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Transitional Care Management Services (TCM) UPDATE

New service for 2013

By: Codapedia Editor (Tue, Feb/26/2013)

DATE of Service: counting the discharge as day 1, bill on day 30. That is, after 29 days after the date of discharge has passed.

PLACE of Service: place where the mandated, bundled, non-reportable E/M service took place.

By now, you've heard the news that one of the ways in which Medicare plans to support primary care practices is by paying PCPs to provide post-discharge care of patients. (Although the service is not limited to PCPs as you'll see if you read further.) The new service, defined by CPT®, includes both face-to-face and non-face-to-face component in the definition. Medicare rarely defines a covered service that does not require a face-to-face service with a beneficiary, so this service stands out

Lets start with the CPT® definitions. When Medicare first proposed the service in the summer of 2012, they intended to develop a HCPCS GXXXX code. However, instead they decided to use CPT® codes 99495 and 99496. These are new codes in the 2013 CPT® book.

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 at least high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge.

These services are provided to patients who are discharged from inpatient or observation status admissions, skilled nursing facilities (SNF) and partial hospitalization programs back into the community. The payment is for the work of the physician or Non-Physician Practitioner who accepts the care of the patient post-discharge without a gap and takes responsibility for the patient's care. TCM may not be billed for transfer from a hospital to a SNF. TCM may not be billed by a surgeon when the patient is in the global period. TCM may be billed by the same physician who discharged the patient from the hospital. TCM may be billed by any specialty physician.

The physician may only bill the service 30 days after the discharge and only one provider will be paid TCM for any one patient discharge. Although CPT® defines these as services to new patients, CMS states they may be reported for new or established patients. The service is for patients whose medical and/or psychosocial problems require high or moderate complexity.

Here is how CMS describes the components of TCM in the 2013 Final Rule:

Transitional care management is comprised of one face-to-face visit within the specified time frames, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction. It is our expectation that the services in the two lists of non-face-to-face services below will be routinely provided as part of transitional care management service unless the practitioner's reasonable assessment of the patient indicates that a particular service is not medically indicated or needed.

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, may include:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
- Communication with home health agencies and other community services utilized by the patient.
- Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living.
- Assessment and support for treatment regimen adherence and medication management.
- Identification of available community and health resources
- Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

- Obtaining and reviewing the discharge information (for example, discharge summary, as available, or continuity of care documents).
- Reviewing need for or follow-up on pending diagnostic tests and treatments.
- Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems.
- Education of patient, family, guardian, and/or caregiver.
- Establishment or reestablishment of referrals and arranging for needed community resources.
- Assistance in scheduling any required follow-up with community providers and services.

Transitional care management requires a face-to-face visit, initial patient contact, and medication reconciliation within specified time frames. The first face-to-face visit is part of the transitional care management service and not reported separately. Additional E/M services after the first face-to-face visit may be reported

separately. Transitional care management requires an interactive contact with the patient or caregiver, as appropriate, within 2 business days of discharge. The contact may be direct (face-to-face), telephonic, or by electronic means. telephonic, or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit.

Some of the work of TCM may be performed by “clinical staff under the direction of the physician or other qualified health care professional” according to CPT® and CMS. This includes communication and education with the patient and/or caregiver, communication with home health agencies, assessment and support for treatment and adherence to medication regimen, assessment of available community and health resources, and facilitating care. The physician or NPP would obtain/review the discharge documents, review the need for follow up or pending diagnostic tests, interact with other health care professionals involved in the patient’s care, educate the patient/family as needed, establish or reestablish community resources and assist in scheduling medical or community resources.

TCM does require a face-to-face service within the time frames above and the first face-to-face service is not separately billable. Subsequent E/M services during the 29 day period or other diagnostic or therapeutic services may be billed separately. Note that medication reconciliation must be done no later than the first E/M service and that E/M service must occur within the time frame for each code.

Finally, how do we define the difference between moderate and high complexity? Again, from the 2013 Physician Rule, CMS reminds us that the source is the Documentation Guidelines, and reviews the difference between moderate and high.

Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of transitional care management. Documentation includes the timing of the initial post discharge communication with the patient or caregivers, date of the face-to-face visit, and the complexity of medical decision making.

(The E/M Services Guidelines define levels of medical decision making on the basis of the following factors:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options.?Medical decision making of moderate complexity requires multiple possible diagnoses and/or the management options, moderate complexity of the medical data (tests, etc.) to be reviewed, and moderate risk of significant complications, morbidity, and/or mortality as well as comorbidities. Medical decision making of high complexity requires an extensive number of possible diagnoses and/or the management options, extensive complexity of the medical data (tests, etc.) to be reviewed, and a high risk of significant complications, morbidity, and/or mortality as well as comorbidities)

Before we end this discussion, remember to document the work that is done. Document the non-face-to-face services, the contact at two days, the medication, the phone calls, the education, the coordination.

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