Transitional Care Management: Better Care for Our Patients

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Learning Objectives

1. Define transitional care management (TCM)

2. Determine the benefits and challenges to implementing a TCM program

3. Identify the requirements to bill Medicare for TCM services

4. Describe the steps for implementation of a TCM program into various health care settings
What is Transitional Care Management (TCM)?

TCM includes services provided to a patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient’s community setting (home, domicile, rest home, or assisted living).

American Academy of Family Physicians (AAFP), 2013
Why Take the Time for TCM?

Better Patient Care
Better Outcomes
Reduces Risk of Readmission
Reduces No Show Rates
Enhanced Billing Opportunity
Why Take the Time for TCM?

Better Patient Care

- Reviewing discharge information
- Providing education
- Arranging for community resources
Why Take the Time for TCM?

Better Outcomes

Interacting with other health care professionals who will assume or reassume care of the beneficiary

Scheduling required follow-up appointments and services.
Why Take the Time for TCM?
Reduces Risk of Readmission

The University of Colorado credits a reduction in readmission rates by 30 percent to their Care Transitions Intervention (CTI).

PYA Leadership Briefing: Providing and Billing Medicare for Transitional Care Management, 2014
Why Take the Time for TCM?

Reduces No Show Rates

SUNY Upstate – no show rate from discharge to the 1st Joslin appointment:

Prior to 2012 - > 50%
2012-2013 - 7%
2014 to date - 5%
Why Take the Time for TCM?

Enhanced Billing Opportunity!

Code 99495
Moderate Medical Complexity

Code 99496
High Medical Complexity
Why Take the Time for TCM?

Enhanced Billing Opportunity!

**Code 99495**: performed in a non-facility setting (e.g., a physician’s office) would be approximately $30 more than in a facility setting and requires:

• communication with the patient and/or caregiver within 2 business days of discharge;

• medical decision making of at least **moderate complexity** during the service period; and a

• face-to-face visit within 14 calendar days of discharge.
Why Take the Time for TCM?

**Enhanced Billing Opportunity!**

**Code 99496**: performed in a non-facility setting, would be approximately $35 more than if performed in a facility setting and requires:

- 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; and a

- face-to-face visit within 7 calendar days of discharge.
## Moderate vs High Complexity

### Elements for Each Level of Medical Decision Making

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Number of Possible Diagnoses and/or Management Options</th>
<th>Amount and/or Complexity of Data to Be Reviewed</th>
<th>Risk of Significant Complications, Morbidity, and/or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>High Complexity</td>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
</tr>
</tbody>
</table>

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services, ICN 908628, 2013
Why Not Just Bill for an Office Visit?

- The total relative value units (RVUs) for a 99214/5 in 2014 translates using a conversion factor to:
  
  99214  Established patient office visit, Level 4
  $107.29

  99215  Established patient office visit, Level 5
  $143.65

- The national payment rates for TCM are:
  
  99495  $172.66 (moderate complexity)

  99496  $243.60 (high complexity)

Using **99495/96** in the office setting will pay more than billing an office visit.

PYA Leadership Briefing: Providing and Billing Medicare for Transitional Care Management, 2014
Additional Billing Opportunities

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.

Also added in 2014, both services may be furnished through telehealth.

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- take advantage of their generosity!!!
Three Requirements

During the 30 days beginning on the date the beneficiary is discharged from a hospital inpatient setting, the following three TCM components must be furnished:

• An interactive contact;
• Certain non-face-to-face services; and
• A face-to-face visit.
Who Can Deliver TCM Services?

Physicians (any specialty); and

The following non-physician practitioners (NPP) are legally authorized and qualified to provide the TCM services

• Certified nurse-midwives;
• Clinical nurse specialists;
• Nurse practitioners; and
• Physician assistants.
Interactive Contact

• An interactive contact with the beneficiary and/or caregiver, as appropriate, within 2 business days following the beneficiary’s discharge to the community setting. The contact may be via telephone, e-mail, or face-to-face.

• Contact may be made by Licensed Clinical Staff under the direction of the Physician or NPP.
Interactive Contact

• If two or more separate attempts are made in a timely manner, but are unsuccessful and other TCM criteria are met, the service may be reported. Medicare, however, expects attempts to communicate to continue until they are successful.
Non-Face-to-Face Services

Certain non-face-to-face services may be furnished by licensed clinical staff under your direction.

Services Furnished by Physicians or NPPs

You may furnish the following non-face-to-face services:

- Obtain and review discharge information (for example, discharge summary or continuity of care documents);
- Review need for or follow-up on pending diagnostic tests and treatments;
- Interact with other health care professionals who will assume or reassume care of the beneficiary’s system-specific problems;
- Provide education to the beneficiary, family, guardian, and/or caregiver;
- Establish or re-establish referrals and arrange for needed community resources; and
- Assist in scheduling required follow-up with community providers and services.
Face-to-Face Services

Services Furnished by Licensed Clinical Staff Under the Direction of a Physician or NPP

Licensed clinical staff under your direction may furnish the following face-to-face services:

- Communicate with agencies and community services used by the beneficiary;
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living;
- Assess and support treatment regimen adherence and medication management;
- Identify available community and health resources; and
- Assist the beneficiary and/or family in accessing needed care and services.
A FACE-TO-FACE VISIT

One face-to-face visit must be furnished within certain timeframes as described by the following two new Current Procedural Terminology (CPT) codes (effective for services furnished on or after January 1, 2013):

- CPT Code 99495 – Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge); or

- CPT Code 99496 – Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge).

The face-to-face visit is part of the TCM service and is not reported separately.
Steps for Implementation for a TCM Program at Your Facility: Staying One Step Ahead!
Step 1: Determine a Process to Identify Patients for This Services

- Determine which patients need TCM services
- Utilize an EMR
- Educate phone staff
- Make hospital contacts
Step 2: Calling the Patient

• Utilize a worksheet/template for the initial phone contact (Medicare has one)
• Identify clinical staff to make the initial call
• Make the initial call within the first 48 hours after discharge
• The initial contact can be phone, e-mail, text, or direct face-to-face. It can be with the patient or their caregiver
Step 2: Calling the Patient

- Use the worksheet
- Make a Smart Phrase
- This counts as non-face-to-face services
Step 3: Schedule the Patient

• The patient must be scheduled within 7-14 business days, dependent upon the level of complexity.
• Be prepared! Patients cancel and reschedule.
Step 4: Face-to-Face Visit

You must document the following information, at a minimum, in the beneficiary’s medical record:

- Date the beneficiary was discharged;
- Date you made an interactive contact with the beneficiary and/or caregiver;
- Date you furnished the face-to-face visit; and
- The complexity of medical decision making (moderate or high.)
Step 5: Billing Facts

Select the appropriate code:

99495- face-to-face visit within 14 days
Moderate Medical Complexity

99496- face-to-face visit within 7 days
High Medical Complexity
Step 5: Billing Facts

• If the patient is not readmitted or deceased, the claim can be sent to Medicare 29 days after the initial date of discharge.

• Only one individual may report TCM services and only once per beneficiary within 30 days of discharge.

• Medicare will only pay the first eligible claim submitted, in the case that two providers submit a claim. The second provider would receive a standard office visit fee.
Step 5: Billing Facts

• Report services once per beneficiary during the TCM period (30 days.)

• The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day discharge management services are reported.
Step 5: Billing Facts

If billing with the TCM coders, the medical provider may not also report the following codes during the TCM period:

• Care plan oversight services: Healthcare Common Procedure Coding System (HCPCS) codes G0181 and G0182; and

• End-Stage Renal Disease services: CPT codes 90951 – 90970.
Bringing TCM to Your Facility

• The need is evident for better care coordination and management of patients as they transition from an inpatient to an outpatient setting.

• Recognize the potential for an RN or Social Worker to work as a Transitions Coach.

• Consider the possibilities!
Please feel free to contact me with any questions or thoughts at:

shaverk@upstate.edu

THANK YOU!!
References

• DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services, ICN 908628, 2013


References


