Transition Care Management in the Clinic Setting
Update on Payment Programs

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• Qualis Health is one of the nation’s leading healthcare consulting organizations, partnering with our clients across the country to improve care for millions of Americans every day

• Serving as the Medicare Quality Improvement Organization (QIO) for Idaho and Washington

• QIOs: the largest federal network dedicated to improving health quality at the community level
What problem are we trying to solve?
Pay for performance?
The good old days

PCPs and specialists talking over patients in the hospital cafeteria.
Assume Accountability

- Why must the medical home assume primary responsibility for coordinating care when accountability is obviously shared?
  - Because specialists, ERs, and hospitals aren’t.
Percent of Discharges Readmitted: Past Three Years

- WA % of discharges readmitted
- WA Median (15.2%)
- ID % of discharges readmitted
- ID Median (13.1%)
Days until Readmission

**WA**

**ID**

Days after discharge patient is readmitted

Percent of Readmissions

0% 2% 4% 6% 8%
Days until First Physician Visit for Individuals Discharged to Home

**WA**

<table>
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<tr>
<th>Days until Outpatient Visit</th>
<th>Percent of Discharges to Home</th>
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<td>Over 30</td>
<td>17.53%</td>
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**ID**

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<td>Over 30</td>
<td>21.96%</td>
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Individuals discharged to home who were readmitted who had an outpatient physician visit prior to readmission

Had an outpatient physician visit prior to readmission

- WA: 62.38%
- ID: 56.60%
Risk Factors for Readmission

- Dual-Eligible Medicare/Medicaid
- Presence of Four or More Chronic Diseases
- Age Under 65
- Prior Hospitalization Within 180 Days
- Race (Native American, Black)
- Behavioral Health as Secondary Diagnosis
- Gender (Male)
Percent of Discharges Home with a TCM Code

- WA
- ID

WA TCM Code Denial Rates
ID TCM Code Denial Rates

The graph shows the number of TCM claims and the percent of claims denied from January 2013 to March 2014. The number of TCM claims varies throughout the months, with some months having significantly more claims than others. The percent of claims denied generally decreases from January to March 2013, followed by an increase in December 2013 and January 2014, and then a decrease in February and March 2014.
Transitional Care Codes

Michelle M. Lott, CPC, CPMA
Associate Director,
WSMA Practice Resource Center
Transitional Care Management Services (TCM)

- The transition in care is **from**:
  - an inpatient hospital setting
  - partial hospital
  - observation status in a hospital
  - skilled nursing facility/nursing facility
• Transitional Care Management Services (TCM)
  ➤ To the patient’s community setting:
    • home
    • domiciliary
    • rest home
    • or assisted living
• Transitional Care Management Services (TCM)

  ➤ CPT 99495 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.
Transitional Care Management Services (TCM)

- CPT 99495 required elements:
  - Medication reconciliation and management must be documented no later than the date of the face-to-face visit.
  - Per Medicare guidance this service should have 40 minutes of in service.
Transitional Care Management Services

- CPT 99496 required elements:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post discharge.
  - Medical decision making of high complexity during the service period.
  - Face-to-face visit, within 7 calendar days of discharge.
Transitional Care Codes

● Transitional Care Management Services
  ▶ CPT 99496 required elements:
    ● Medication reconciliation and management must be documented no later than the date of the face-to-face visit.
    ● Per Medicare guidance this service should have 50 minutes of in service.
Transitional Care Codes

- Transitional Care Management Services (TCM)
  - Medicare reimbursement for Transitional Care Management Code 99495 (moderate complexity) services is calculated based on the following relative values:
    - Work RVU: 2.11
    - Malpractice RVU: 0.13
    - Practice expense RVU: 2.34 (non-facility) and 0.87 (facility)
    - CMS Payment for Rest of Washington $163.70
Transitional Care Codes

- **Transitional Care Management Services (TCM)**
  - Medicare reimbursement for Transitional Care Management Code 99496 (high complexity) services is calculated based on the following relative values:
    - Work RVU: 3.05
    - Malpractice RVU: 0.19
    - Practice expense RVU: 3.23 (non-facility) and 1.26 (facility)
    - CMS Payment for Rest of Washington $231.13
Workflow Considerations

• Patient identification
• Data Collection
• Patient Contact
  ▶ Initial communication with patient occurs within 2 business days of discharge
  ▶ Medication reconciliation/management and assessment
  ▶ Appointment, documentation, notification
• Medical encounter
• Tracking and billing for 30 days
TCM: Operational Rules

- Communication with the patient, family, caregiver may be completed by clinical staff under “provider direction” (e.g., RN, LPN, MA, other)
- Medical encounter must be face-to-face
- Medical encounter may NOT occur on the same day as discharge
- Documentation guidelines may not apply (e.g., pre-encounter communication)
- Not billable for 30-days
Tips for Using these Codes:

- Medication reconciliation should take place no later than the face-to-face visit.
- Billing should occur on the 30th day post-discharge.
- The TCM codes include one evaluation and management (E/M) visit though there are several restrictions. Any E/M visits beyond the bundled initial one, must be billed separately.
Tips for Using these Codes:

• The E/M visit cannot occur on the same day as a discharge management service.

• Covered services include communication within two business days, communication with home health agencies and other relevant community services, patient and/or family member education on self-management.

• Only one provider can bill per patient.
Tips for Using these Codes:

- Attempts at communication should continue after the first two attempts in the two business days post-discharge until they are successful.
- Cannot bill if there is no communication between in the 30-day period post-discharge.
- Document communication between medical office and patient.
- Try to anticipate and adjust scheduling to accommodate the face-to-face visits.
Reason for Denials

• If following all guidelines and claim denied
  ➢ Hospital has not submitted the hospital bill yet
  ➢ Another provider has billed for the TCM
  ➢ Billed prior to the 30th day of discharge
  ➢ Some insurers are not covering these services.
Develop an Action Plan

• Day 0 – Discharge: How will you
  ▶ Know if your patients have been discharged
  ▶ Obtain the discharge summary
  ▶ Gather data from your hospitals— is data sent electronically, by fax, or paper?

• Day 1 or 2 – Initial Contact: How will you:
  ▶ Contact your patient within two business days?
  ▶ Contact the patient, and how/what is your documentation process?
  ▶ Schedule an appointment while being mindful of the 7 or 14 day limits?
Develop an Action Plan

- Day 7 or 14 – Encounter: How will you:
  - Complete the encounter BUT not submit a charge?
- Provider needs to know this is a “transition encounter”
  - Document the place of the encounter
  - Complete the medication reconciliation
- Pre-encounter vs. Encounter
  - Document complexity of the patient (moderate vs. high), ensure compliance with 7 or 14 day limits.
Develop an Action Plan

• Day 30 – Billing: How will you
  ▶ 30 days after discharge process the claim
    • How will you remember this? Electronic, Spread Sheet, Tickler File
Complex Chronic Care Coordination Services (CCCC) Patients:

- Typically have 1 or more chronic continuous or episodic health conditions expected to last 12 months or until death.
- Commonly require the coordination of a number of specialties and services.
- May have medical and psychiatric behavioral co-morbidities complicating their care.
- May have social support weaknesses or access to care difficulties.
AMA - 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.
Medicare Chronic Care Management

• The 2015 proposed rule released by CMS:
  ▶ Reimburses physicians for providing chronic care management services starting in 2015, including developing and revising a patient’s plan of care, communication with other treating health care providers, and medication management.
  ▶ This new code could be billed once a month per patient.
  ▶ CMS also proposes adding greater flexibility in the supervision of clinical staff providing these services.
Medicare Chronic Care Management

- Physicians would bill Medicare for chronic-care management using a new G code.
- It would apply to at least 20 minutes of management services over 30 days for a patient whose **multiple chronic conditions** are expected to last at least 12 months, or until death, and that represent a significant risk for death, functional decline, or acute exacerbation or decompensation.
Medicare Chronic Care Management

- Chronic-care services must be available on a 24/7 basis.
- Specifically, the agency proposes a per patient payment of $41.92 that can be billed no more than once per month for patients with two or more chronic conditions.
  
  - Chronic care management services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management.
Medicare Chronic Care Management

- Medicare defines chronic care management as including:
  - regular development and revision of a plan of care,
  - communication with other treating health professionals, and medication management
**Medicare vs. AMA CPT**

- CMS will not recognize or price the AMA CPT Codes 99487-99489.
- CMS requires the patient to have 2 or more chronic conditions.
- Care management services can be provided only if patients agree in writing. Patients will pay about 20 percent of the $42 fee.
- Final rule and additional guidance is not available.
Resources

• WSMA Practice Resources Center – www.wsma.org

• Noridian Transitional Care Management Services (TCM) Q&A - https://med.noridianmedicare.com/web/jeb/education/event-materials/transitional-care-management-q-a
Resources

- American Academy of Family Physicians
  - Transitional Care Management 30-Day Worksheet -
    [Link](http://www.aafp.org/online/etc/medialib/aafp_org/documents/prac_mgt/codingresources/tcmworksheet.Par.0001.File.dat/TCM30day.pdf)
  - Frequently Asked Questions -
    [Link](http://www.aafp.org/online/etc/medialib/aafp_org/documents/prac_mgt/codingresources/tcmfaq.Par.0001.File.dat/TCMFAQ.pdf)
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