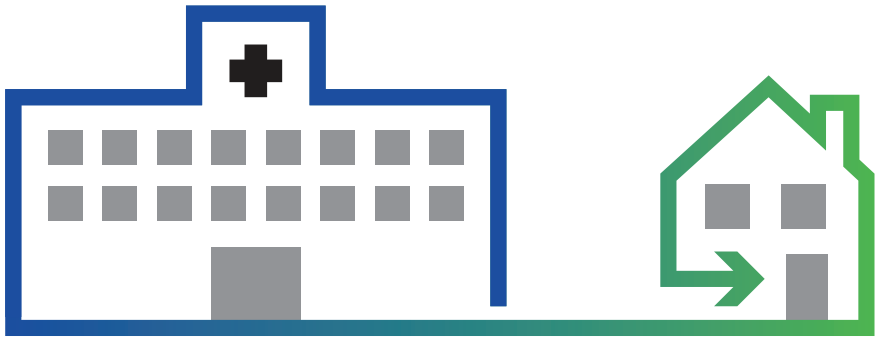
PYA

PYALeadership Briefing

Providing and Billing Medicare for Transitional Care Management

Updated November 2014



Providing and Billing Medicare for Transitional Care Management:

Keeping up with all the new healthcare payment and delivery models is challenging. Figuring out how to best position your organization for coming changes can be overwhelming.

A recent article in the New England Journal of Medicine entitled *Lessons Learned in Preparing for Medicare Bundled Payments,*[1] offers valuable insight:

> [Medicare claims data] show that Medicare typically spends as much or more in the 90 days after discharge as it spends for the initial hospitalization… [T]he data [also] show wide variation in average post-acute care spending… This variation highlights opportunities for hospitals and their partners to improve quality and reduce spending by reaching out to patients after discharge and reconciling medications, scheduling timely primary care visits, establishing plans for addressing common problems, and coordinating with post-acute care providers.

Simply stated, one of the greatest opportunities for increasing savings and efficiency–and for improving outcomes–is to provide patients discharged from an institutional setting with certain follow-up care. ***Health systems that have implemented even the most rudimentary transitional care management programs have realized impressive results.***

Proven Success

A recent *Health Affairs* article profiled the Coordinated-Transitional Care (C-TraC) Program at the William S. Middleton Memorial Veteran's Hospital in Madison, Wisconsin. The C-TraC is hardly rocket science:

> The program uses a registered nurse case manager to coordinate the veteran's transitional care through active participation in inpatient multidisciplinary discharge rounds, a single brief protocol-driven inpatient encounter, and one to four protocol-driven post-hospital telephone calls with the veteran and, if available, the veteran's caregiver.[2]

The C-TraC program is credited with an 11 percent reduction in re-hospitalizations, resulting in nearly $1 million in cost avoidance over an 18-month period. After accounting for all program costs, the net cost avoidance per veteran enrolled was $1,225.[3]

Another program with demonstrated success is the University of Colorado's Care Transitions Intervention (CTI).[4] This approach involves nurses

---

1 Robert Mechanic, M.B.A., and Christopher Tompkins, Ph.D., *Lessons Learned In Preparing For Medicare Bundled Payments,* N. ENGL. J. MED. 2012; 367:1873-1875 (Nov. 15, 2012) (available at http://www.nejm.org/doi/full/10.1056/NEJMp1210823).

2 Amy J.H. Kind, Laury Jensen, Steve Barczi, Alan Bridges, Rebecca Kordahl, Maureen A. Smith, and Sanjay Asthana, *Low-Cost Transitional Care With Nurse Managers Making Mostly Phone Contact With Patients Cut Rehospitalization At A VA Hospital,* HEALTH AFFAIRS, December 2012 vol. 31 no. 12 2659-2668 (available at http://content.healthaffairs.org/content/31/12/2659.short).

3 The C-TraC program toolkit, which includes forms and templates, is available without charge through the Health Innovation Program at the University of Wisconsin-Madison, http://www.hipxchange.org/C-TraC.

4 Detailed information regarding the Care Transitions Intervention program is available at http://www.caretransitions.org/overview.asp.

and social workers who serve as "transitions coaches." After meeting the patient in the hospital, the coach follows up with home visits and phone calls over a four-week period.

The transitions coach supports the patient in developing four self-care management skills: (1) managing medications; (2) scheduling and preparing for follow-up care; (3) recognizing and responding to "red flags" that could indicate a worsening condition; and (4) taking ownership of a core set of personal health information.

Like the C-TraC program, CTI shows impressive results. In a large integrated delivery system in Colorado, CTI was credited with reducing 30-day hospital readmissions by 30 percent and 180-day hospital readmissions by 17 percent. These reductions cut average costs per patient by nearly 20 percent.[5]

Financial Barriers

Given these impressive results, why have providers been slow to implement transitional care management programs? In a word, money.

Until now, there has been no financial incentive for a hospital, skilled nursing facility, physician practice, or other provider to furnish or arrange for any sort of post-discharge services. Because they generated no revenue to offset their costs, transitional care management programs were viewed as luxuries few could afford. With the new hospital readmission rate penalties having come on line in October 2012, however, these programs are getting a second look. Many hospitals now are exploring transitional care management programs as a tool to reduce costly readmissions.

Still, the link between today's investment in care management and tomorrow's avoidance of a financial penalty is too tenuous for some. Many believe transitional care management programs will be the exception, not the rule, unless and until providers receive direct payment for those services.

New Medicare Payment For Transitional Care Management Services

That day has arrived. As of January 1, 2013, payment is available for transitional care management services. Specifically, Medicare now pays physicians and other qualified non-physician professionals for post-discharge transitional care management services (TCM services) under two new CPT® codes, 99495 and 99496.[6]

Based on the 2014 conversion factor of $35.8228, the national payment rates for TCM are $172.66 (for 99495) and $243.60 (for 99496). (The facility rates are approximately 15 percent less.) Check your Medicare Administrative Contractor's fee schedule for the payment rate for your location.

Additionally, in 2014, CMS listed TCM as a rural health clinic and federally qualified health center service. RHCs and FQHCs now can bill for TCM services under their applicable all-inclusive rate.

The Centers for Medicare & Medicaid Services (CMS) anticipate two-thirds of all discharges will be eligible for TCM. Based on these estimates, CMS expects to spend well over ***$1 billion*** on TCM services annually.

---

[5] *See* Health Affairs Health Policy Brief, *Improving Care Transitions* (Sept. 13, 2012), (available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=76).

[6] Current Procedural Terminology (CPT) is a registered trademark of The American Medical Association.

Billing for TCM Services

The following is a detailed summary of the requirements to bill Medicare for TCM services, based on the preamble to the 2013 Medicare Physician Fee Schedule final rule:[7]

The American Medical Association (AMA) developed the two new CPT codes for TCM services, 99495 and 99496, at CMS' request.[8] However, CMS diverged from the AMA's description of these codes in establishing the billing rules for TCM services in two important ways.

While it is likely commercial payors will follow CMS' lead by paying for TCM services, we do not know at this time whether those payors will require compliance with the specific CMS' billing rules or instead use the elements identified by the AMA. Thus, the differences between the two are noted in the following table.

Who is eligible to receive TCM services?	Beneficiaries discharged from acute care hospitals (inpatient, observation, and outpatient partial hospitalization); rehabilitation hospitals; long-term acute care hospitals; skilled nursing facilities; and community mental health center partial hospitalization programs. This does not include patients discharged to a skilled nursing facility (SNF) or to a community mental health center (CMHC) partial hospitalization program.
What is the time period for TCM services?	A provider may bill for one unit of 99495 or 99496 for services furnished during the period beginning with the date of discharge and continuing for 29 days.
Who is eligible to bill for TCM services?	MDs and DOs (regardless of specialty), physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives (referred to as "qualified professionals").
For what is the qualified professional responsible?	Generally, providing or overseeing the management and coordination of services, as needed, for all medical conditions, psychosocial needs, and activity of daily living supports.

[7] 77 Fed. Reg. 68,891 (Nov. 16, 2012) (available at http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf).

[8] For a discussion of the AMA's work, see http://www.ama-assn.org/resources/doc/cpt/03-cms-physician-fee-schedule-bryant.pdf. The AMA also developed new CPT codes for complex chronic care coordination services (99487 and 99488), but CMS decided not to provide payment for these services in 2013.

Must the beneficiary be an established patient of the qualified professional?	Previously established relationship is not required. (The AMA description requires there be an established relationship between the patient and the qualified professional providing TCM services, *i.e.*, a visit within the last three years.)
What are the required elements for TCM services?	1. Communication with patient or caregiver within two business days of discharge (or two separate, unsuccessful attempts at communication) (see further explanation below). 2. Face-to-face visit within seven days (99496) or 14 days (99495) (see further explanation below). 3. Medication reconciliation and management performed no later than date of face-to-face visit. 4. Non-face-to-face care management services (see further explanation below). 5. Medical decision making of moderate complexity (99494) or high complexity (99496) during the service period (see further explanation below).
What are the requirements for the initial communication?	1. May be by direct contact, telephone, or electronic means. 2. Must include capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care. 3. May be performed by clinical staff under the general supervision of a qualified professional.[9] 4. Date of communication (or two failed attempts) must be documented.
What are the requirements for the face-to-face visit?	1. Performed by the qualified professional under whose NPI claim is submitted (billing provider). 2. Level/elements of visit not specified. Referred to as E/M service; thus should meet at least level 1 visit requirements. 3. Cannot be furnished by the same qualified professional on the same day as the discharge management service. (The AMA description does not impose this limitation.) 4. May be performed at any appropriate location. 5. First E&M service performed by billing provider during 7- or 14-day period bundled into TCM payment; subsequent E&M services separately payable.

[9] Effective January 1, 2015, CMS has revised the "incident to" regulation to require general supervision (as opposed to direct supervision) for clinical staff providing non-face-to-face care management services. *See* 42 CFR§ 410.26(b)(5).

May the face-to-face visit be performed on the same day the patient is discharged?	Yes, the face-to-face visit may be performed any time after the patient is discharged, even before the patient physically leaves the facility. However, the qualified professional who bills a discharge day management code for a patient cannot rely on the professional's interaction with the patient on the day of discharge to satisfy the face-to-face visit requirement to bill for TCM services; that professional would have to see the patient again within the 7- or 14-day period.
May the face-to-face visit be performed via telemedicine?	Yes, but only if the visit satisfies CMS requirements for billing telemedicine. Specifically, the patient must be present at an approved originating site (*i.e.,* physician office, hospital, critical access hospital, rural health clinic, federally qualified health center, SNF, hospital-based dialysis center, or CMHC). The patient must be physically present at one of these sites, not at his or her home or other location.
What constitutes medical decision making of moderate or high complexity?	Moderate complexity: multiple possible diagnoses and/or management of options; moderate complexity of medical data (*e.g.,* tests) to be reviewed; and moderate risk of significant complications, morbidity, and/or mortality, as well as co-morbidities. High complexity: extensive number of possible diagnoses and/or management of options; extensive complexity of medical data (*e.g.,* tests) to be reviewed; and high risk of significant complications, morbidity, and/or mortality, as well as co-morbidities.
When can claims for TCM services be submitted?	No sooner than 30 days following discharge.
What are the documentation requirements for TCM services?	Documentation must include: (1) timing of initial post-discharge communication; (2) date of face-to-face visit; and (3) complexity of medical decision-making. CMS has *not* listed specific documentation requirements regarding: (1) content of face-to-face visit performed by qualified professional; (2) non-face-to-face services furnished by the qualified professional or clinical staff.
Can multiple TCM claims be submitted for the same patient covering the same time period?	CMS will pay for only one TCM claim for the 30-day period following discharge. The first claim to be filed will be paid (similar to radiology interpretation and Annual Wellness Visit). CMS will not pay a second TCM claim in connection with a discharge that occurs within 30 days of the original discharge, *i.e.,* if the patient is readmitted within the 30-day period.

What are the limits on submitting claims for TCM services?	A qualified professional billing for procedure with 10- or 90- day global billing period cannot bill for TCM services for the same time period. A qualified professional who bills for TCM services cannot bill for the following services during the 30-day period: Home healthcare oversight (G0181) Hospice care plan oversight (G0182) Care plan oversight services (99339, 99340, 99374-99380) Prolonged services without direct patient contact (99358, 99359) Anticoagulant management (99363, 99364) Medical team conferences (99366-99368) Education and training (98960-98962, 99071, 99078) Telephone services (98966-98968, 99441-99443) End stage renal disease services (90951 – 90970) Online medical evaluation services (98969, 99444) Preparation of special reports (99080) Analysis of data (99090, 99091) Complex chronic care coordination services (99481X , 99483X) Medication therapy management services (99605-99607) The fact that the aforementioned services are billed by one or more qualified professionals for a patient during the 30-day post-discharge period alone does not preclude another qualified professional from billing for TCM services, provided that qualified professional satisfies all requirements. No modifier is required.
What other payment policies apply to TCM services?	1. TCM services do not qualify for the Primary Care Incentive Payment program. 2. 20 percent beneficiary co-payment applies. Attention should be paid to demonstrating the value of TCM services to beneficiaries to improve collection rates.
What are the discharging provider's responsibilities with regard to TCM services?	1. Inform patient that he/she should receive TCM services, and that Medicare will pay for it. 2. Ask patient to identify the qualified professional from whom patient wishes to receive TCM services. May suggest a specific qualified professional if patient does not identify. 3. Document above in discharge note and discharge instructions. The discharging provider may also bill for TCM services. However, that provider cannot count services provided on the day of discharge to satisfy the face-to-face visit requirement.

What non-face-to-face care management services are required?

CMS *expects* the following services to be routinely provided unless qualified professional's reasonable assessment of the patient indicates a particular service is not medically indicated or needed:

Performed by qualified professional:

1. Obtain and review discharge information.
2. Review need for, or follow-up on, pending diagnostic tests and treatments; interact with other providers involved in patient's care.
3. Educate patient, family, guardian, and/or caregiver.
4. Arrange for needed community resources.
5. Assist in scheduling any required follow-up with community providers and services.

Performed by clinical staff/case manager under the general supervision of the qualified professional:

1. Communicate with home health agencies and other community services utilized by patient.
2. Educate patient and/or family/caretaker regarding self-management, independent living, and activities of daily living.
3. Assess and support treatment regimen adherence and medication management.
4. Identify available community and health resources.
5. Facilitate access to necessary care and services.

Strategies for Successful Transitional Care Management Programs

With some money on the table and rules in place, now is the time to develop and deploy a TCM program. There are several options for delivering these services:

- A physician practice may create a program to serve its patients only. However, only larger practices are likely to have sufficient patient volume to justify the necessary investment in staffing and technology.
- A physician practice may contract with other physician practices to provide TCM services for their patients. For example, a primary care practice may contract with surgical specialists to provide TCM services if the referring physician does not wish to provide the service.
- A hospital or SNF may contract with a physician or mid-level provider to furnish the required professional services and supervision (*e.g.,* the face-to-face visit), with the hospital or facility providing the other services (*e.g.,* medication reconciliation, patient education, follow-up calls). The physician or mid-level provider would reassign his or her right to bill for the service to the hospital.
- A hospital or SNF may develop a TCM program utilizing its currently employed or contracted physicians or mid-level providers. For example, hospitalists may have sufficient capacity to deliver the required professional services and supervision, with other hospital staff delivering the other components of TCM services.
- A physician practice may contract with a hospital, SNF, or other entity (*e.g.,* a management services organization) for the support staff and technology needed to operate a TCM program. Under such an arrangement, the physician practice would bill for the TCM service and pay the hospital, SNF, or other entity fair market value for the support staff and other services. Such an arrangement would permit a smaller practice otherwise lacking necessary resources to provide TCM services.

Conclusion

"Where do we start?"

We hear this question more than any other, as our clients face rapid changes in healthcare. Having carefully studied new payment and delivery system models – everything from shared savings to bundled payments and beyond – we are convinced today's investments in care management will yield the greatest dividends over the next several years.

In addition to focusing attention on high-cost patients and conditions, a care management program offers an excellent training ground for provider integration. Working together to coordinate post-discharge patient care teaches the value of teamwork between primary care and specialist physicians and hospital staff.

Now, with Medicare reimbursement for transitional care management services, there is even more reason to move forward with a post-discharge TCM program.

For more information about implementing a Transitional Care Management Program, please contact:

Martie Ross
mross@pyapc.com
(800) 270-9629

Lori Foley
lfoley@pyapc.com
(800) 270-9629

About PYA

For nearly 30 years, healthcare organizations have turned to PYA as a national leader in comprehensive healthcare consulting services. From the complexities of healthcare compliance to reimbursement challenges and healthcare transactions and valuation, we support a wide range of healthcare organizations including acute care hospitals, physician practices, long-term and rehabilitation facilities and behavioral health organizations. With a team of knowledgeable and experienced professionals, PYA has earned clients' trust by providing exceptional service.