Enhancing Strategies for Reimbursement-Chronic Care and Transition Care Management

December 2015
Chat box feature

• Chat Box is available to you to ask questions or make comments anytime throughout today’s webinar.

• Submit to “Host” and click the send button
ACO Announcements

• Reminders:
  – ACO Notifications- November change
  – CMS reviews will begin in Jan 2016
Agenda

• Transitions of Care and Chronic Care Management-Market place concerns
• Who is eligible and requirements
• Process examples and billing experiences
• Question & Answer Section
HOSPITAL

HOW DO WE GET FROM...

PRIMARY CARE

Images:
http://medschool.umaryland.edu/familymedicine/about.asp
http://umm.edu/programs/pulmonary/professionals/pulmonary-fellowship/facilities
What is transitional care?

• Transitional care services are time-limited services designed to ensure:
  – health care continuity,
  – avoid preventable poor outcomes among at-risk populations
  – promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another.

• Complementary to primary care, care coordination, discharge planning, disease management/case management.

• Focus on highly vulnerable, chronically ill patients
  – emphasis on educating patients and family caregivers to address root causes of poor outcomes
Why important?

- Hospitalizations account for nearly one-third of the health care expenditures in the United States.
- Approximately 20% of Medicare beneficiaries discharged from hospitals were re-hospitalized within thirty days
  - 34% were readmitted within ninety days.
- This “churning” accounts for an estimated $15 billion in annual Medicare spending.

People with multiple chronic conditions use more health care resources.

Average Yearly Per Capita Health Spending for Individuals with Chronic Conditions, 2006

Quality Measurement: Domains

33 quality measures are separated into the following four key domains that will serve as the basis for assessing, benchmarking, rewarding, and improving ACO quality performance:

1. Patient/Caregiver Experience
2. Care Coordination/Patient Safety
3. Preventive Health
4. Clinical Care for At Risk Population
Quality Metrics...

Patient Experience
- Timely appointments
- Patient rating of MD
- Access to specialists

Preventive Health
- Influenza/Pneumococcal immunizations
- Depression screening
- Colon rectal/Mammography screening

Care Coordination/
Patient Safety
- All condition readmissions
- Ambulatory Sensitive Conditions
  (eg. COPD/Asthma/Heart Failure)

Disease Specific Measures
- Diabetes/Hypertension/
  Coronary Artery Disease
Transition Care Management (TCM)

- CPT codes 99495 & 99496 effective 1/1/2013
- Used to report physician or qualifying non-physician practitioner care management services for a patient following a discharge from the hospital
- Only ONE physician can bill for this service
- Cannot be billed until 30 days from the date of discharge for MEDICARE ONLY
• **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 *Cannot occur on same date 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 *Cannot occur on same date of discharge
Overlapping Programs

- Reducing Readmissions
- PCMH-Hospital Tracking
- Clinical Integration Care Management Measures-Calling patient and getting them seen within x amount of days
**Transitional Care Management Resources**


Medicare Information for Beneficiaries: [http://www.medicare.gov](http://www.medicare.gov) on the CMS website
2/3 of Medicare beneficiaries had 2 or more chronic conditions

About 1/3 had 4 or more chronic conditions

Source: [http://www.cdc.gov/pcd/issues/2013/12_0137.htm](http://www.cdc.gov/pcd/issues/2013/12_0137.htm)
How do patients qualify?

- Patient has multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of a patient.
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- Comprehensive care plan established, implemented, revised or monitored.
Chronic Care Management (CCM)

• New CPT code 99490 in CY2015
• NON Face to Face care management and coordination services
• Can be billed once per calendar month if a minimum of 20 minutes of qualifying services are furnished
• Reimbursed approx. $43/visit
• Provider needs to have initial visit (E&M or Wellness Visit) where they discuss this with the patient and have them sign an agreement
Overlapping Programs

- Patient Centered Medical Home
- Enhanced Care Mgmt program-patients with an HCC score of 1.1 or >
- ACO Goal of reducing Budget by 2%
- Aligns with CI Care Management Measures
CCM Resources

Chronic Conditions

Chronic Conditions Data Warehouse: https://www.ccwdata.org/web/guest

Final Rules in the Federal Register (policies governing CCM services)


Medicare Administrative Contractor (MAC) Contact Information:

Transitional Care Management (TCM)

Tami Kaczmarek, CPC, CMOM, CBO
Accessium Billing & Consulting, Inc
2821 Wehrle Drive Suite 12
Williamsville, NY 14221
716-863-6092
Transitional Care Management

Average reimbursements (across all lines of business)

Established office visit
- 99214 - $ 93.00  (moderate complexity)
- 99215 - $126.00  (high complexity)

Transitional Care Management
- 99495 - $154.95  (moderate complexity)
- 99496 - $218.96  (high complexity)
Care of Coordination Team

Track and monitor all admissions
1. Inpatient hospital
2. Long-term acute care hospital
3. Partial hospital
4. Observation status in a hospital
5. Skilled nursing facility

Once discharged
1. Retrieve discharge summary
2. Engage patient or caregiver within 2 business days from discharge

1. Review & assess patient’s understanding of discharge orders
2. Review & Reconcile Medications
3. Review and assess appropriate care and support at home
4. Schedule Hospital follow up appointment with provider (Use a specific appointment type)
Documentation & verification of visit

- Discharge summary is filed in chart
- CMP-HOSPT – Hospital Tracking Document

**Date Created:** 09/02/15

**ER/Hospital Admission Date:** 08/27/2015  
Summary of Care provided? Yes  Date: 08/28/15  No  Elective Admission

**Discharge Date:** 09/01/2015  
Discharge Summary obtained? Yes  Date: 09/02/15  No  Attempts: 1

**Date of Follow up call:** 09/02/2015

Follow up Appointment Scheduled: **09/10/2015**

Medication Reconciliation complete: Yes  see updated list in chart. Son states that insurance would not cover Amlodipine

- Progress note

  **CC:** Patient presents HOSPITAL FOLLOW UP
  Provider determines the complexity of the visit
TCM-Screenshots

• Retrieve hospital tracking document
TCM-Screenshots

- Complete Hospital Tracking document
TCM-Screenshots

- Hospital Tracking document shows date of next upcoming appointment
• Documentation of Hospital follow up
Chronic Care Management (CCM)

Tami Kaczmarek, CPC, CMOM, CBO
Accessium Billing & Consulting, Inc
2821 Wehrle Drive Suite 12
Williamsville, NY  14221
716-863-6092
Compare your Care Coordination Program

To the recognized CPT billable Code:

99490 Chronic Care Management Services

- At least 20 minutes of clinical staff time
- Multiple chronic conditions that place the patient at a significant risk (2 or more)
- Comprehensive care plan

New task: Patient agreement and tracking time
Chronic Care Management-Screenshots

• Enhanced Care Management Document
Chronic Care Management - Screenshots

• Care Management Flow sheet
Chronic Care Management - Screenshots

2 separate contents:
- Chronic Care Notification - past (CCMCONSENT - future implementation for billing CCM)
- Flagged, indicators of high risk

Most recent TCM date
Completed comprehensive care plan
Flow sheet: Documented time; Monthly total

Each month is separated and summarized with a total for billers to easily identify who has reached minimum time to bill for the monthly service.

PC-CCMREC:
Recommendation/referral into CCM program (implementation for CCM Billing)

Additional charge entry documentation verification:
PCC-CCMSTP: Chronic Care MGMT Stop Form
QUESTIONS??
Announcements

• Next Lunch & Learn: 1/20/2016
• Topic: Optimizing Medicare Annual Wellness Visit-How?
• ACO Notifications – November Change
• CMS reviews will begin in Jan 2016!

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(716)862-2453
The Centers for Medicare & Medicaid Services (CMS) recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending.

Beginning January 1, 2015, Medicare pays separately under the Medicare Physician Fee Schedule (PFS) under American Medical Association Current Procedural Terminology (CPT) code 99490, for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions. CPT 99490 is defined as follows:

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This fact sheet provides background on the newly payable chronic care management (CCM) service, identifies eligible providers and patients, and details the Medicare PFS billing requirements.

Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer’s disease and related dementia;
- Arthritis (osteoarthritis and rheumatoid);
- Asthma;
- Atrial fibrillation;
- Autism spectrum disorders;
- Cancer;
- Chronic Obstructive Pulmonary Disease;
- Depression;
- Diabetes;
- Heart failure;
- Hypertension;
- Ischemic heart disease; and
- Osteoporosis.

2/3 of Medicare beneficiaries had 2 or more chronic conditions

About 1/3 had 4 or more chronic conditions

Source: http://www.cdc.gov/pcd/issues/2013/12_0137.htm

Practitioner Eligibility

Physicians and the following non-physician practitioners may bill the new CCM service:

- Certified Nurse Midwives;
- Clinical Nurse Specialists;
- Nurse Practitioners; and
- Physician Assistants.

Only one practitioner may be paid for the CCM service for a given calendar month.

NOTE: Eligible practitioners must act within their State licensure, scope of practice, and Medicare statutory benefit. The CCM service may be billed most frequently by primary care physicians, although specialty physicians who meet all of the billing requirements may bill the service. The CCM service is not within the scope of practice of limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, therefore these practitioners cannot furnish or bill the service. However, CMS expects referral to or consultation with such physicians and practitioners by the billing practitioner to coordinate and manage care.
Services provided directly by an appropriate physician or non-physician practitioner, or by clinical staff incident to the billing physician or non-physician practitioner, count toward the minimum amount of service time required to bill the CCM service (20 minutes per calendar month).

Non-clinical staff time cannot be counted. Consult the CPT definition of “clinical staff” and the Medicare PFS “incident to” rules to determine whether time by specific individuals may be counted towards the minimum time requirement. Practitioners may use individuals outside the practice to provide CCM services, subject to the Medicare PFS “incident to” rules and regulations and all other applicable Medicare rules.

**Supervision**

CMS provided an exception under Medicare’s “incident to” rules that permits clinical staff to provide the CCM service incident to the services of the billing physician (or other appropriate practitioner) under the **general supervision** (rather than direct supervision) of a physician (or other appropriate practitioner).

**Patient Eligibility**

Patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline are eligible for the CCM service.

**Patient Agreement Requirements**

A practitioner must inform eligible patients of the availability of and obtain consent for the CCM service before furnishing or billing the service. Some of the patient agreement provisions require the use of certified Electronic Health Record (EHR) technology. For a complete listing of the Patient Agreement and Related EHR Requirements, see Table 1.

Patient consent requirements include:

- Inform the patient of the availability of the CCM service and obtain written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers.
- Explain and offer the CCM service to the patient. In the patient’s medical record, document this discussion and note the patient’s decision to accept or decline the service.
- Explain how to revoke the service.
- Inform the patient that only one practitioner can furnish and be paid for the service during a calendar month.
This agreement process should include a discussion with the patient, and caregiver when applicable, about:

- What the CCM service is;
- How to access the elements of the service;
- How the patient’s information will be shared among practitioners and providers;
- How cost-sharing (co-insurance and deductibles) applies to these services; and
- How to revoke the service.

Informed patient consent need only be obtained once prior to furnishing the CCM service, or if the patient chooses to change the practitioner who will furnish and bill the service.

**CCM Scope of Service Elements - Highlights**

The CCM service is extensive, including structured recording of patient health information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. Some of the CCM Scope of Service elements require the use of a certified EHR or other electronic technology. For a complete listing of the CCM Scope of Service elements and electronic technology requirements that must be met in order to bill the service, see Table 1.

<table>
<thead>
<tr>
<th>Structured Data Recording</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record the patient’s demographics, problems, medications, and medication allergies and create structured clinical summary records using certified EHR technology.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues).</td>
</tr>
<tr>
<td>Provide the patient with a written or electronic copy of the care plan and document its provision in the medical record.</td>
</tr>
<tr>
<td>Ensure the care plan is available electronically at all times to anyone within the practice providing the CCM service.</td>
</tr>
<tr>
<td>Share the care plan electronically outside the practice as appropriate.</td>
</tr>
</tbody>
</table>

Although patient cost-sharing applies to the CCM service, CCM may help avoid the need for more costly face-to-face services in the future by proactively managing patient health, rather than only treating disease and illness.
Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list;
- Expected outcome and prognosis;
- Measurable treatment goals;
- Symptom management;
- Planned interventions and identification of the individuals responsible for each intervention;
- Medication management;
- Community/social services ordered;
- A description of how services of agencies and specialists outside the practice will be directed/coordinated; and
- Schedule for periodic review and, when applicable, revision of the care plan.

Access to Care

- Ensure 24-hour-a-day, 7-day-a-week (24/7) access to care management services, providing the patient with a means to make timely contact with health care practitioners in the practice who have access to the patient’s electronic care plan to address his or her urgent chronic care needs.
- Ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient’s care. Do this through telephone, secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
Care management services such as:

- Systematic assessment of the patient’s medical, functional, and psychosocial needs;
- System-based approaches to ensure timely receipt of all recommended preventive care services;
- Medication reconciliation with review of adherence and potential interactions; and
- Oversight of patient self-management of medications.

Manage care transitions between and among health care providers and settings, including referrals to other providers, including:

- Providing follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities.

 Coordinate care with home and community based clinical service providers.

**EHR and Other Electronic Technology Requirements**

CMS requires the use of certified EHR technology to satisfy some of the CCM scope of service elements. In furnishing these aspects of the CCM service, CMS requires the use of a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year (referred to as “CCM certified technology”). For more information, visit [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms) on the CMS website.

At this time, CMS does not require the use of certified EHR technology for some of the services involving the care plan and clinical summaries, allowing for broader electronic capabilities. These are described in Table 1, CCM Scope of Service and Billing Requirements.

For CCM payment in calendar year (CY) 2015, practitioners may use EHR technology certified to either the 2011 or 2014 edition(s) of certification criteria.
### Table 1. CCM Scope of Service and Billing Requirements

<table>
<thead>
<tr>
<th>CCM Scope of Service Element/Billing Requirement</th>
<th>Certified EHR or Other Electronic Technology Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation during an AWV, IPPE, or comprehensive E/M visit (billed separately).</td>
<td>None</td>
</tr>
<tr>
<td>Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.</td>
<td>Structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology.</td>
</tr>
<tr>
<td>Access to care management services 24/7 (providing the beneficiary with a means to make timely contact with health care practitioners in the practice who have access to the patient’s electronic care plan to address his or her urgent chronic care needs regardless of the time of day or day of the week).</td>
<td>None</td>
</tr>
<tr>
<td>Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments.</td>
<td>None</td>
</tr>
<tr>
<td>Care management for chronic conditions including systematic assessment of the beneficiary’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.</td>
<td>None</td>
</tr>
<tr>
<td>Creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues. Share the care plan as appropriate with other practitioners and providers.</td>
<td>Must at least electronically capture care plan information; make this information available on a 24/7 basis to all practitioners within the practice whose time counts towards the time requirement for the practice to bill the CCM code; and share care plan information electronically (other than by fax) as appropriate with other practitioners and providers.</td>
</tr>
<tr>
<td>CCM Scope of Service Element/Billing Requirement</td>
<td>Certified EHR or Other Electronic Technology Requirement</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.</td>
<td>Document provision of the care plan as required to the beneficiary in the EHR using CCM certified technology.</td>
</tr>
<tr>
<td>Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.</td>
<td>Format clinical summaries according to CCM certified technology. Not required to use a specific tool or service to exchange/transmit clinical summaries, as long as they are transmitted electronically (other than by fax).</td>
</tr>
<tr>
<td>Coordination with home and community based clinical service providers.</td>
<td>Communication to and from home and community based providers regarding the patient’s psychosocial needs and functional deficits must be documented in the patient’s medical record using CCM certified technology.</td>
</tr>
<tr>
<td>Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary’s care through not only telephone access, but also through the use of secure messaging, Internet or other asynchronous non-face-to-face consultation methods.</td>
<td>None</td>
</tr>
<tr>
<td>Beneficiary consent—Inform the beneficiary of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers. Document in the beneficiary’s medical record that all of the CCM services were explained and offered, and note the beneficiary’s decision to accept or decline these services.</td>
<td>Document the beneficiary’s written consent and authorization in the EHR using CCM certified technology.</td>
</tr>
<tr>
<td>Beneficiary consent—Inform the beneficiary of the right to stop the CCM services at any time (effective at the end of the calendar month) and the effect of a revocation of the agreement on CCM services.</td>
<td>None</td>
</tr>
<tr>
<td>Beneficiary consent—Inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month.</td>
<td>None</td>
</tr>
</tbody>
</table>
Other Billing Requirements

CPT code 99490 cannot be billed during the same service period as CPT codes 99495–99496 (transitional care management), Healthcare Common Procedure Coding System (HCPCS) codes G0181/G0182 (home health care supervision/hospice care supervision), or CPT codes 90951–90970 (certain End-Stage Renal Disease services). Also consult CPT instructions for additional codes that cannot be billed during the same service period as CPT code 99490. There may be additional restrictions on billing for practitioners participating in a CMS sponsored model or demonstration program.

Payment

CMS pays for the new CCM service separately under the Medicare PFS. To find payment information for a specific geographic location, access the Medicare PFS Look-Up tool at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup on the CMS website.

CCM and Other CMS Advanced Primary Care Initiatives

The CCM service provides payment of care coordination and care management for a beneficiary with multiple chronic conditions within the Medicare Fee-For-Service Program. Medicare will not make duplicative payments for the same or similar services for beneficiaries with chronic conditions already paid for under the various CMS advanced primary care demonstration and other initiatives, such as the Multi-payer Advanced Primary Care Practice (MAPCP) or the Comprehensive Primary Care (CPC) Initiatives. For more information on potentially duplicative billing, consult the CMS staff responsible for these separate initiatives. As CMS implements new models or demonstrations that include payments for care management services, or as changes take place that affect existing models or demonstrations, it will address potential overlaps with the CCM service and seek to implement appropriate payment policies.
Resources


Table 2 provides resources for additional information on CCM services.

Table 2. CCM Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCM Frequently Asked Questions (FAQs)</td>
<td><a href="http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched">http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched</a></td>
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<td><a href="http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS">http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS</a></td>
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<td>Chronic Conditions Data Warehouse</td>
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</tbody>
</table>
This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Transitional Care Management Services

This publication provides the following information:

- Transitional Care Management (TCM) services;
- Health care professionals who may furnish TCM services;
- TCM services settings;
- Components included in TCM;
- Billing TCM services;
- Frequently Asked Questions; and
- Resources.

**TCM SERVICES**

The requirements for TCM services include:

- The services are required during the beneficiary’s transition to the community setting following particular kinds of discharges;
- The health care professional accepts care of the beneficiary post-discharge from the facility setting without a gap;
- The health care professional takes responsibility for the beneficiary’s care; and
- The beneficiary has medical and/or psychosocial problems that require moderate or high complexity medical decision making.

The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days.

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HEALTH CARE PROFESSIONALS WHO MAY FURNISH TCM SERVICES

The following health care professionals may furnish TCM services:

- Physicians (any specialty); and
- The following non-physician practitioners (NPP) who are legally authorized and qualified to provide the services in the State in which they are furnished:
  - Certified nurse-midwives;
  - Clinical nurse specialists;
  - Nurse practitioners; and
  - Physician assistants.

When “you” is used in this publication, we are referring to these health care professionals.

TCM SERVICES SETTINGS

TCM services are furnished following the beneficiary’s discharge from one of the following inpatient hospital settings:

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

Following discharge from one of the above settings, the beneficiary must be returned to his or her community setting, such as:

- His or her home;
- His or her domiciliary;
- A rest home; or
- Assisted living.

COMPONENTS INCLUDED IN TCM

During the 30 days beginning on the date the beneficiary is discharged from a hospital inpatient setting, the following three TCM components must be furnished:

- An interactive contact;
- Certain non-face-to-face services; and
- A face-to-face visit.

Each component is discussed in more detail on pages 3 and 4.
AN INTERACTIVE CONTACT
You must make an interactive contact with the beneficiary and/or caregiver, as appropriate, within 2 business days following the beneficiary’s discharge to the community setting. The contact may be via telephone, e-mail, or face-to-face.

For Medicare purposes, attempts to communicate should continue after the first two attempts in the required 2 business days until they are successful. A successful attempt requires a direct exchange of information and appropriate medical direction by clinical staff with the beneficiary and/or caregiver and not merely receipt of a voicemail or e-mail without response from the beneficiary and/or caregiver. You may not bill the TCM if there was no successful communication within the 30-day period between the facility discharge and the date of service for the post-discharge TCM code.

CERTAIN NON-FACE-TO-FACE SERVICES
You must furnish non-face-to-face services to the beneficiary, unless you determine that they are not medically indicated or needed. Certain non-face-to-face services may be furnished by licensed clinical staff under your direction.

Services Furnished by Physicians or NPPs
You may furnish the following non-face-to-face services:

- Obtain and review discharge information (for example, discharge summary or continuity of care documents);
- Review need for or follow-up on pending diagnostic tests and treatments;
- Interact with other health care professionals who will assume or reassume care of the beneficiary’s system-specific problems;
- Provide education to the beneficiary, family, guardian, and/or caregiver;
- Establish or re-establish referrals and arrange for needed community resources; and
- Assist in scheduling required follow-up with community providers and services.

Services Furnished by Licensed Clinical Staff Under the Direction of a Physician or NPP
Licensed clinical staff under your direction may furnish the following face-to-face services:

- Communicate with agencies and community services used by the beneficiary;
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living;
- Assess and support treatment regimen adherence and medication management;
- Identify available community and health resources; and
- Assist the beneficiary and/or family in accessing needed care and services.

A FACE-TO-FACE VISIT
One face-to-face visit must be furnished within certain timeframes as described by the following two new Current Procedural Terminology (CPT) codes (effective for services furnished on or after January 1, 2013):

- CPT Code 99495 – Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge); or

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CPT Code 99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge).

The face-to-face visit is part of the TCM service and is not reported separately.

**Medical Decision Making**

Medical decision making is determined by considering 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), selecting the diagnostic procedure(s), and/or selecting the possible management options.

The table below shows the elements for each level of medical decision making. Note that to qualify for a given type of medical decision making, two of the three elements must be either met or exceeded.

### Elements for Each Level of Medical Decision Making

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Number of Possible Diagnoses and/or Management Options</th>
<th>Amount and/or Complexity of Data to Be Reviewed</th>
<th>Risk of Significant Complications, Morbidity, and/or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>


**Medication Reconciliation and Management**

Medication reconciliation and management must be furnished no later than the date you furnish the face-to-face visit.

**BILLING TCM SERVICES**

Information about billing TCM services is provided below:

- Only one health care professional may report TCM services;
- Report services once per beneficiary during the TCM period;
The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day discharge day management services are reported;

Reasonable and necessary evaluation and management (E/M) services (other than the required face-to-face visit) to manage the beneficiary’s clinical issues should be reported separately;

You may not bill TCM services and services that are within a post-operative global period (TCM services cannot be paid if any of the 30-day TCM period falls within a global period for a procedure code billed by the same practitioner);

When you report CPT codes 99495 and 99496 for Medicare payment, you may not also report the following codes during the TCM period:

- Care plan oversight services: Healthcare Common Procedure Coding System (HCPCS) codes G0181 and G0182; and
- End-Stage Renal Disease services: CPT codes 90951 – 90970; and

You must document the following information, at a minimum, in the beneficiary's medical record:

- Date the beneficiary was discharged;
- Date you made an interactive contact with the beneficiary and/or caregiver;
- Date you furnished the face-to-face visit; and
- The complexity of medical decision making (moderate or high).

**FREQUENTLY ASKED QUESTIONS**

**What date of service should be used on the claim?**

The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The reported date of service should be the 30th day.

**What place of service should be used on the claim?**

The place of service reported on the claim should correspond to the place of service of the required face-to-face visit.

**If the codes became effective on January 1, 2013, and, in general, cannot be billed until 29 days past discharge, will claims submitted before January 29, 2013, with the TCM codes be denied?**

Because the TCM codes describe 30 days of services and because the TCM codes are new codes beginning on January 1, 2013, only 30-day periods beginning on or after January 1, 2013, are payable. Thus, the first payable date of service for TCM services is January 30, 2013.

**The CPT book describes services by the physician’s staff as “and/or licensed clinical staff under his or her direction.” Does this mean only registered nurses and licensed practical nurses or may medical assistants also provide some parts of the TCM services?**

Can the services be provided in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)?

While FQHCs and RHCs are not paid separately by Medicare under the Medicare Physician Fee Schedule (PFS), the face-to-face visit component of TCM services could qualify as a billable visit in a FQHC or RHC. Additionally, physicians or other qualified providers who have a separate Fee-For-Service practice when not working at the RHC or FQHC may bill the CPT TCM codes, subject to the other existing requirements for billing under the PFS.

If the beneficiary is readmitted within the 30-day period, can TCM still be reported?

Yes, TCM services can still be reported as long as the services described by the code are furnished by the practitioner during the 30-day period, including the time following the second discharge. Alternatively, the practitioner can bill for TCM services following the second discharge for a full 30-day period as long as no other provider bills the service for the first discharge. CPT guidance for TCM services states that only one individual may report TCM services and only once per beneficiary within 30 days of discharge. Another TCM may not be reported by any practitioner for any subsequent discharge(s) within 30 days.

Can TCM services be reported if the beneficiary dies prior to the 30th day following discharge?

Because the TCM codes describe 30 days of care, in cases when the beneficiary dies prior to the 30th day, practitioners should not report TCM services but may report any face-to-face visits that occurred under the appropriate E/M code.

Medicare will only pay one physician or qualified practitioner for TCM services per beneficiary per 30-day period following a discharge. If more than one practitioner reports TCM services for a beneficiary, how will Medicare determine which practitioner to pay?

Medicare will only pay the first eligible claim submitted during the 30-day period that commences with the day of discharge. Other practitioners may continue to report other reasonable and necessary services, including other E/M services, to beneficiaries during those 30 days.

Can TCM services be reported under the primary care exception? Can the services be reported with the -GC modifier?

TCM services are not on the primary care exception list, so the general teaching physician policy applies as it would for E/M services not on the list. When a physician (or other appropriate billing provider) places the -GC modifier on the claim, he or she is certifying that the teaching physician has complied with the requirements in Chapter 12, Sections 100.1 through 100.1.6, of the “Medicare Claims Processing Manual” (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf on the CMS website.

Can practitioners under contract to the physician billing for the TCM service furnish the non-face-to-face component of the TCM?

Physician offices should follow “incident to” requirements for Medicare billing. “Incident to” recognizes numerous employment arrangements, including contractual arrangements, when there is direct physician supervision of auxiliary personnel. This issue is addressed in greater detail in Chapter 15, Section 60, of the “Medicare Benefit Policy Manual” (Publication 100-02) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf on the CMS website.

During the 30-day period of TCM, can other medically necessary billable services be reported?

Yes, other reasonable and necessary Medicare services may be reported during the 30-day period, with the exception of those services that cannot be reported according to CPT guidance and Medicare HCPCS codes G0181 and G0182.

If a beneficiary is discharged on Monday at 4:30 p.m., does Monday count as the first business day and then Tuesday as the second business day, meaning that the communication must occur by close of business on Tuesday? Or, would the provider have until the end of the day on Wednesday?

In the scenario described, the practitioner must communicate with the beneficiary by the end of the day on Wednesday, the second business day following the day of discharge.
Can TCM services be reported when furnished in the outpatient setting?

Yes. CMS has established both a facility and non-facility payment for this service. Practitioners should report TCM services with the place of service appropriate for the face-to-face visit.

### RESOURCES

The table below provides TCM resource information.

#### Transitional Care Management Resources

<table>
<thead>
<tr>
<th>For More Information About...</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Information for Beneficiaries</td>
<td><a href="http://www.medicare.gov">http://www.medicare.gov</a> on the CMS website</td>
</tr>
</tbody>
</table>
Check out CMS on:

Twitter LinkedIn YouTube

8 Transitional Care Management Services
Frequently Asked Questions about Billing Medicare for Transitional Care Management Services

Effective January 1, 2013, Medicare pays for two CPT codes (99495 and 99496) that are used to report physician or qualifying nonphysician practitioner care management services for a patient following a discharge from a hospital, SNF, or CMHC stay, outpatient observation, or partial hospitalization. This policy is discussed in the CY 2013 Physician Fee Schedule final rule published on November 16, 2012 (77 FR 68978 through 68994). The following are some frequently asked questions that we have received about billing Medicare for transitional care management services.

- What date of service should be used on the claim?

  The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The reported date of service should be the 30th day.

- What place of service should be used on the claim?

  The place of service reported on the claim should correspond to the place of service of the required face-to-face visit.

- If the codes became effective on Jan. 1 and, in general, cannot be billed until 29 days past discharge, will claims submitted before Jan. 29 with the TCM codes be denied?

  Because the TCM codes describe 30 days of services and because the TCM codes are new codes beginning on January 1, 2013, only 30-day periods beginning on or after January 1, 2013 are payable. Thus, the first payable date of service for TCM services is January 30, 2013.

- The CPT book describes services by the physician’s staff as "and/or licensed clinical staff under his or her direction." Does this mean only RNs and LPNs or may medical assistants also provide some parts of the TCM services?

  Medicare encourages practitioners to follow CPT guidance in reporting TCM services. Medicare requires that when a practitioner bills Medicare for services and supplies commonly furnished in physician offices, the practitioner must meet the “incident to” requirements described in Chapter 15 Section 60 of the Benefit Policy Manual 100-02.

- Can the services be provided in an FQHC or RHC?

  While FQHCs and RHCs are not paid separately by Medicare under the PFS, the face-to-face visit component of TCM services could qualify as a billable visit in an FQHC or RHC. Additionally, physicians or other qualified providers who have a separate fee-for-service practice when not working at the RHC or FQHC may bill the CPT TCM codes, subject to the other existing requirements for billing under the MPFS.
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• **Can TCM services be reported if the beneficiary dies prior to the 30th day following discharge?**

Because the TCM codes describe 30 days of care, in cases when the beneficiary dies prior to the 30th day, practitioners should not report TCM services but may report any face-to-face visits that occurred under the appropriate evaluation and management (E/M) code.

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• **Can practitioners under contract to the physician billing for the TCM service furnish the non-face to face component of the TCM?**

Physician offices should follow “incident to” requirements for Medicare billing. “Incident to” recognizes numerous employment arrangements, including contractual arrangements, when there is direct physician supervision of auxiliary personnel.


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- If a patient is discharged on Monday at 4:30, does Monday count as the first business day and then Tuesday as the second business day, meaning that the communication must occur by close of business on Tuesday? Or, would the provider have until the end of the day on Wednesday?

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- Can TCM services be reported when furnished in the outpatient setting?

  Yes. CMS has established both a facility and non-facility payment for this service. Practitioners should report TCM services with the place of service appropriate for the face-to-face visit.