What You Need to Document in Order to Get Paid

TCM Codes

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Information Courtesy of:

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St Vincent Medical Group – Indianapolis

HOUSTON Methodist℠

LEADING MEDICINE

PHYSICIANS' ALLIANCE FOR QUALITY

TCM – Transitional Care Management : Caution

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- The following information is based on content from the CMS Final Rule – pages 279 to 331
- There are references in the Final Rule to additional information and instructions to be released from CMS
- CMS Just released a FAQ document with some add'l information
- Note: These codes are in the CPT book – but CMS stated they will make some modifications

The New Codes

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- 99495 Transitional Care Management Services with the following 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.

- 99496 Transitional Care Management Services with the following required elements:
  - ++ 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.
  - ++ Face-to-face visit, within 7 calendar days of discharge.

Resources to Assist

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Converging Initiatives

- It's not often that CMS acknowledges the non face-to-face services we render to our patients are not adequately reimbursed
- The general thought is that these are already included in what we are paid for in E/M services
- CMS is providing us with an opportunity for new revenue in conjunction with doing the right thing for our patients

Pioneers

- If you search "TCM" on the CMS web site, a list of previous initiatives will appear – Here however they term applies to Transitional Care MODELS, versus Transitional Care Management
- This approach at readmission reduction is not entirely new as CMS has already conducted a number of similar initiatives in select areas
- Details and tools on each of these programs is available on the CMS web site

Contact Within 2 Business Days

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- CMS did accept the AMA's explanation that business days are Monday through Friday, except holidays, without respect to normal practice hours or the date of notification of discharge.
- CMS and AMA agreed that if two or more separate attempts are made in a timely manner, but are unsuccessful and other criteria for TCM are met, the service may still be reported.
- Caution: If you miss this window you will not qualify for billing the codes

Potential Stumbling Blocks?

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No Discharge Dictation Available

- There were also concerns expressed about the availability of hospital discharge records, but CMS expects this issue to "decline dramatically" as both physicians and hospitals respond to the incentive payments.

Readmission

- If the patient is readmitted within the 30 day period of an initial discharge – the "count" does NOT start over.
- Regardless of multiple admissions and or discharges, the code is only billable once per 30 days, and by only one provider.

TCM – Not Billable When….

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- Not billable by Rural Health Providers
- The TCM codes cannot be billed when a patient is discharged to a SNF as Medicare considers these patients to be inpatients.
- CMS will not allow a provider to also bill Care Plan Oversite, Home Health Oversite, or Hospice Care Plan Oversite in addition to TCM services for the first 30 days post discharge.
- Physicians who submit a code with a 10-90 day global period are prohibited from also billing the TCM code.

Who Can Bill & Be Paid For TCM?

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Only One Provider

- CMS anticipates that most who furnish the service will be PCP providers, however they also believe cardiologists, oncologists or other specialists will also be in a position to furnish TCM after hospital discharge.
- CMS believes the requirement to furnish multiple specific services within a restricted time period will limit the circumstance under which more than one provider might be able to bill TCM.

First Claim In

- In the event more than one provider submits the TCM code, CMS will be using the "first claim" policy as determination for payment.
- Also keep in mind the service can not be billed until the 30th day post discharge or thereafter

Discharge Physician Expectations

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- CMS expects providers to inform the patients that they should receive TCM services from their provider after discharge, and that Medicare will pay for these services.
- As part of this process they expect the discharging physician to ask the patient to identify the provider they wish to furnish these services.
- If the patient does not have a preference, the physician may suggest a specific physician who might be in the best position to furnish the services.
- CMS states it would be helpful for the discharging physician to record this information in the discharge record and in discharge instructions.
- **Discuss this piece with any hospitalists you may work with in providing in-patient care**

What Are The Non Face to Face Services

Sample Listed in Final rule

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- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge.
- Communication with 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.
- Facilitating access to care and services needed by the patient and/or family.

More Expectations

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- Obtaining and reviewing the discharge information (for example, discharge summary, as available, or 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 reassume care of the patient's system-specific problems.
- Education of patient, family, guardian, and/or caregiver.
- Establishment or reestablishment of referrals and arranging for needed community resources.
- Assistance in scheduling any required follow-up with community providers and services.

Medication Reconciliation

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- CMS anticipates that medication reconciliation will occur at the point contact is made within 2 business days with the patient
- CMS further states it can NOT occur any later than the initial face to face service

What Is The Reimbursement?

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Pages 279-331 CMS Final Rule Reimbursement:

- Moderate complex patient - $163 (includes one face to face E/M visit within 14 days of D/C)
- High complexity patient - $230 (includes one face to face E/M visit within 7 days of D/C)

Operational Issues

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- The required visit within either 7 or 14 days depending on the severity level is inclusive to the TCM code
- The TCM code cannot be billed until the 30th day
- How will you "hold" the E/M code, and how will you know when to release it?
- CMS does state a second face to face service in the 30 day period IS billable, it is just the initial E/M that is included and not separately billable (This is a change from the "proposed rule" and the proposed "G codes" – this stated the initial visit could be billed)

Implementation Thoughts

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- Will probably need two "dummy codes" i.e. TCMmod, TCMhig – These would be selected by the provider at the time of the initial face to face service.
  - This will allow for tracking of the services
  - In the event another provider is paid for TCM services, we would then go back and bill for these services
  - The person making contact with the patient via phone will probably have a role in flagging this visit and ensuring it is not billed
  - May also need a visit "type" to schedule a visit here and mark as a "TCM visit" versus a hospital follow up.

Implementation Thoughts

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- How will the actual code be entered and released?
  - The person involved with the non face to face services is the most likely person to submit the charge for billing purposes
  - Since the end of 30 days will not likely involve an actual "patient encounter", there will need to be a process for someone to enter the charge and bill for the service
  - Need to discuss how this process would work with electronic medical records, paper encounters, and ultimately hit the billing system.

Implementation Thoughts

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- Who will render the services – face to face
  - The required visit within either 7 or 14 days could be rendered by a physician or a midlevel provider
  - This could not be a nurse only as they are not a "billable provider" for an E/M service above a level 1.
- Who will render – non face to face services
  - These services can be provided by "clinical staff" – i.e. RN, LPN, etc.
  - Would need to match service to skill levels
    - i.e. cardiology offices typically have RNs and already do this with post MI, CHF, and post intervention pts
    - PCP practices may only have MA's and a wider range of conditions

Implementation Tools

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- Anticipate that there may be medical record requests for the first year
- Consider a tool to help document the essential elements – discharge date, pt contact date, nature of non face-to-face services, level of medical decision making
- See draft tool

Draft Tool

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TRANSITIONAL CARE MANAGEMENT

99495 – Transition Care Management	99496 – Transition Care Management
___ Contact Patient/Care Giver w/in 2 business days ___ Medical Decision Making – **MODERATE** ___ Face-to-Face Visit w/in 14 Days ❑ MODERATE Discharge Date: _____ Contact Date: Contact Means: __ Phone, __ Direct, __ Electronic Add'l Documented Attempts: _____ _____ Medication Reconciliation Included ❑ Yes, ❑ No (must occur no later than Face-to-Face Visit) VISIT WITHIN 14 DAYS: Date/Not billable	___ Contact Patient/Care Giver w/in 2 business days ___ Medical Decision Making – **HIGH** ___ Face-to-Face Visit w/in 7 Days ❑ HIGH Discharge Date: _____ Contact Date: Contact Means: __ Phone, __ Direct, __ Electronic Add'l Documented Attempts: _____ _____ Medication Reconciliation Included ❑ Yes, ❑ No (must occur no later than Face-to-Face Visit) VISIT WITHIN 7 DAYS: Date/Not billable

NON FACE-TO-FACE ELEMENTS:

- ❑ Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of D/C
- ❑ Communication with home health agencies and other community services utilized by the patient.
- ❑ Patient and/or family/caretaker education to support self-mgmnt, 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.

NON FACE-TO-FACE PROVIDED BY THE PHYSICIAN OR OTHER QUALIFIED HLTH CARE PROVIDER may include:

- ❑ Obtaining & reviewing the D/C info (for example, discharge summary, as available, or continuity of care documents).
- ❑ Reviewing need for or follow-up on pending diagnostic tests and treatments.
- ❑ Interaction with other qualified hlthcare prof. who will assume or re-assume care of the pts system-specific problems.
- ❑ Education of patient, family, guardian, and/or caregiver.
- ❑ Establishment or re-establishment of referrals and arranging for needed community resources.
- ❑ Assistance in scheduling any required follow-up with community providers and services.

MISCELLANEOUS

1. Code includes initial E/M – but canNOT be billed before **30 days**
2. Billable by only ONE Provider (first claim in will be paid)
3. NOT Billable by Provider in a 10-90 Day GLOBAL Period
4. NOT Billable by RHC in a 10-90 Day GLOBAL Period
5. NOT Billable if Patient Discharged to a Nursing Home
6. ReAdmission within 30 Days does NOT "RESET" the Day Count
7. When Billing TCM cannot Also Bill:
   - Care Plan Oversight, • AntiCoag Management,
   - Home Health Oversight, • Hospice Care Plan Oversight

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99495 – Transition Care Management	**99496 – Transition Care Management**
___ Contact Patient/Care Giver w/in 2 business days	___ Contact Patient/Care Giver w/in 2 business days
___ Medical Decision Making – **MODERATE**	___ Medical Decision Making – **HIGH**
___ Face-to-Face Visit w/in 14 Days	___ Face-to-Face Visit w/in 7 Days
❑ MODERATE	❑ HIGH
Discharge Date: _____	Discharge Date: _____
Contact Date: _____	Contact Date: _____
Contact Means: __ Phone, __ Direct, __ Electronic	Contact Means: __ Phone, __ Direct, __ Electronic
Add'l Documented Attempts: _____	Add'l Documented Attempts: _____
Medication Reconciliation Included ❑ Yes, ❑ No (must occur no later than Face-to-Face Visit)	Medication Reconciliation Included ❑ Yes, ❑ No (must occur no later than Face-to-Face Visit)
VISIT WITHIN 14 DAYS: _____ Date/Not billable	VISIT WITHIN 7 DAYS: _____ Date/Not billable

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Implementation Plans: Missed Date Range

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- The contact within 2 business days is critical – work with hospitalists, faxing info, etc. may be necessary - If this is missed – you have eliminated your opportunity to bill
- If the visit within 7 business days is missed – i.e. pt seen at day 10 instead – we would need to drop down to the moderate code that allows for a 14 day window even though the services met medical necessity for a high level
- The person making the contact within 2 business days, or discharging provider should set up the visit – but we know patients cancel from time to time

CMS Additional Information Needs

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- CMS stated they intend to release additional information as to how this will apply to new patients
- For the majority issues they accepted the AMA guidelines and information can be found in the CPT book
- A FAQ Document was just released, but does not address new patient visits
- FAQ information states to use 30 days post D/C as the date of service
- We need confirmation that it can still be billed if all other qualifiers are met, but the patient was in observation status - Per FAQ Yes
- What if the patient only lives 27 days post discharge? – Per FAQ – bill face to face, but not TCM

Transitional Care Management in athenaNet

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This document is intended to help you develop a workflow for documenting communication with patients qualifying for these services. It is not intended to give you guidance on how and when to bill for these services. Please consult your billing team or other resources for more detailed information and guidelines.

- Beginning 1/01/2013, two new codes were introduced for transitional care services: **99495** and **99496**. These services are to be provided within 30 days of discharge to established patients whose medical and/or psychosocial problems require moderate or high complexity decision making.
- The transition is from an inpatient hospital setting to an outpatient setting, including acute care, rehab hospital, long-term acute, observation status, or skilled nursing care facility.

Workflow outside of athenaNet: Identify your Patient Population

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While much of the workflow for transitional care management can be completed electronically within athenaNet, some critical elements fall outside of athenaNet

1st Consideration

- If not in place, you will need to develop a process to identify patients as they are discharged from local hospitals. Consider having this information flow to a central source, such as a nurse administrator. HMPAQ has created an email which comes to you daily to let you know of people admitted into the hospital. Patients are not always 100% accurate when being admitted so please encourage your patients to call your office, or email on the portal indicating that they are in the hospital. Download from MethOD the discharge summary packet. If you are not able to retrieve this discharge summary packet, call the Care Navigators at 713-441-0001 and request assistance with obtaining a discharge summary packet.

Workflow outside of athenaNet: Communication with Patient and/or caregiver

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While much of the workflow for transitional care management can be completed electronically within athenaNet, some critical elements fall outside of athenaNet

2nd Consideration

- Communication with the patient can be in-person, by telephone, or electronic. Additionally, it can be in the office setting, patient's home, or other care facility. Your practice may want to consider if all of these types and locations of communication warrant the same documentation style in athenaNet, or if alternate documentation styles should be employed.

Recommended Workflow in athenaNet

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Below is a workflow that we can recommend; note that your practice may want to customize this to your specific needs and setup.

Nurse identifies patient and calls patient and/or caregiver (initial contact)

- The nurse uses a patient case to document contact with the patient and/or caregiver. The nurse leaves the patient case in REVIEW to the provider, and the provider closes the patient case after reviewing. *It is important that the provider reviews the phone call and hospital visit prior to the office visit in order to plan for the visit.*

Recommended Workflow in athenaNet (continued)

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Below is a workflow that we can recommend; note that your practice may want to customize this to your specific needs and setup.

Nurse schedules patient for a visit within 7 days of discharge

- After documenting the patient case, the nurse schedules the patient for a visit with the provider. This visit will need to comply with the expected time frames (7 days for ***99496***, or 14 days for ***99495***).

athenaNet Recommendation: Use an established visit appointment type for these visits, to ensure that the encounter layout contains all sections needed to document moderate-to-high complexity visits.

Recommended Workflow in athenaNet (continued)

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Below is a workflow that we can recommend; note that your practice may want to customize this to your specific needs and setup.

Provider sees patient (face-to-face visit)

- The provider documents the visit as a standard visit, and signs off of the encounter. If the patient comes in after the 7 or 14 day visit say for something else submit as a regular sick visit and drop a separate bill. Document all encounters with the patient.

athenaNet Recommendation: Consider using an encounter plan, which allows the intake staff to select the encounter reason and automatically trigger the appropriate templates and discussion documentation for editing.

Recommended Workflow in athenaNet (continued)

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Below is a workflow that we can recommend; note that your practice may want to customize this to your specific needs and setup.

Claim is held until 30 days post-discharge

- By using a custom claim rule, these claims will remain in hold until 30 days have passed since discharge, in order to ensure that the patient has not been re-admitted. Ask your patients to call the office day 29 to make sure all is going well and they have not been back into the hospital.

athenaNet Recommendation: In order to bill for these services, add these new codes, **99495** and **99496** to your fee schedule.

Methodist Physicians' Alliance for Quality

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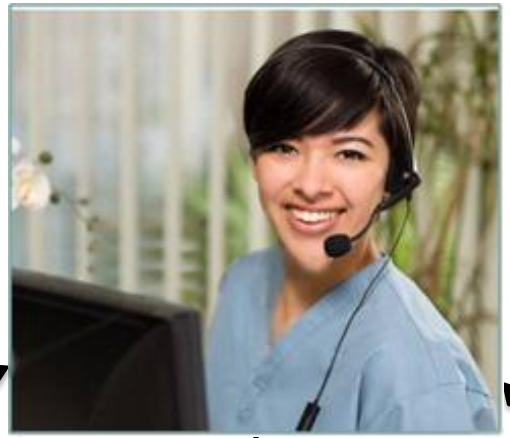
Discharge Initiative Communication

Methodist Sugar Land Hospital
Diane McGraw

San Jacinto Methodist Hospital (eff. 03/30/12)
Robert Bain



The Methodist Hospital
Maureen Disbot /
Dr. Stuart Dobbs

SJMH; MSLH; MWHH; MWH
12/01/11 – Began calling Medicare FFS Discharges with Primary DX: CHF, AMI, PN

Methodist Willowbrook Hospital
Susan Lindsay

Methodist West Houston Hospital
Sherry Nelson

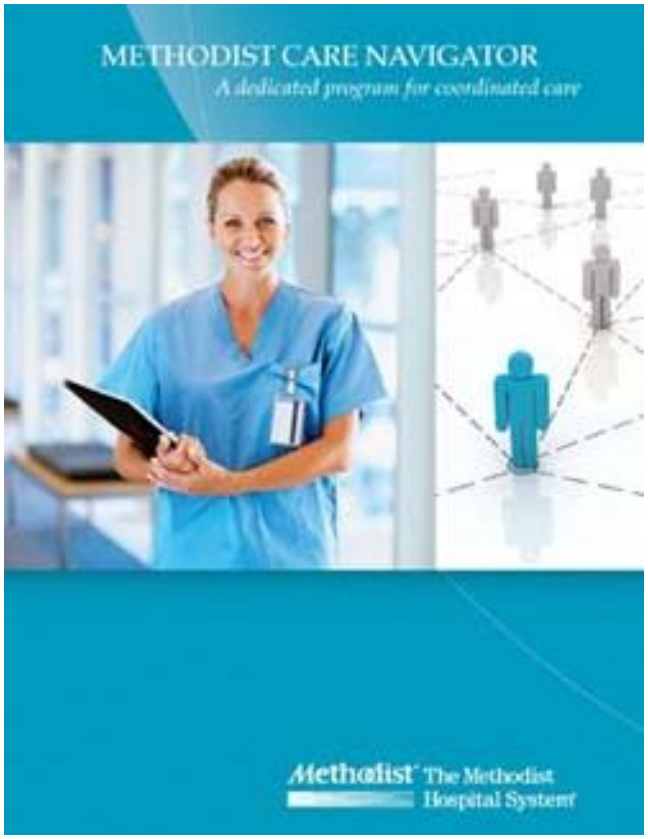
Quality Discharge Initiative:

RN Care Navigator coordinates the post-discharge continuum of care so that patient's post-episode and primary care providers have the most up-to-date information.

- Contacts patient within 72 hours
- Reconciles medications
- Assists with DME and home health
- Assures follow-up appointments with appropriate physician(s)
- Provides treatment information to patient's primary care provider

TMH Quality Discharge Initiative:
Includes all Medicare FFS Discharges 65 years and above (↓65 yrs, Primary DX CHF, AMI, PN)
(Excl. ESRD, Transplant, Cancer, Psych)

What is currently being done at Houston Methodist Hospital?



The Care Navigators consist of nurses who can, among other things:

- Help patients establish a PCP relationship
- Assist on choosing physician specialists
- Procure durable medical equipment
- Schedule home health visits
- Answer drug-related questions

Pharmacist role

You can also enter referrals for post-discharge follow up!

Three ways to refer:

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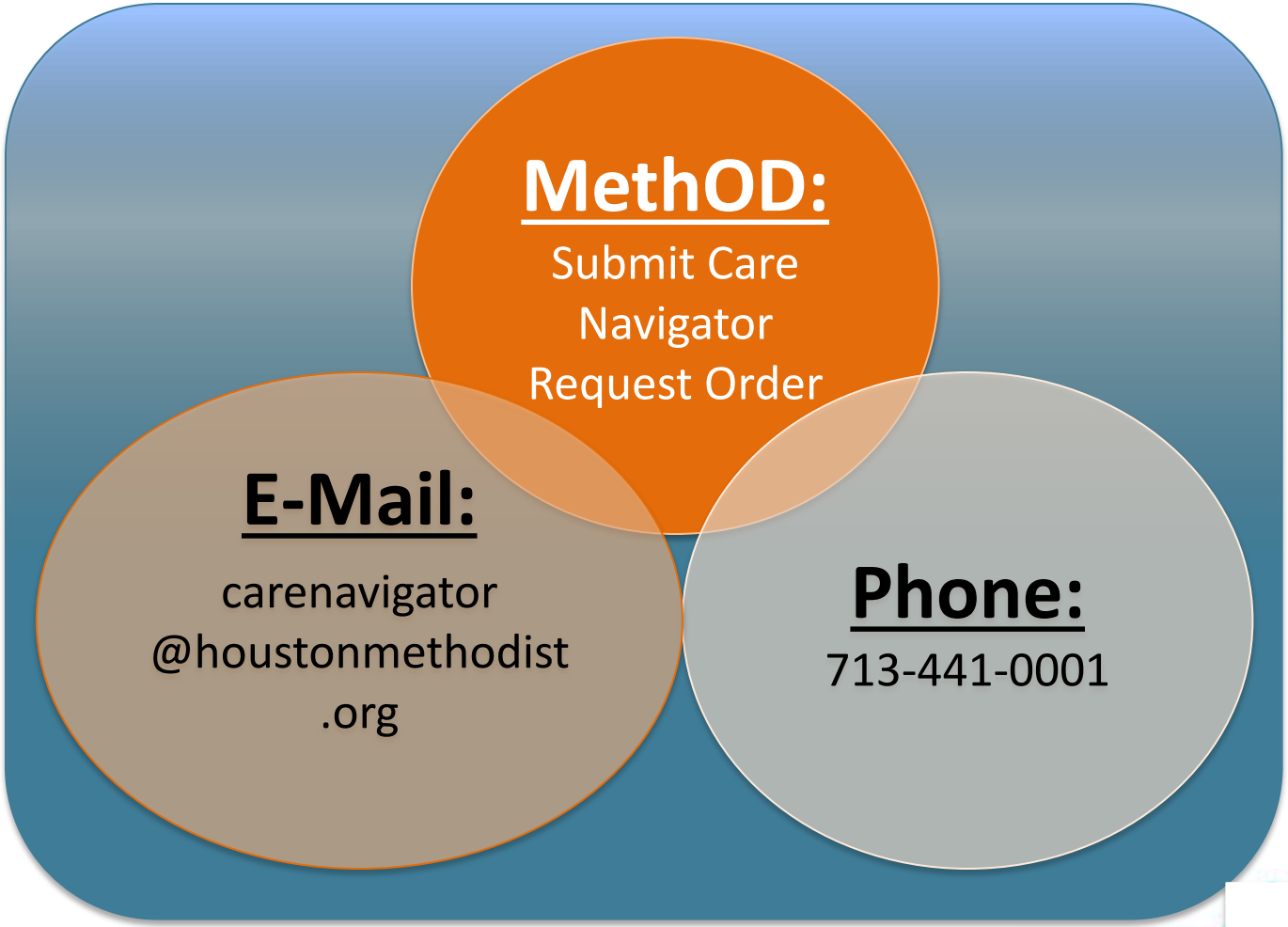

How to enter 'Care Navigator' in MethOD

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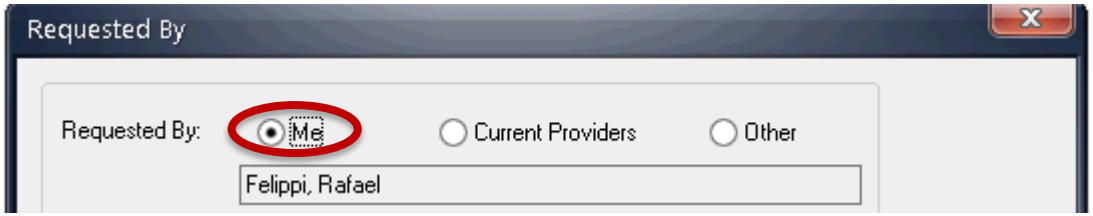
- Considerations for referrals:
  - Noncompliance
  - Re-teaching
  - Medication access concerns (i.e. insurance coverage)
  - Other reasons (please be specific)

- Steps:
  - Click on the order tab in MethOD
    - Can change 'Requested By' to 'Me'



  - Type '**Care Navigator**' under orders tab in MethOD

How to enter ‘Care Navigator’ in MethOD

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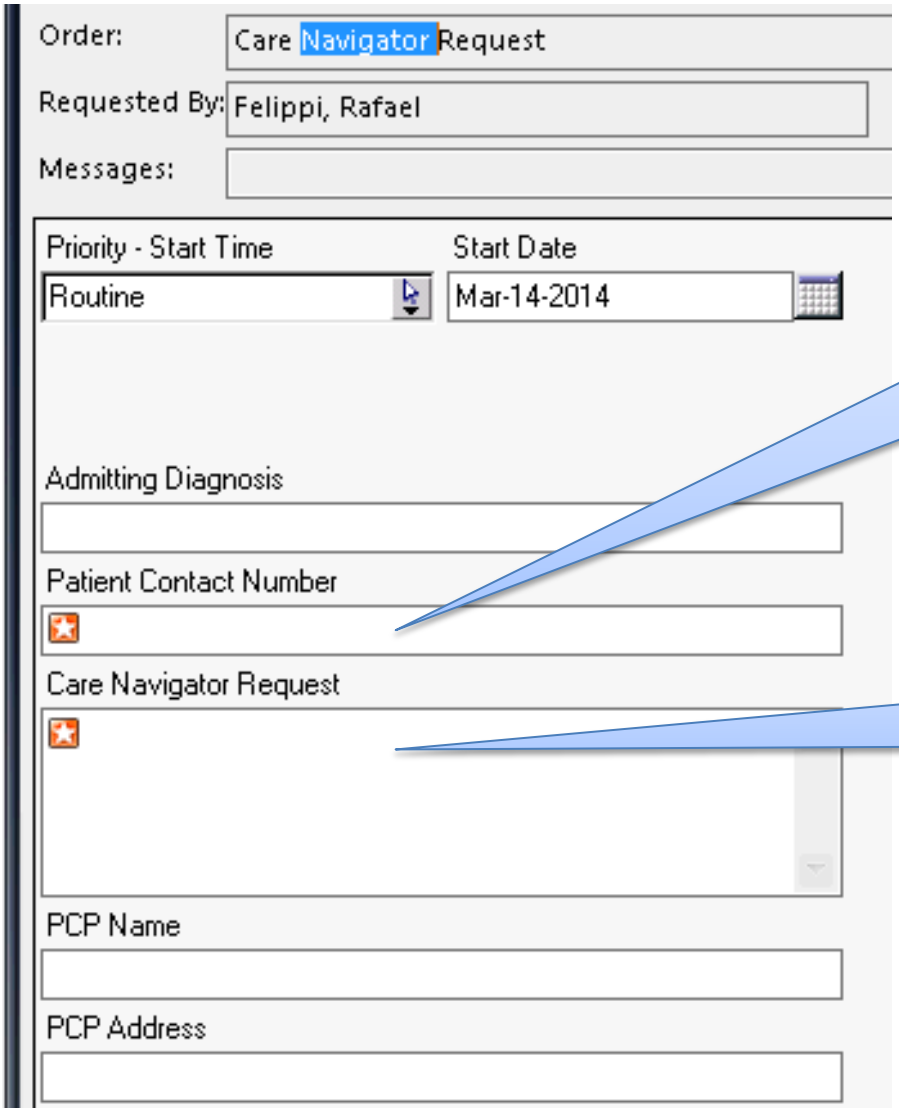

Patient Contact Number

Please ask patient/caregiver for best contact number and let them know they will be contacted after discharge

Reason for Request

Please be specific and provide pertinent details

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