. You must be contracted with the MCO in order to bill them.

**Q: I'm not a primary care provider. Can I bill these codes?**
**A:** Specialists can bill these codes. Psychiatrists and Psychiatric Advanced Practice Providers (APPs) part of Provider Type 16 (Clinic – Practitioner) or Provider Type 25 (Non-Physician Practitioner – Group) can bill HCPF directly for these codes.

**Q. I'm an RHC, FQHC, or IHS provider. Can I bill these codes?**
**A:** Yes. RHCs, IHS, and FQHCs that provide TOC services will follow standard reimbursement rules. TOC services that meet the definition of an FQHC or RHC visit should be billed directly to HCPF using Revenue Code 529 (FQHCs) or Revenue Code 521 (RHCs). IHS providers use Revenue Code 529.

**Q: I am a Comprehensive Safety Net Provider (CSNP) or a Community Mental Health Center (CMHC). Can I bill these codes?**
**A:** Provider Type 78 (CSNP) and Provider Type 35 (CMHC) providers have been excluded as billing entities and are unable to bill these codes.

**Q: What happens if two providers bill a TOC code for a patient?**
**A:** The first provider who uses the TOC code for a patient is the provider reimbursed for that visit.

**Q. What happens if a specialist already billed a TOC code, and my claim got denied?**
A: If the bill gets denied, the provider can resubmit the claim with the 99214 or 99215 E/M code.

**Q: What happens if I billed a TOC code for a patient that was readmitted within 30 days?**
**A:** HCPF will ask for adjustment of the code. It is best to use the TOC code and adjust later if needed.

**Q: If hospitalization is for a bundled payment or global (elective surgery) can I use these codes?**
**A:** No, in these cases the TOC codes are not covered.