Internal Medicine Coding Alert

CPT® 2013: Learn All About Transitional Care Management (TCM) Codes of 2013

Tip: Watch individual days, not just calendar months.

CPT® 2013 introduced two new codes for transitional care management services, 99495 and 99496. Although the book includes a page of associated guidelines, here's what you need to know when your internal medicine physician is considering whether to report either code for a patient.

Get Familiar With Potential Scenarios

The codes provide a way for physicians to account for the work involved in managing a patient transferring from an inpatient hospital, partial hospital, observation unit, or skilled nursing facility/nursing facility back to the patient's community setting. Your choices include:

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.

"These codes are for an established patient whose situation requires moderate or high complexity medical decision making during transitions," explains **David A. Ellington, M.D.,** an AMA CPT® Editorial Panel member. "The patient generally has multiple problems that could potentially complicate the transition. The physician overseeing the transition may need to coordinate care between multiple disciplines or community service agencies."

"Basically, for family and internal medicine, the typical example would be an elderly patient with multiple chronic conditions who is being discharged from the hospital to the community setting (i.e., home) after an acute episode that necessitated the hospitalization," adds **Kent Moore,** senior strategist for physician payment at the American Academy of Family Physicians in Leawood, Ks.

Consider these examples from CPT® Changes 2013:

"An 84-year-old female with hypertension and osteoarthritis is discharged from the hospital after a 1-week stay for congestive heart failure." You would report 99495.

"A 93-year-old male is discharged after hospitalization for a myocardial infarction, complicated by hyperglycemia and delirium." Submit 99496.

Count the Days Correctly

Descriptors for both codes 99495 and 99496 include the terminology "during the service period." The codes are intended to represent the 30-day period beginning with the patient's date of discharge.

The clock: The 30-day time limit begins on the day of discharge.

"Remember that the code is only reported by one individual," Ellington cautions. "And remember that you're going by individual days, not a calendar month. The time you're reporting may cross months."

"The biggest challenge will be ensuring that the hospital communicates with the physician when the patient is discharged," Ellington adds. "The clock for TCM starts ticking at discharge, so it behooves all of us to have good communication with the hospitals where our patients are admitted."

Balance Face-to-Face with Non Face-to-Face

Although the code descriptors only specify a face-to-face visit, non face-to-face time also comes into play. Time that the physician or other qualified healthcare professional spends on issues related to the transition also count as part of the service.

During the face-to-face time, the physician might communicate with the patient or decision makers about the transition; educate the patient or family members on self care, independent living, or other pertinent areas; assess medications; identify community or health resources that could benefit the patient; or help coordinate the patient's access to care and services.

Non face-to-face time might be spent obtaining and reviewing discharge information; assessing whether the patient needs follow-up tests or treatments; interacting with health professionals who will be involved with the patient's care; educating the patient or family members; handling arrangements for help from community resources; or helping schedule required follow-ups with community providers and services.

The TCM codes also encompass non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional. Per CPT, these may include:

communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care,

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.

"A face-to-face visit is required within a specific time frame after the patient's discharge, depending on which code you're reporting," Ellington says. "The initial interactive contact face-to-face, phone call, or email should be within two business days of discharge. If you make two attempts to contact the patient or caregiver within that time but are unsuccessful, CPT® states that you can still report transitional services if the other criteria are met."

"This is different from the timing of the initial face-to-face visit," Ellington adds. "That's counted in terms of calendar days, not business days."

Note: The initial E/M visit during the 30 days is included in the applicable transitional care management code. If the patient comes to the physician's office at another time during the 30 days, you can report that encounter separately as a standard E/M visit.

Document to Justify the Codes

You can only report 99495 or 99496 when medical decision making reaches either the "moderate" or "high complexity" level. According to CPT® instructions, base your judgment on the same criteria as E/M service guidelines.

For moderate complexity decision making, report 99495 when the patient's first face-to-face visit is within the 14 calendar days following discharge.

For high complexity decision making, report 99496 when the patient is seen within 7 calendar days of discharge. When the patient is seen within 8 to 14 calendar days following discharge, submit 99495.

The physician should track all interactions and coordinating care for the patient during the 30 days before assigning a TCM code.

Here's why: "The level of medical decision making encompasses the services provided during the entire 30 days, not just a single visit," Ellington says. "You're reporting for what you've done over the course of 30 days."

Final advice: As with some other coding situations, Medicare doesn't completely agree with CPT® guidelines regarding some nuances of transitional care coding. For example, CPT® states that the codes should only be used for established patients, but Medicare allows physicians to report the codes for both new and established patients. Medicare also requires physicians to bill the codes no earlier than the end of the 30-day period, but CPT® guidelines are silent on that point. That's why it's always important to verify each payer's positions before submitting claims, especially when you're dealing with new codes.