Maine Quality Counts presents…

QC Provider Lunch & Learn

New CMS Primary Care Transitional Care Management Services & Billing Codes: What Practices Need to Know

August 6, 2013 (12PM - 1PM)

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Debra McGill, Population Health Manager, Maine Medical Partners

Speakers

Elaine MacLeod, is a manager in the Healthcare Consulting Division of Baker Newman Noyes with experience in multi specialty auditing, coding, billing, compliance and provider education. She became a Certified Professional Coder through the American Academy of Professional Coders and a Physician Coding Specialist through the American College of Medical Coding Specialists.

Debra McGill, RN, is the Population Health Manager for Maine Medical Partners. Under the guidance of the MMP Quality Program, Debra has developed a successful Care Transition Program using several components of the Dartmouth Institute’s Clinical Microsystem approach to quality improvement.
The transition in care is from:
- an inpatient hospital setting
- partial hospital
- observation status in a hospital
- skilled nursing facility/nursing facility

To the patient’s community setting:
- home
- domiciliary
- rest home
- or assisted living

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TCM Criteria

• CPT TCM are services for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care.

• TCM services address any needed coordination of care performed by multiple disciplines and community service agencies.

TCM Criteria

• Codes 99495, 99496 require:
  - A face-to-face visit within the specified time frames
    • 99495
  - Interactive contact with the patient or caregiver within 2 business days of discharge and may be direct (face-to-face), telephonic, or by electronic means.
  - Medication reconciliation and management no later than the date of the face-to-face visit
TCM CRITERIA

• Codes 99495, 99496:
  – Are reported once per patient within 30 days of discharge
  – Are selected based on medical decision making and the date of the first face-to-face visit
  – May only be reported by one individual

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
  – work RVU = 2.11 and 40 minutes intra-service time
TCM CRITERIA

- **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
  - **work RVU = 3.05**

TCM & CMS

- CMS indicated they will modify the prefatory instructions to allow physicians to bill these codes for **new** patients, not only established patients as specified in CPT.
- CMS clarifies post-discharge service period in prefatory language
  - The physician who reports a global procedure should not be permitted to also report the TCM service.
  - “The same individual should not report transitional care management services provided in the post-operative period for a service with a global period.”
TCM & CMS

- CMS indicated the same physician may bill the discharge day management code for this patient and the TCM code for this patient
  - CMS is concerned about overlap and will monitor
- CMS indicated that the same physician cannot bill the discharge day management code and the TCM included E/M visit on the same day.
  - The E/M visit is included in the TCM code, one assumes CMS will monitor when the E/M visit occurred via auditing documentation
- CMS states “We wish to avoid any implication that the E/M services furnished on the day of discharge as part of the discharge day management service could be considered to meet the requirement for the TCM service that the physician or nonphysician practitioner must conduct an E/M service within 7 or 14 days of discharge.”

TCM CODING TIP

- If another individual provides TCM services within the postoperative period of a surgical package, modifier 54 is not required.
The required contact with the patient or caregiver, as appropriate, may be by the physician or qualified health care professional or clinical staff. Within two business days of discharge is Monday through Friday except holidays without respect to normal practice hours or date of notification of discharge. The contact must include capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care. If two or more separate attempts are made in a timely manner, but are unsuccessful and other transitional care management criteria are met, the service may be reported.

TCM Coding Tip

- TCM Includes:
  - Care Plan Oversight Services
  - Prolonged Services Without Direct Patient Contact
  - Anticoagulant Management
  - Medical Team Conferences
  - Education and Training
  - Telephone Services
  - End Stage Renal Disease Services
  - On-Line Medical Evaluation
  - Preparation of Special Reports
  - Analysis of Data
  - Medication Therapy Management
TCM CODING TIP

• Per CPT “The first face-to-face visit is part of the TCM service and not reported separately. Additional E/M services after the first face-to-face visit may be reported separately.”

Example:

• Jan 1st 2013 - discharged from hospital
• Jan 3rd 2013 - 99495/99496 (within 7 or 14 days of discharge – based on patient’s complexity)
• Jan 14th 2013 - separate E/M visit (99201-99215) is billable
• Jan 21st 2013 - separate E/M visit (99201-99215) is billable

COMPLEX CHRONIC CARE COORDINATION SERVICES

• Complex Chronic Care Coordination Services are:
  – Patient centered management and support services provided by physicians, other qualified health care professionals (QHP), and clinical staff.
  – Provided to an individual residing in a home or in a domiciliary, rest home, or assisted living facility.
  – A care plan directed by a physician or QHP and typically implemented by clinical staff.
  – Services that address the coordination of care by multiple disciplines and community service agencies.
**Complex Chronic Care Coordination Services**

- Codes 99487-99489:
  - Are reported once per calendar month
  - Include all non-face-to-face CCCC services
  - Include none or 1 face-to-face office or other outpatient, home, or domiciliary visit
  - May only be reported by the single physician or other QHP who assumes the care coordination role with a particular patient for the calendar month.

- **Are currently NOT COVERED**

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**Questions?**

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**Thank You!**
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Performing & Billing for  
Transitional Care Management

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Maine Medical Partners

Maine’s largest multi-specialty medical group
Maine Medical Center, the State’s largest tertiary care center
Part of MaineHealth, Maine’s largest healthcare system
MMP employs a team of more than 300 physicians and 1,500 employees

New CPT Codes Introduced

• CMS approved the following new CPT codes in 2013:
  - 99495
  - 99496
• Designed to provide reimbursement for post-hospital transitional care management
• Can be billed by only one provider
A Natural Fit

Care Transition Program implemented in 2010

Program Design has always included:

- Telephone contact to patient within 24-72 hours
- Early provider follow-up

MMP Care Transition Program Design

[Diagram showing the care transition program design with roles such as Patient, Home Health, Rx, Hospital Discharge, Patient, Community Resources, MMC CHF Nurses, PHO Care Manager, and MMP Care Transition Nurse.]
Medication Reconciliation

- Review hospital discharge instructions & discharge summary
- Review PCP EMR
- Ask the patient “what are you ACTUALLY taking?”

Ensure Early Follow-Up

- Schedule if no appointment made
- Change what was scheduled
- Confirm what was scheduled
Intensive Telephone Intervention

- Confirm ordered services have been initiated
- Identify lack of resources
- Make referrals as necessary
  - Home Health Care
  - Community Services
  - Med Access

Re-Admission Rates

<table>
<thead>
<tr>
<th>Readmission Rate</th>
<th>Study Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.9% phone call</td>
<td>20.0% no phone call</td>
<td></td>
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</table>
Implementing Use of the Codes

1. Assembled a multidisciplinary team
   • PCP
   • Application Support
   • EPIC Report Writer
   • Coding & Compliance
   • Billing
   • Care Transition
   • Operations Specialist

2. Reviewed current process for performing Care Transition Intervention

3. Identified opportunities within existing processes
   • TCM Episode
   • Visit Reason
   • Spreadsheet for Charge Entry Specialists
Implementing Use of the Codes

4. Education to practice staff - providers & MAs:
   • Care Transition nurse
   • Coding & Compliance Manager
   • Application Support

5. Go live!

Process

• Patient identified as discharged from inpatient or observation status
• Care transition telephone intervention completed
• Schedule early follow-up
  – Early f/u visit reason = TCM EPISODE, Hosp f/u
• Open episode in EPIC
• Charge entry monitors TCM Worksheet
## Checklist for Charge Entry Specialist When Determining TCM Eligibility

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Must Meet?</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Patient was discharged from an inpatient or observation status</td>
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<td>2. Patient received a completed telephone intervention by an MMP Care Transition nurse or designee within 2 business days of hospital discharge</td>
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<td>3. If no completed telephone intervention by an MMP Care Transition Nurse or designee, 2 attempts were made to reach the patient by telephone within 2 business days of hospital discharge</td>
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<td>4. A Transitional Care Episode was opened in the patient's EPIC record</td>
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<tr>
<td>5. The telephone encounter or 2 attempted telephone calls are linked to the Transitional Care Episode</td>
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<tr>
<td>6. The patient had a hospital follow-up visit with a provider within 14 calendar days of hospital discharge</td>
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<tr>
<td>7. The hospital follow-up visit was linked to the Transitional Care Episode in the patient's EPIC record</td>
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<tr>
<td>8. The patient was not re-hospitalized in the 29 days following the Transitional Care Episode start date (ER visits are ok)</td>
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<tr>
<td>9. Patient is alive on the 30th day following hospital discharge?</td>
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</tbody>
</table>

### Actions
- To Care Transition for clarification
- To provider for code review
- Charge ok to bill

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**Action:**

- To Care Transition for clarification
- To provider for code review
- Charge ok to bill
Readmission During TCM Episode

• If a patient is re-hospitalized during an open TCM Episode, the TCM codes cannot be used.

• You may start a new TCM Episode upon subsequent discharge of patient.

Coding & Compliance Highlights

With minor exceptions, any additional services during the 29 days are separately billable.

Exceptions include:
• Anticoagulation management
• care plan management
Successes

- Easy to operationalize
- Providers becoming more familiar with the use of the codes
- Encourages cross continuum communication and collaboration
- Already had successful submission & reimbursement

Challenges

- Catching 99212-99215 codes before they drop
- MAs remembering to link the visit to the episode to cue the provider to use the 99495 or 99496 code
- Tracking re-admissions within the episode
- Varying levels of understanding of process by staff & providers
Next Steps

- Focused education to providers and staff to address identified gaps
- Coding & compliance audits
- Collaboration with the central billing office
- Work with MaineHealth to negotiate with Anthem to recognize TCM codes

Questions?
Contact Information

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