Part B Insider (Multispecialty) Coding Alert

E/M Services: CMS: You Needn't Hold Transitional Care Management Claims for 30 Days

Date of face-to-face service can now be your DOS.

Tracking your practice's transitional care management (TCM) services can be a documentation headache—after performing the face-to-face visit, you've had to track that patient for a month, and then remember to submit your claim after the 30-day period ends. Fortunately, you're no longer stuck watching the calendar before you send your TCM claims to Medicare, thanks to a policy change for 2016.

Background: Ever since Medicare established the TCM codes in 2013, practices have been pleased to have a way to bill for the practitioner's work helping a patient transition from an inpatient location to their home or other community setting. Because the TCM services cover 30 days of care, practices were initially advised to hold the claims and not bill the TCM services until after 30 days had passed. This made claim tracking difficult, because practices had to remember to submit the claim weeks after they actually administered a face-to-face visit.

Submit Claims Right Away

Fortunately, you've got some more leeway this year in terms of when you can submit your TCM claims. According to a Transitional Care Management FAQs document that CMS published on March 17, you no longer have to wait until 30 days have passed before you send your claim to the applicable MAC.

"The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days," CMS says in the document. "The date of service you report should be the date of the required face-to-face visit. You may submit the claim once the face-to-face visit is furnished and need not hold the claim until the end of the service period."

Faster reimbursement: Practices across the country are pleased about the new rules. In particular, practitioners will be glad that they could get paid two weeks earlier than in the past, says Coding Consultant **Donelle Holle, RN**. "It's good news as far as I am concerned."

Fee Schedule Explained Change

The updated advice stems from a little-noticed TCM adjustment printed in the 2016 Physician Fee Schedule Final Rule, which read, "Regarding TCM services, we are adopting the commenters' suggestions that the required date of service reported on the claim be the date of the face-to-face visit, and to allow (but not require) submission of the claim when the face-to-face visit is completed" (page 131 of the Fee Schedule).

Therefore, your practice can either submit your TCM claim on the date of the face-to-face visit—as is now allowed—or you can wait until later in the month, as you have done since 2013. You'll report the services using the following 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.

Keep the Two-Day Window in Mind

To report TCM services, you must initiate contact with the patient and/or his caregiver either in person, via email or by phone, within two days of the patient's discharge from the inpatient setting.

"Any attempts to communicate should continue after the first two attempts until they have directly interacted with the beneficiary or caregiver," says Part B MAC Cahaba GBA in its Transitional Care Management Billing fact sheet. "A voicemail or e-mail without a response **will not** meet the requirement for post-discharge communication. Providers may not bill for transitional care management if contact was not successful within **30 days** between the facility discharge and date of service for the post-discharge code."

Meet These Documentation Requirements

You should ensure that your TCM documentation includes the following information, according to Cahaba GBA's fact sheet:

- The date the beneficiary was discharged
- The date interactive communication with beneficiary or caregiver was established
- The date the face-to-face visit was furnished
- The complexity of the medical decision process (i.e.) moderate or high

The last documentation rule mentioned above is particularly important because it drives your code choice. If you're treating a patient with moderate complexity decision-making, you must report 99495 and see the patient within 14 days of discharge. If, however, the physician notes a high complexity of decision-making for the patient, you should bill 99496 and document that you saw the patient within seven days of inpatient discharge.

Resource: To read the complete FAQs on Transitional Care Management that CMS published in March, visit www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/downloads/faq-tcms.pdf.