PRISMA HEALTH®

62nd Annual Greenville Postgraduate Seminar

Spotlight: Primary Care

Wifi: Greenville ONE Center
Login: Conference1
Disclaimer

- No conflicts of interest or financial disclosure
Objectives

• Review the history of Transitional Care Management (TCM) services and reimbursement
• Understand the current requirements for TCM visit including
  • 30 day expectations
  • 2 day contact
  • Face to face visit
• Review common exclusions and stipulations
A little history... back in 2009

• 20 percent of Medicare beneficiaries discharged from hospitals were re-hospitalized within 30 days

• 34 percent were re-hospitalized within 90 days

• Medicare wasn’t happy
2010 Affordable Care Act

• Section 3026 established the **Community-Based Care Transitions Program**

• Provided $500 million from 2011 to 2015 to health systems and community organizations that provided at least one transitional care intervention to high-risk Medicare beneficiaries.

• Center for Medicare and Medicaid Innovation (Section 3021) allocated $10 billion for the period 2011-2019 to identify, evaluate, and disseminate innovative care delivery and payment models, including transitional care.
2013 CMS creates payments for TCM

- CMS established the TCM codes 99495 and 99496
- CMS estimated 2/3 of hospital discharges would be eligible
- CMS predicted the codes would result in increased payments to physicians and APP’s
  - 4% family medicine*
  - 3% internal medicine and pediatrics
  - 2% gerontologists
  - 2% nurse practitioners and physician assistants

*For a provider making $200k, that equals 40-50 visits per year

## Reimbursement

<table>
<thead>
<tr>
<th>&lt; 7 days, high complexity</th>
<th>&lt; 14 days and/or moderate complexity</th>
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<tbody>
<tr>
<td>99496</td>
<td>99495</td>
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<tr>
<td>3.05 wRVU</td>
<td>2.11 wRVU</td>
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<tr>
<td>Average Office bill $235</td>
<td>Average Office bill $166</td>
</tr>
<tr>
<td>Average Facility bill $162</td>
<td>Average Facility bill $112</td>
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Purpose of TCM codes

• Reduce readmissions
• Reduce overall cost to Medicare
• Reimburse for services most PCP’s were providing

• **Increase reimbursement for primary care without changing wRVU tables**
First financial move towards total patient care

• First CMS payment made for non-face-to-face services
• Emphasized the importance of a patient’s medical home in coordination of care
The Elements of a Transitional Care Management Visit
99495, 99496
Transition from?

**Included**
- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care hospital
- Skilled nursing facility
- Inpatient rehabilitation facility
- Hospital observation
- Hospital or Psychiatric partial hospitalization

**Not Included**
- Emergency Room
- Newborn Nursery
Transition to...

• Home
• Assisted Living
• Nursing Home
Who can perform a TCM Visit?

- Physicians
- Certified nurse-midwives
- Clinical nurse specialists
- Nurse practitioners
- Physician assistants
99495 “14 Day, Moderate”

- Communication within 2 days of discharge
- Medical decision making of moderate complexity
- Face-to-face visit within 14 calendar days of discharge
99496 “7 day, High”

- Communication within 2 days of discharge
- Medical decision making of high complexity
- Face-to-face visit within 7 calendar days of discharge
What if you see a high complexity patient 10 days after discharge?

• Must bill the lower, 14 day, 99495 code
Communication within 2 Days

- 2 business days, not counting holidays
- Clinical staff or provider
- Contact either patient or caregiver
- At least 2 attempts
  - Telephone
  - Electronic (email or patient portal)
  - One of each
- No time limit between attempts
- Additional attempts are encouraged
- Patient must have left the hospital
Transitional Care Management Face to Face Visit Elements

• Required documentation
  • Date the beneficiary was discharged
  • Date and time interactive contact was made with the beneficiary and/or caregiver and by whom
  • Date you provided the face-to-face visit

• Medication Reconciliation

• Complexity of medical decision making (moderate to high)
30 Days of Care Coordination

- Reimbursement for all care coordination for 30 days
- Other visits during 30 day window can bill E/M code
- Clock begins day of discharge
Non face to face services included

- Communication with patient, family, guardian, caretaker, and/or other professionals
- Communication with home health agencies and other community services used by the patient
- Patient and/or caretaker education to support self-management, independent living, and activities of daily living
- Assessment and support for treatment regimen adherence and medication management
- Identification of available community and health resources
- Facilitating access to care and services needed by the patient and/or family
Provider expectations

- Obtain and review discharge information
- 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
- Assist in scheduling required follow-up with specialty providers and services like home health
Clinical staff expectations

• Communicate with agencies and community services the beneficiary uses

• 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 adherence and medication management

• Identify available community and health resources

• Assist the beneficiary and family in accessing needed care and services
The Fine Print: Exceptions and Exclusions

99495, 99496
Where can the Face to Face Visit occur?

• In office
• Home/Facility visit
• Telehealth visit
What if the patient is readmitted within 30 days?

- If patient readmitted within 30 days, you can only bill for one TCM period

  - Example: Discharged 6/1/19, Seen 6/5/19,
    - Readmitted 6/15/19
    - Discharged 6/20/19, Seen 6/25/19

  - Bill period 1: 6/1 – 6/30/19 OR
  - Bill period 2: 6/20 – 7/20/19
  - Bill E/M code for other visit
New patients?

• Yes, may bill for new or established patients
What if the patient dies within 30 days of discharge?

- Cannot bill the TCM code
- May bill face to face visit with an E/M code
Can more than one provider bill?

- Whomever bills the TCM code first, wins
- Designed to be billed by PCP, but any licensed physician may bill
- Example:
  - Cardiologist sees patient 5 days post discharge and PCP sees patient 6 days post discharge.
  - If cardiologist bills 99496, the PCP cannot
Can TCM codes be billed for other insurances?

• Yes!

• All* private and federal insurances
  • *Prisma Health Upstate has not received any rejected claims from private insurance, Tricare, or Obamacare plans. This is not a statement guaranteeing payment. Copay and deductibles could apply.

• SC Medicaid is currently under review and may retroact to 7/1/19.
Can I bill an E/M visit with a TCM code?

• Technically, yes
• BUT, be careful. Could invite an audit.
• Must be for a new and completely unrelated problem to the Transition of Care
• Cannot use time to justify the code
• Add 25 modifier to E/M code
• For example, patient seen 5 days post discharge for pneumonia, but fell yesterday and hurt her back
What codes cannot be billed with a TCM code?

- **Global codes** (e.g., knee replacement, delivery)
- **Chronic Care Management (CCM) 99490 services**
- **Home health or hospice supervision: HCPCS codes G0181 and G0182**
  - Care plan oversight services (99339, 99340, 99374-99380)
  - Prolonged services without direct patient contact (99358, 99359)
  - Home and outpatient INR monitoring (93792-93793)
  - 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)
  - Complex chronic care coordination services (99487, 99489)
  - Medication therapy management services (99605-99607)
Has TCM been effective?

- Yes!
- In 2017, readmission rates averaged 8.4%

CMS official Transitional Care Management Code information guide
