AMERICAN GERIATRICS SOCIETY

NEW CODES AVAILABLE FOR TRANSITIONS OF PATIENT CARE – WHAT DOES THIS MEAN FOR OUR PATIENTS?

[*Created December 2012*]

The inclusion of the CPT Transitional Care Management codes into the 2013 Physician Fee Schedule is major. The entire coding framework is significant to geriatrics healthcare providers. These FAQs are an attempt to answer your specific questions.

Why is CMS' decision to incorporate the Transitional Care Management services into the 2013 physician fee schedule so important?

There are two main reasons. First, CMS has recognized that the transition of patients from an inpatient setting to an outpatient setting is fraught with the risk of rehospitalization due to suboptimal communication between providers, medication errors, and inadequate implementation and coordination of outpatient services and social supports. Consequently, CMS recognizes what AGS has advocated for years, that transitional care represents a distinct set of services coordinated by a dedicated healthcare provider and staff. Secondly, CMS understood that the combination of office staff services and non-face-to-face services by the physician or qualified health care provider required by effective transitional care was not previously recognized by available evaluation and management codes, nor reimbursed accordingly. By incorporating these services into the physician fee schedule, CMS now recognizes and reimburses these important services.

What role has AGS played in this and for how long has it been involved in efforts to compensate clinicians for their efforts to ensure that transitions of care are as smooth as possible?

AGS has played a key role in publishing and implementing these codes. It was due to our efforts in working with CMS and the American Medical Association's CPT/RUC Chronic Care Coordination Workgroup (C3W) that a code family for transitional care management services was first drafted. Furthermore, members of AGS around the country have pioneered the development of programs and interventions to improve transitional care and reduce rehospitalization, resulting in a credible and robust scientific basis for these services. AGS continued its leadership role in surveying these codes and successfully presenting them to the AMA RUC in conjunction with several other professional societies.

What does the final rule mean for physicians and other clinicians?

It means that physicians and qualified healthcare providers who were previously unable to be reimbursed for these transitional care coordinated services, will now be able to deploy their office staff and provide appropriate services to more safely and successfully achieve transitions of care when patients are discharged from an inpatient setting. Those offices that already have the necessary staffing will be able to be reimbursed for the services and those that don't will have the option of reconfiguring their staff to start providing these services.

What will this development mean for patients and their caregivers?

This means that over the next few years, patients being discharged from inpatient settings can expect their providers to better coordinate their outpatient services by having a more active role in communicating with all the specialists and agencies involved in their care. Moreover, they can expect better assessment, monitoring and reconciliation of their discharge medications with their previous regimen, better insuring a rational regimen that is more cost effective and less apt to result in redundancies and adverse effects.

What documentation requirements are necessary for the TCM codes?

The final rule did not outline specific documentation requirements for this code, but the required elements should be documented by the physician or the clinical staff who performs each element. The key points that must be documented are: (**1**) contact within 2 business days of discharge, (**2**) medication reconciliation by the first visit, and (**3**) the date of the first face-to-face visit and the complexity of the medical decision making. To provide support for this code, we would recommend the following documentation:

- Document the date, time and content of the initial communication with the patient and/or caregiver.
- Summarize the inpatient course, based on the discharge summary, if available, and conversations with the patient, caregiver and others involved in the care. The purpose of this would be to establish the anticipated complexity of the services.
- Document all communications with home health agencies, qualified healthcare providers and other individuals and agencies involved in the patient's care.
- Document the face-to-face visit as you would any E&M visit, making sure that the medication reconciliation is adequately documented, as well as the plan of care. Although the face-to-face visit does not need to meet the requirements for existing E&M codes, documentation should support the medical necessity and complexity of the overall transitional care management services.
- Have clinical staff document the date, time, duration and content of any of their communications involving the patient.

CMS has added one additional rule that goes beyond CPT, what is the allowance?

CMS has clarified in the final rule, that these TCM services may be used for new Medicare patients. Specifically, CMS states, they plan to modify the AMA CPT prefatory instructions, to allow a physician to bill these codes for new Medicare patients (provided that the physician meets visit requirements and all other requirements for the CPT TCM codes.

What are the required elements of TCM?

TCM services require a face-to- face visit, initial patient contact and medication reconciliation within the specified time frames of each CPT code. For details see the CPT code descriptions 99495 and 99496 provided below:

99495 TCM 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 TCM 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

CPT provides detailed introductory language in the AMA CPT book; we encourage providers to review as it contains inclusionary and exclusionary guidance.

What are the optional elements of TCM?

As with any service, providers should contact your Medicare administrative contractor or the patient's insurer regarding local guidance for billing TCM services.