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Internal Medicine Coding Alert

Transitional Care Management: 4 Points To Remember When Reporting Transitional Care to Medicare

New rules apply when you follow CMS guidelines instead of CPT®

Now that you've had a few months to adjust to the new transitional care management (TCM) codes, ensure that you're reporting them correctly to Medicare. The latest advice came from a recent CMS Rural Health Open Door Forum call, moderated by **Matthew Brown** of the CMS office of communications.

Starting point: CPT® 2013 includes two new TCM codes:

- 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.

CMS pays for transitional care services 30 days after the patient's discharge. In general, you'll follow CPT® guidance when submitting TCM claims for Medicare patients. CMS representatives, however, pointed out four differences you should remember for their claims.

Any patient: Medicare allows you to report TCM codes for both new and established patients if documentation for the visit and other services fulfill the requirements of CPT® guidance. CPT® guidelines, by contrast, state that the TCM codes are only for established patients.

Separate days: Sometimes a patient has a face-to-face visit with a physician in his office on the same day as the hospital discharge. However, Medicare requires the face-to-face visit associated with TCM services to be on a different day from discharge if the same practitioner sees the patient in both places. If your physician sees the patient in the hospital and in his office on discharge day, you cannot count the office visit as the face-to-face requirement associated with 99495 or 99496.

Extra time: CPT® guidelines state that the direct communication with the patient or caregiver must take place within two business days of the patient's discharge. CMS gives physicians a bit more leeway in regards to that initial communication by saying TCM may still be billed if two or more separate, unsuccessful attempts at communication occur in a "timely fashion." If your practice isn't able to make contact within the first two business days, CMS wants to see documentation that an effort was made to connect within that timeframe; additional documentation showing the practice continues the effort until successful would also be helpful.

Other code plan: The TCM codes are reported for services provided by a single physician or other healthcare provider (and their staff) during a 30-day period. If other physicians or qualified health care practitioners in your office provide reasonable and necessary services to the patient within that timeframe, they may continue to report those services using other CPT® codes (e.g. E/M codes) with the exception of those services that cannot be reported according to CPT guidance and codes G0181 (Physician supervision of a patient receiving Medicare-covered services provided by a

participating home health agency [patient not present] requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication [including telephone calls] with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more) or G0182 (Physician supervision of a patient under a Medicare-approved hospice [patient not present] requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication [including telephone calls] with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more).

Final note: Medicare only pays transitional care services for the first claim received, beginning 30 days after the patient's discharge. Other providers' services will be paid, but only the first physician will be reimbursed for TCM ($163.99 for code 99495 and $231.36 for non-facility claims, based on the national conversion factor of $34.023).