MED Minutes Podcast - Script

An Introduction to CMS's Transitional Care Management Services Codes

Host: Hello. This is John DeStefano from the New England QIN-QIO. Thank you for joining us for today's podcast. Our topic for today is:

"An Introduction to Transitional Care Management Services "

In 2013, the Centers for Medicare and Medicaid Services (CMS) created two new codes, 99495 and 99496. Known as the Transitional Care Management codes, these new codes were created for reimbursing primary care providers for services that are typically part of follow up care for patients following discharge from an inpatient setting. The "**Transitional Care Management"** codes now allow primary care providers and specialists to receive higher reimbursement rates for providing their patients transitional care. The goal is to reduce or prevent re-admissions.

I'm pleased to have Laura Schwartz from the New England QIN-QIO as our guest speaker today to help us better understand the elements of the **Transitional Care Management** codes and what clinicians need to do to bill these codes.

Guest: Thank you, John. I'm glad to participate in this podcast.

Host: Laura, can you give our listeners an overview of the Transitional Care Management services?

Guest: I'd be happy to. According to statements from CMS, they recognize transitional care management is crucial to reducing or preventing inpatient readmissions. These services include follow-up care and coordination of care for patients who have been discharged from an inpatient setting and transitioned to their home or other qualified setting.

Transitional Care Management, or I'll call it TCM for short, reimburses providers for the follow up and coordination of care during a 30 day period after the patient is discharged. The day of discharge counts as Day 1 and continues for the following 29 days.

Host: Thank you for the overview. Do patients need to be discharged from a hospital in order to qualify?

Guest: Actually, no. There are a variety of settings that are considered inpatient such as:

- Inpatient acute care hospitals
- Inpatient psychiatric hospitals
- Long term care hospitals
- Skilled nursing facilities
- Inpatient rehabilitation facilities or
- Hospital outpatient observations or partial hospitalizations
- Or partial hospitalizations at Community Mental Health Centers

Host: That's quite a long list. And on the flip side, do patients need to be discharged home in order to qualify?

Guest: Again, no. A Medicare beneficiary's home or domiciles are qualified discharged locations, but so are rest homes or assisted living facilities.

Host: What types of beneficiaries are TCM services intended for?

Guest: TCM services are for beneficiaries with medical and/or psychosocial problems that require moderate or high complexity in medical decision making. Additionally, TCM services are for beneficiaries who need assistance in making the transition to the outpatient setting following particular kinds of discharges. And by billing the TCM codes, the provider is taking responsibility for the beneficiary's care.

Host: Can you tell us what services providers are required to perform in order to bill for TCM?

Guest: Providers must make contact with the beneficiary or caregiver within 2 days of the discharge. This can be via telephone, e-mail, or face-to-face. In addition, providers must have a face-to-face visit within 14 days post discharge or 7 days post discharge, depending on the complexity. Other services include:

- Educating the patient, their family, and/or their caregiver
- Assessing and supporting treatment regimen adherence and medication management
- Review and follow-up on pending diagnostic tests and treatments
- Assisting with scheduling follow up appointments
- Coordinating community care with other providers and community resources
- And lastly providing non-face-to-face care management services

Host: Are there some TCM services that could be performed by a physician's staff?

Guest: Yes, there are some services that licensed clinical staff can perform under the direction of a physician, APRN, or PA such as:

- Making the initial contact with the patient
- Identifying available community and health resources the patient may need

- Performing patient and family/caregiver education around self-management, independent living, and activities of daily living

Host: So there are two codes. How does the provider know which of the two codes to use?

Guest: The codes are based on the provider's level of medical decision making (MDM). 99495 is used for a moderate level of MDM; 99496 is used when there is a high level of MDM.

Also, the codes can only be billed at the end of the 30 day period, and cannot be used if other codes, such as the Chronic Care Management code, are being billed for the same period of time.

Host: How often can a provider bill the TCM codes?

Guest: A provider can only bill any TCM code once per beneficiary during each transitional period. If the provider sees the patient multiple times in the 30-day period, he/she can bill those additional visits as normal evaluation and management services.

Host: What if the primary care provider is the same provider who discharged the beneficiary from the hospital?

Guest: That's allowed. CMS's only caveat is that the required face-to-face visit may not take place on the same day that the discharge management services are billed. Additionally, providers cannot bill TCM and other services that are within a post-operative global period billed by the same provider.

Host: What about specialist physicians, can they bill for TCM services?

Guest: Yes. The TCM codes can be billed by either the provider who discharged the patient from an inpatient setting or by the primary care provider. The reimbursement will go to whoever billed the TCM services first: some say "first come, first served."

Host: Since we are on the subject of billing, what is the reimbursement for the TCM codes?

Guest: The national average rate of reimbursement for **99495** is **$165.42**. For **99496** it is **$233.09**.

Host: There's a significant opportunity there for practices to bring in additional revenue.

Guest: Yes, as long as the billing codes' requirements are met.

Host: Are there other requirements, such as the patient's access to care, or other services similar to services needed for the Chronic Care Management codes?

Guest: Actually, no. There are certain things, such as documentation, medication management, and specific billing cycles that are part of both services; otherwise the services do not share the same requirements.

Host: And what are the documentation requirements?

Guest: Sort of**.** At a minimum, providers must document in the beneficiary's medical record:

- The date the beneficiary was discharged
- The date the office made an interactive contact with the beneficiary or caregiver
- The date of the face-to-face visit
- And finally, the complexity of medical decision making, whether it was moderate or high

All of this information could easily be documented in an encounter either on paper or in an electronic health record.

Host: Great overview, thank you. I think our listeners are in a much better position to start providing and billing TCM services. For those who are interested, where can they get more information?

Guest: Good question, John. There is a lot of information on the TCM code. CMS's brochure on the TCM code is available on our website at www.Healthcarefornewengland.org. Practices should also reach out to their EHR vendors for guidance, as well as their representative from the New England QIN-QIO.

Host: That concludes today's podcast. I would like to Laura Schwartz for sharing her expertise and helping us understand the fundamentals of the TCM code.

Thank you to everyone listening. We hope you have found this podcast helpful.