

# Transitional Care Management Services: New Codes, New Requirements



**Two new codes will help you get paid for managing a patient's transition from the inpatient to outpatient setting, but they come with new expectations.**

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**O**n Jan. 1, 2013, the much anticipated transitional care management (TCM) codes arrived. These codes can be found in the evaluation and management (E/M) section of the 2013 CPT manual.<sup>1</sup> They have potential benefits not just for you, the physician, but also for your patients and your local hospitals.

Transitional care management addresses that period of handoff between an acute care setting and the outpatient setting. Commonly the patient has just experienced a medical crisis, had a change in therapy, or received one or more new diagnoses and is now expected to follow-up

with his or her primary care physician, as well as previous or new specialists. The risk for medical error and readmission during this period is high, especially among older patients. The 30-day readmission rate for Medicare patients with primarily medical admissions was 16 percent in 2010.<sup>2</sup> Many of these readmissions are felt to be preventable with better primary care follow-up after discharge, which the TCM codes were introduced to promote.

Seeing a patient through this transition is often time-consuming. The new codes recognize the extra work with higher reimbursement than the usual E/M codes, but they come with new expectations as well. Your office is

## About the Authors

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now expected to reach out to the patient, rather than wait for the patient to call you. And you are expected to do this quickly – within two business days.

The *Federal Register* went into great detail about the new codes,<sup>3</sup> 99495 and 99496, yet some questions remain. It is likely that we will see further clarifications after the Centers for Medicare & Medicaid Services (CMS) and the CPT Editorial Panel make additional recommendations later in 2013. While CMS has been instrumental in the creation of these new codes, they are pertinent outside of Medicare and will affect your commercially insured patients as well. Here's what we know now about the TCM codes.

### Defining “discharge”

For the purpose of TCM, “discharge” refers to a discharge from an inpatient setting such as an acute care hospital, rehabilitation hospital, long-term acute hospital, or skilled nursing facility. It also refers to discharge from observation status in a hospital, or from a partial hospital program, which is a program for mental health and substance abuse disorders that involves spending the day at the treatment center and the night at home. No other discharges are allowed under the guidelines. Emergency department discharges are excluded, as well as discharges from assisted living facilities.

### CODE REQUIREMENTS

The transitional care management codes require one face-to-face visit, certain non-face-to-face services (as described in the article), and medication reconciliation and management during the 30-day service period.

**Code 99495** has the following requirements:

- Communication (direct contact, telephone, electronic) with the patient or caregiver within two business days of discharge,
- Medical decision making of at least *moderate* complexity during the service period,
- A face-to-face visit within 14 days of discharge.

**Code 99496** has the following requirements:

- Communication (direct contact, telephone, electronic) with the patient or caregiver within two business days of discharge,
- Medical decision making of *high* complexity during the service period,
- A face-to-face visit within seven days of discharge.

### Initial contact required within two business days

Contact with the patient, family member, or caregiver must occur within two business days after discharge. Business days are Monday through Friday from 8 a.m. to 5 p.m. Nights, weekends, and holidays don't count toward the two-day allowance.

Contact can be made by the provider or designated clinical staff and can be made by telephone, electronically (e.g., via a patient portal), or in person. This communication must be documented in the patient's chart and

should be more substantive than merely scheduling the follow-up face-to-face visit. The provider's office should try to gather as much information as possible regarding the discharge diagnoses, procedures performed, and what follow-

up services the patient might require.

Medication reconciliation should be initiated as well, although it does not have to be completed until the face-to-face visit. Patients should be asked whether they are on any new medications and, if they aren't sure, to bring in all the medications they are taking and any new prescriptions they've received. The discharge summary will often contain much of this information, but many times this summary is not available when the provider (or designated staff) makes the initial contact within the two-business-day time frame.

CMS states that if the provider (or designated staff) attempts to contact the patient or caregiver at least twice and is unable to make contact within two business days, the provider may still bill the TCM codes if all the other criteria are met during the 30 days after discharge. The two failed attempts must be documented in the patient's chart or the TCM codes cannot be billed (no exceptions).

If by chance a patient contacts you or comes into the office within two days of discharge and you discuss the discharge then, you will have met the contact requirement.

See page 14 (or <http://www.aafp.org/fpm/2013/0500/fpm20130500p12-rt2.pdf>) for a paper or electronic template you can use to document this initial contact.

### The face-to-face visit: complexity and timing

A face-to-face visit with the provider must occur within seven to 14 calendar days after

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discharge. However, if the patient is seen for follow-up of his or her discharge within two business days, then that visit meets the initial contact and face-to-face visit requirements.

Code 99496 should be used if the face-to-face visit requires medical decision making of high complexity within seven days; code 99495 should be used if the face-to-face visit requires medical decision making of moderate to high complexity within seven to 14 days (see the code requirements on page 13). For ease of understanding, think of the complexity as similar to the decision-making complexity component of an E/M office visit code. If the patient has a potentially life- or limb-threatening problem with a significant risk of readmission within the next 30 days and/or if you

have to review a large amount of testing and consultation information and yet diagnostic uncertainty persists, high complexity decision making (99496) is likely. In this highly complex scenario, it wouldn't be safe to make the patient wait more than a week to see you. Otherwise, it is more likely that the situation falls in the moderately complex (99495) realm.

## Components of TCM

Many of the services associated with TCM will occur outside the face-to-face visit. CMS states that clinical staff, under the direction of the physician or nonphysician provider, may provide the following non-face-to-face services:

- Make the initial contact with the patient or caregiver,
- Communicate with home health agencies and other community services the patient uses,
- Educate the patient or caregiver regarding self-management, independent living, and activities of daily living,
- Assess the patient's adherence with his or her treatment regimen, including medication use, and provide support,
- Identify community and health resources available to the patient,
- Help the patient or family get access to care and services they may need.

The physician or nonphysician provider must perform the following non-face-to-face services:

- Obtain and review the discharge information,
- Review the need for follow-up on pending diagnostic tests and treatments,
- Interact with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems,
- Educate the patient or caregiver on issues not addressed by staff,
- Establish or reestablish referrals and order any needed community resources,
- Order any required follow-up with community providers and services.

The face-to-face visit, then, will primarily involve an examination of the patient, medication reconciliation (if it was not completed previously), and possibly creating orders for follow-up testing, referrals, or other services (such as education programs, community services, rehabilitation services, durable medical equipment, and home health). All of this

### INITIAL TRANSITIONAL CARE CONTACT

Patient name: \_\_\_\_\_

Date of contact: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sources of information:

- Patient, family member, or caregiver  
(Name: \_\_\_\_\_)
- Hospital discharge summary
- Hospital fax
- List of recent hospitalizations or ED visits
- Other \_\_\_\_\_

Discharged from: \_\_\_\_\_  
on \_\_\_\_/\_\_\_\_/\_\_\_\_

Diagnosis/problem: \_\_\_\_\_  
\_\_\_\_\_

Medication changes:  Yes  No

Medication list updated:  Yes  No

Needs referral or lab:  Yes  No

Needs follow-up appointment:

- Within seven days of discharge (highly complex visit).
- Within 14 days of discharge (moderately complex visit).

Appointment made for \_\_\_\_/\_\_\_\_/\_\_\_\_  
with \_\_\_\_\_

Additional information needed and requested:

- Yes: \_\_\_\_\_
- No

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should be documented.

It is a good idea to make reference to your initial contact note in the face-to-face visit note. These two notes do not have to be combined into one. See below (or <http://www.aafp.org/fpm/2013/0500/fpm20130500p12-rt1.pdf>) for a recommended paper or electronic template to use in the plan section of your face-to-face visit note.

### When to submit the TCM claim, and when to bill for other services

Because the TCM codes represent a 30-day service period, they should be billed no sooner than the 30th day after the patient was discharged – *not* at the conclusion of the face-to-face visit – and the date of service should be the 30th day after discharge. These codes should not be used more than once every 30 days after the initial day of discharge. If a patient returns to see you for the same problem after the initial TCM visit but before the 30 days are up, you can still bill for that visit but will need to use an E/M office visit code such as 99213 or 99214.

Additional E/M services, including preventive services, provided on the same day as the face-to-face TCM visit cannot be billed separately; however, additional E/M services provided *after* the face-to-face TCM visit can be billed separately. Labs, electrocardiograms, etc., can also be billed separately, even if they occur on the same day as the face-to-face TCM visit. Services such as care plan oversight and anticoagulation management cannot be billed at all during the period covered by the TCM codes. The full list of services that cannot be billed is found in the 2013 CPT guidelines.

### What do the TCM codes pay?

Noridian, a CMS contractor for a large part of the western United States (including Arizona where we live) pays approximately \$162 for 99495 and \$229 for 99496. This compares quite favorably to the reimbursement for established patient office visits 99214 at \$105 and 99215 at \$141, or new patient office visits 99204 at \$163 and 99205 at \$202. You'll want to check the reimbursement rates for these new codes from the Medicare contractor in your area. They should be similar to these numbers. Additionally, many other insurance

carriers are now paying for these codes.

While new and established patient visits can be billed using the TCM codes (per the *Federal Register* and recent CPT changes), payment is the same for both. You may prefer to bill a new patient code (99204 or 99205) in lieu of a TCM code based on the type of exam and information that you need to collect on a new patient. For established patients, you will clearly see an increased benefit to your bottom line when you use the TCM codes rather than the E/M office visit codes. ➤

#### FACE-TO-FACE TRANSITIONAL CARE VISIT DOCUMENTATION

*For use in plan section of visit note.*

##### Medication reconciliation:

- Medication list updated
- New medication list given to patient/family/caregiver

##### Referrals:

- None needed
- Referrals made to: \_\_\_\_\_

##### Community resources identified for patient/family:

- None needed
- Home health agency
- Assisted living
- Hospice
- Support group
- Education program: \_\_\_\_\_

##### Durable medical equipment ordered:

- None needed
- DME ordered: \_\_\_\_\_

##### Additional communication delivered or planned:

- Family/caregiver: \_\_\_\_\_
- Specialists: \_\_\_\_\_
- Other: \_\_\_\_\_

##### Patient education:

Topics discussed: \_\_\_\_\_

Handouts given: \_\_\_\_\_

Initial transitional care contact was made on  
\_\_\_\_/\_\_\_\_/\_\_\_\_ (see separate note)

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## Who can bill these codes?

Specialty designation of the provider has not been specified other than to say that dentists and podiatrists cannot bill these codes. Surgeons who have performed a surgery during the hospitalization typically cannot bill these codes because most surgical follow-up visits are covered under the original surgical payment, which often includes a global period that lasts longer than the 7- to 14- day period during which the face-to-face TCM visit must occur. However, a discharging physician (other than the physician who performed surgery) can use these codes on the 30th day after discharge. Nonphysician providers such as physician assistants and nurse practitioners may also bill these codes following the incident-to coding rules.

A key point to remember is that only one provider, per patient and per discharge, may bill a TCM code during the 30 days following discharge. This creates a potential conflict if the patient follows-up with more than one physician post-discharge, a common occurrence. It appears that the first provider to bill will be the one to receive payment.

## How do you quickly find out that the patient was discharged?

The toughest problem with these codes is the requirement to contact the patient within two business days of discharge. This is no problem at all if you are the discharging physician, but many family physicians no longer work in the hospital. It is not uncommon for a family physician to be notified of a discharge more than two days after the event or sometimes not at all. So how do you get timely notification? This is a problem that will likely have unique solutions in every setting, but here are a few suggestions:

- **Work with your local hospitals.** For example, request same-day fax notification – or, even better, a secure email exchange or a phone call – when your patients are discharged from all area hospitals. If you are not

part of a large medical group or integrated system that can push for this, perhaps your local medical society can help. Given the new CMS penalties for hospitals with high readmission rates for certain medical conditions, it is in the hospital's best interest to make sure the transition of care goes well.

- **Work with your patients.** Educate

your patients to notify your office, or have a family member notify your office, whenever they are admitted to a hospital. When you learn that a

patient has been admitted, have your staff follow up with the patient or family and ask them to contact your office upon discharge.

- **Work with your hospitalists.** If you interact with one or more specific hospitalist groups, you may be able to work out an arrangement where they notify you (by fax, phone, email, or text) the day your patients are discharged.

- **Pay close attention to those discharge faxes.** Don't let them sit in a stack of unread papers. Create an office process to act on the discharge notice as soon as it is discovered.

## How do you get the information you need?

One of the advantages of contacting the patient before the face-to-face visit is that you and your staff can learn what occurred during the acute care stay and can then proactively obtain relevant discharge summaries, operative reports, imaging reports, tests, labs, and consult notes. This will prevent the dismay of having a patient show up after a hospitalization and you and your staff having no idea what happened to the patient.

If you already have a great way of automatically getting detailed information within a day or two of the patient's discharge, bravo! You are in a much better situation than most physicians. The traditional way to get details about a patient's hospital stay has been to contact the hospital records department. That is not always an efficient process. More and more hospitals are offering physician portals where doctors can view and download patient

Once you learn that the patient was discharged, you have precious little time to act.

■ Only one provider may bill a TCM code for each patient discharge, so there could be a race to bill if the patient follows up with more than one physician.

■ Your practice will need to identify ways to get timely notification of the patient's discharge.

■ You will also need to obtain relevant discharge summaries, operative reports, imaging reports, tests, labs, and consult notes.

records. If that is available to you, sign up. You should try to get access to the portal of every hospital in your community. Designate one or more staff to log on and download the information you need. If you are lucky enough to be part of a health information exchange in your community, you may need only one log-in versus separate log-ins for each facility.

### Figure out your office workflow

Once you learn that the patient was discharged, you have precious little time to act. Make sure your office has figured out what should happen after you learn about the discharge. Who will call the patient? Who makes sure additional records are obtained? Who makes the face-to-face visit appointment? We

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recommend the use of a paper or electronic template, as described earlier, for managing key steps in the transition of care workflow.

In addition, practices will need to develop a tracking system that reminds them to bill for these services at 30 days post-discharge. Solutions could range from creating a tickler file to creating a new appointment code for TCM and running weekly reports to see which patients have reached the 30-day window.

All of this requires extra work, but most of it is work that you have probably already been doing. Now you can be paid fairly for it, and your patients will benefit. Good luck on your transitions of care! **FPM**

1. *Current Procedural Terminology 2013: Standard Edition*. Chicago: American Medical Association; 2012.
2. *The Revolving Door: A Report on U.S. Hospital Readmissions*. Princeton, NJ: Robert Wood Johnson Foundation; February 2013.
3. "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013 (Final Rule)." *Federal Register*. 2012;77(222):68978-68994.

■ If your hospital offers a physician portal for accessing patient records, make sure you're signed up.

■ Figuring out what TCM tasks need to happen, when, and by whom will prepare your practice to act promptly when you learn that a patient has been discharged.



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