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New Transitional Care Management (TCM) Codes: More Opportunities for Smart Practices

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The CMS 2013 Final Rule offers new transitional care management (TCM) codes expressly designed to recognize "primary care and care coordination as critical components in achieving better care for individuals, better health for individuals, and reduced expenditure growth." This is precisely the message that SGIM, American College of Physicians (ACP), and the American Academy of Family Physicians (AAFP) have been promoting for several years. Persistence and focus have resulted in real changes in the service code choices available to primary care physicians. The physician fee schedule (PFS), the national resource updated annually by CMS, assigns relative value units (RVUs) to all professional services. Though the PFS applies specifically to Medicare patients, it remains the valuation source for the vast majority of compensation models, large and small. CMS estimates that there will be 5.7 million TCM claims (with roughly a quarter at the higher level) and that primary care compensation from Medicare will increase by 7%. Those who do not use these codes will lose an important source of practice revenue.

Here are the ground rules for using these codes:

- TCM service codes can be used by MDs/DOs/PAs/NPs and CNSs only.
- TCM service codes can be used after discharge from the following: inpatient acute care hospital, psychiatric hospital, long-term care hospital, skilled nursing facility, inpatient rehabilitation facility, hospital outpatient for observation or partial hospitalization, and partial hospitalization at a Community Mental Health Center (CMHC).
- The following service codes cannot be used during the time period covered by the TCM service codes (ironically, CMS does not currently pay for some of these codes): 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); and medication therapy management services (99605-99607).
- TCM services were designed to be provided by a clinician-directed team. Services are to be provided by the clinical staff members (e.g. RNs, MAs) and case managers under the supervision of the billing clinician. The payment for these services was developed to recognize the contributions of the billing clinician (the work RVUs) and the clinical and non-clinical support staff (e.g. RNs, MAs, and administrative assistants in the practice expense or PE RVUs).

Service Code Definitions and RVUs

99495 TCM services include the following:

- Communication by direct contact (face to face), telephone, or electronic device with the patient and/or caretaker within two business days of discharge;
- A face-to-face encounter within 14 days;
- Medical decision making (MDM) of at least *moderate complexity* ("Medical decision making of moderate complexity requires multiple possible diagnoses and/or management options, moderate complexity of the medical data (e.g. tests) to be reviewed, and moderate risk of significant complications, morbidity, and/or mortality as well as comorbidities"); and
- Work RVUs = 2.11, liability RVUs = 0.14, PE RVUs = 2.57 (non-facility) and 1.71 (facility); total 4.82 (non-facility) and 3.96 (facility).

99496 TCM services include the following:

- Communication by direct contact (face to face), telephone, or electronically with the patient and/or caretaker within two business days of discharge;
- A face-to-face encounter within seven days;
- MDM of *high complexity* ("Medical decision making of high complexity requires an extensive number of possible diagnoses and/or management options, extensive complexity of

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the medical data (e.g. tests) to be reviewed, and a high risk of significant complications, morbidity, and/or mortality as well as comorbidities"); and
- Work RVUs = 3.05, liability RVUs = 0.20, PE RVUs = 3.54 (non-facility) and 2.56 (facility); total 6.79 (non-facility) and 5.81 (facility).

Visit Content

TCM service code definitions stipulate both face-to face-and non face-to-face content. One face-to-face visit must occur within the specified time frame. (See page 7.) There are no specified history, examination, or MDM requirements (though there are MDM levels, see below). Non-face-to-face services are part of transitional care management unless the practitioner's reasonable assessment of the patient indicates that a particular service is not medically indicated or needed. Non face-to-face services may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction.

Services (face-to-face or non-face-to-face) provided by the *physician or other qualified health care provider* may include:

- Obtaining and reviewing the discharge information (e.g. discharge summary, continuity of care documents);
- Reviewing need for or follow-up on pending diagnostic tests and treatments;
- Interaction with other qualified health care professionals who will assume or resume care of the patient's system-specific problems;
- Education of patient, family, guardian, and/or caregiver;
- Establishment or re-establishment of referrals and arranging for needed community resources; and
- Assistance in scheduling any required follow-up with community providers and services.

Face-to-face or non-face-to-face services provided by *clinical staff*, under the direction of the physician or other qualified health care professional, may include:

- Communication by direct contact, telephone, or electronic device with the patient and/or caregiver within two business days of discharge;
- Communication with the home health agencies and other community services utilized by the patient;
- Patient and/or family/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; and
- Facilitating access to care and services needed by the patient and/or family.

Notes and Implications

TCM codes include all clinical services on the day of the face-to-face visit as well as all related TCM care provided within the 30-day billing period. This allows considerable provider discretion, but it is recommended that the documentation accumulated during the 30-day period identifies all relevant active problems, providers, and home service agencies; reconciles all medications; completes the review of all pending tests and consultations; and includes a physical examination that appropriately matches the individual patient's identified problems. MDM must be moderate or higher depending on the service code billed, but this MDM can occur at the time of the face-to-face visit or throughout the 30-day period.

A single note documenting the needed elements over the 30 days, plus a separate note for the face-to-face visit (all with a TCM heading), may be the best way to track the documentation. Another option would be individual notes by date, all with TCM in the title. Individual practices will have to work with their electronic health record (EHR) to build logical functionality for the documentation of this 30-day service code.

The day count starts on the day of discharge. This means that practices will need to obtain this critical information as soon as it is known. Professional staff will need the flexibility to work in added calls to discharged patients, and clerical staff will need the authority to schedule the required 7- or 14-day follow-up visit. The issue of counting days was clarified by CMS in an FAQ released in early March. For a patient discharged on Wednesday, the professional staff (e.g. RN, NP, PA, or MD) has until Friday to contact the patient. Business days exclude holidays. This may be

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hard for CMS to sort out since there is not a national holiday schedule, and many states and agencies have unique holidays. Some Medicare contractors may consider Monday through Friday as business days, even if offices are open on Saturday. You will need to clarify this.

An attempt to make contact within two days of discharge is defined as "two or more unsuccessful attempts at communication…within a timely fashion." If the office does not reach the patient, documentation of attempts should be sufficient.

Bill submission will have to be coordinated with the date of discharge and triggered only after 29 days (on or after day 30). TCM codes can be billed by any clinician. No prior relationship is required. TCM services can be submitted by the same providers who submit charges for hospital, rehabilitation, or observation discharge. Medicare copayment and deductible rules apply. These are not considered prevention or wellness services. Payment will be made for only one TCM service in a 30-day interval, so if a patient is readmitted, the service will not be paid again. CMS specifically prohibits billing for other services. (See the list on page 7.) Some of these, such as care plan oversight services, will require coordination between the physician billing and the home agency documentation cycles. This applies to other service codes in other ways. Patients may be seen in the 29-day payment interval for additional E/M services after the TCM face-to-face visit. These additional services must be medically necessary, and separate billing can be submitted. Customary CMS documentation requirements will apply.

Payment for TCM services will not be included in the Primary Care Incentive Program (PCIP), but these payments will also not be included in the denominator used for the determination of incentive eligibility. As a result, there is no PCIP penalty to primary care clinicians for using these codes.

Conclusions

Smart practice means moving rapidly to incorporate these TCM codes into the repertoire of primary care services. CMS recognizes the importance of safe care transitions and will now pay for the non-face-to-face care management tasks that consume staff resources. As primary care physicians, we recommend that our SGIM colleagues become early adopters and advocates within their practices—not only to capture the revenue these codes provide but also to demonstrate that the community of primary care physicians understands the importance of proactively managing care transitions for Medicare beneficiaries. This is work that we have been doing. Now we need to seize the opportunity for our practices to be compensated.

Suggested Reading

Bindman AB, Blum JD, Kronick R Medicare's transitional care payment—a step toward the medical home. N Eng J Med 2013; 368:692-4.

http://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf

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