PUBLICATION

CMS Acknowledges Transitional Care Management as Separate Service from E/M [Ober|Kaler]

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Recognizing that care coordination is a key component to achieving better care and health for individuals and reducing expenditure growth, CMS has implemented several new programs to provide payment for such services, including post-discharge transitional care management (TCM) payments. In the 2013 physician fee schedule, CMS created such payments for physicians and certain non-physician practitioners. While CMS states that generally care coordination is a component of an Evaluation and Management (E/M) service, CMS acknowledged that such payments may not be sufficient to support comprehensive management of certain categories of patients, such as those being discharged from institutions to community-based care. Accordingly, CMS has adopted CPT TCM codes 99495 and 99496, with certain modifications, for a single physician who provides care coordination services to a patient within thirty days of the patient's discharge from a hospital, psychiatric hospital, long-term care hospital, skilled nursing facility, or partial hospitalization at a community mental health center to community-based care.

TCM services are comprised of one face-to-face visit and other non face-to-face services that can be provided by the physicians/non-physician practitioners and certain services provided by clinical staff under the physician's direction. Physicians and non-physician practitioners seeking TCM payment will need to provide the following services:

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

- Communication (direct contact, telephone, electronic) with the patient or caregiver within 2 business days of discharge.
- Communication with home health agencies and other community services utilized by the patient.
- Patient and 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.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

- 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.

Physicians claiming reimbursement for these services must attempt communication with the patient or caregiver within two business days and see the patient within 7 days (CPT code 99496) or 14 days (CPT code 99495) of discharge from the hospital or skilled nursing facility. The physician need not have a previous relationship with the patient, as CMS was concerned that such a requirement would perhaps be detrimental to the patients that need care management most – those without established physician relationships. While CMS will allow payment of discharge management CPT codes by the same physician as the physician billing for TCM, an E/M code provided on the day of discharge when a discharge management code is billed cannot be used to meet the TCM face-to-face visit requirement. Additionally, a physician who bills for TCM services is not allowed to also bill for care plan oversight. CMS has stated that it will monitor the various payments to ensure that there is no overlap and perhaps make payment adjustments if necessary. In addition, physicians who bill for a procedure with a 10- or 90-day global surgery period cannot bill TCM codes, as CMS believes that these services are already calculated into the payments during the global surgery period.

CMS will pay for the first claim submitted for TCM services 30 days post-discharge. The agency expects that such claims will mostly be submitted by primary care physicians, but specialists who furnish the requisite services are not excluded. Additionally, NPs, PAs, CNSs, and certified nurse midwives can furnish the full range of E/M services under state scope of practice laws and thus are also eligible for reimbursement. Other non-physician practitioners (such as clinical social workers and dieticians) and “limited-license” practitioners (such as psychologists, optometrists and dentists) are not eligible for TCM reimbursement.

Comments

The acknowledgement that TCM services are separate and distinct from E/M codes is a step in the right direction to coordinating care for patients. In addition, it may be a helpful tool in reducing hospital readmission rates, another health care issue CMS is attempting to tackle.