

# An Action Plan for Improving the Transitional Care Management of Patients with Diabetes



Larry Garrett, PhD, MPH, RN  
Project Coordinator, *HealthInsight*  
[lgarrett@healthinsight.org](mailto:lgarrett@healthinsight.org)  
801-892-6665

## Transitional Care Management Coding

### **Background:**

Approximately one in five Medicare beneficiaries in the United States is readmitted to the hospital within 30 days of discharge; up to 76% of these readmissions may be preventable. A common reason for readmissions is the absence of timely follow-up appointments with primary care providers to assist patients with their new diagnoses, medications, and treatments. The Centers for Medicare & Medicaid Services (CMS) recognize the importance of this transitional period and have started paying medical providers for coordinating Medicare beneficiaries' care transitions. The new payment plan is intended to acknowledge that effective care transitions require care coordination and provide additional reimbursement to support these activities. The 2013 Physician Fee Schedule includes payment for two new CPT codes to support Transitional Care Management Services (TCM).

### **CPT TCM Overview**

The CPT TCM are services for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care. Transitions of care include:

- |   |   |
|---|---|
| The transition of care is <b><u>from:</u></b> | <b><u>To</u></b> the patient's community setting: |
| • Hospital setting                            | • Home  |
| • Observation status in a hospital            | • Skilled nursing facility                        |
| • Skilled nursing facility/nursing facility   | • Assisted living                                 |

CPT 99495 Transitional Care Management Services, 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.

CPT 99496 Transitional Care Management Services, required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver with 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.

The use of either code requires:

- Interactive contact with the patient or caregiver within 2 business days of discharge and may be direct (face-to-face), telephonic, or by electronic means.
- Medication reconciliation and management no later than the date of the face-to-face visit.
- Reportable once per patient 30 days after discharge.
- TCM code selection based on medical decision making at the date of the first face-to-face visit.
- May only be reported by one medical provider.



## TRANSITIONAL CARE BACKGROUND

### The Facts

**1 in 5 Medicare beneficiaries will experience hospital readmission within 30 days of discharge.**

- Estimates that up to 76% of these are due to problems with the transition of care.
- Medicare patients report greater dissatisfaction related to discharge than to any other aspect of care.
- Avoidable hospital readmissions place a physical and emotional burden on patients.

Notes:

### The Facts

**Unnecessary readmissions cost Medicare an estimated \$12 billion annually.**

- Hospitals with high readmission rates are at risk for a financial penalty.
- Penalties are capped at 1% of Medicare payments in 2013 and the cap rises to 3% by 2015.
- 2,222 hospitals penalized; est. recoup \$280 M

Notes:

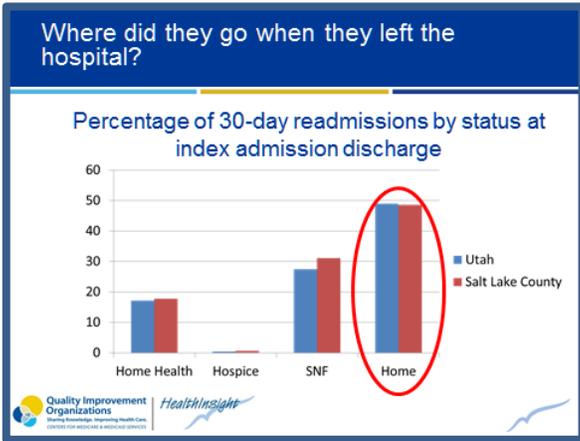
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# TRANSITIONAL CARE BACKGROUND



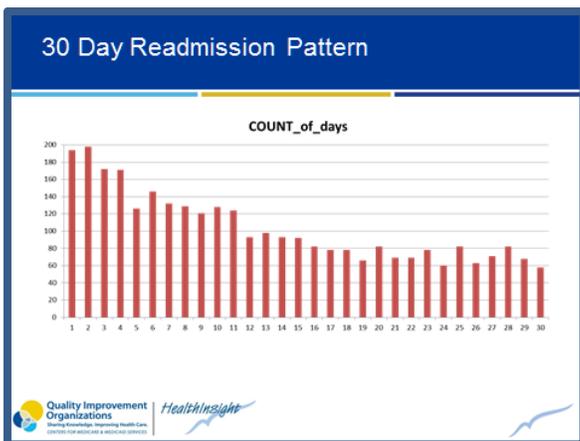
Notes:

### Patient Characteristics of a Patient Readmitted to a Hospital within 30 Days of Discharge

|                               |  |
|-------------------------------|--|
| Gender: Male                  | DRGs: Septicemia, Sepsis, Joint Replacement  |
| Age: 70.6 years               | Common Diagnosis: ESRD, Acute Kidney Failure |
| Dual Eligible: Yes            | Readmission: Metabolic Disorder, Dehydration |
| Index Admission LOS: 4.7 days |  |
| Most common D/C Status: Home  |  |
| Avg. Claim: \$33,818          |  |

Quality Improvement Organizations | HealthInsight

Notes:



Notes:

## Transitional Care Management (TCM) Codes: The Basics

### Transitional Care Management (TCM): 99495

- 99495
  - Communications with patient/family/caregiver within 2 business days post-discharge (Telephone, Direct, Electronic)
  - Medication reconciliation and management prior to date of medical encounter
  - Medical encounter (face-to-face) within 14 days post-discharge
  - Medical Decision Making: Moderate

Notes:

### Transitional Care Management (TCM): 99496

- 99496
  - Communications with patient/family/caregiver within 2 business days post-discharge (Telephone, Direct, Electronic)
  - Medication reconciliation and management prior to date of medical encounter
  - Medical encounter (face-to-face) within 7 days post-discharge
  - Medical Decision Making: Complex

Notes:

### TCM: Operational Rules

- Communication with the patient/family/caregiver may be completed by clinical staff under "provider direction" (e.g. RN, LPN, MA, other)
- Medical encounter must be face-to-face
- Medical encounter may NOT occur on the same day as discharge
- Documentation guidelines may not apply (e.g., pre-encounter communication)
- Not billable for 30-days

Notes:

## Transitional Care Management (TCM) Codes: The Basics

### TCM: Reimbursement

- Reimbursement Schedule:
  - 99495
    - Office: \$134.67
    - Other: \$163.91
  - 99496
    - Office: \$197.58
    - Other: \$231.12
- TCM is billable once per 30-day period

Notes:

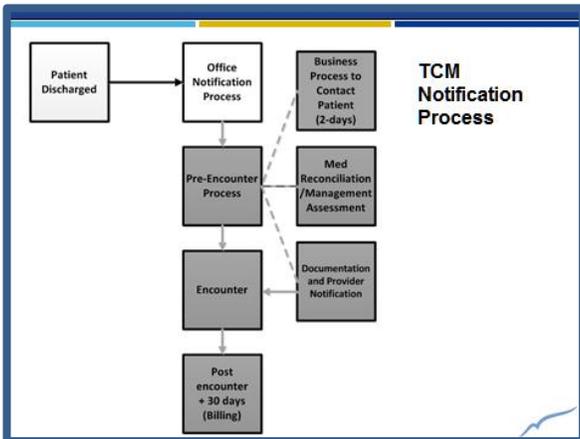
### Workflow Considerations

- Patient identification
- Initial communication of patient within 2 business days
- Medication reconciliation/management and assessment
- Appointment, documentation, notification
- Medical encounter
- Tracking and billing for 30 days

Notes:

Notes:

## Operationalization of the TCM Codes: Workflow

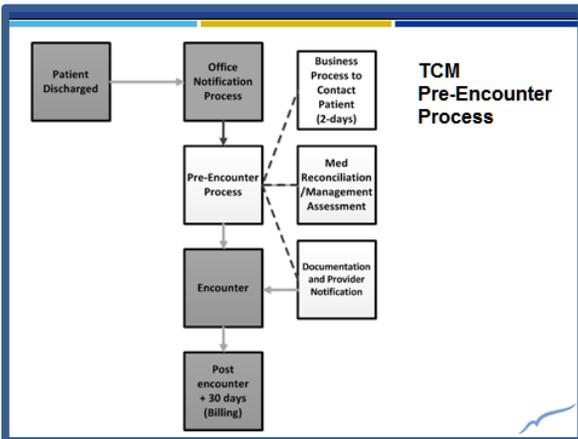


### Considerations:

- Notifications from hospitals, Skilled Nursing Facilities and others
- Two (2) Business Days
- Technology vs. Personal Relationships
- Changing your Phone Messaging

**What Processes Are You Considering To Help Identify Your Patients That Have Been Discharged?**

## Operationalization of the TCM Codes: Workflow



### Considerations:

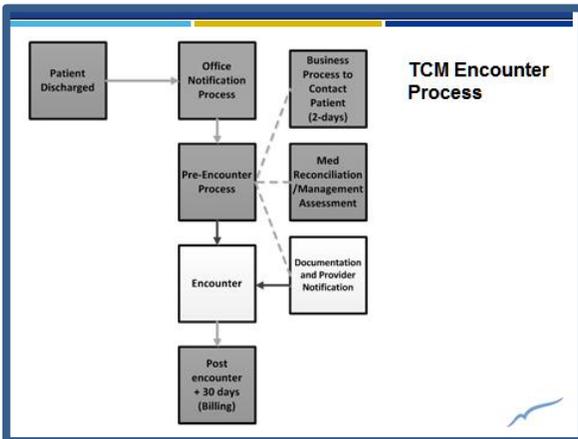
- All activities are "Pre-Encounter"
- Two business days to contact patient
- Medication reconciliation must be completed prior to face-to-face encounter
- Documentation of pre-encounter activities in your EHR/Other
- Use of disease specific template
- Who conducts process

**Who is going to conduct the pre-encounter processes?**

**How are you going to document this information?**

**Are you going to use templates?**

## Operationalization of the TCM Codes: Workflow

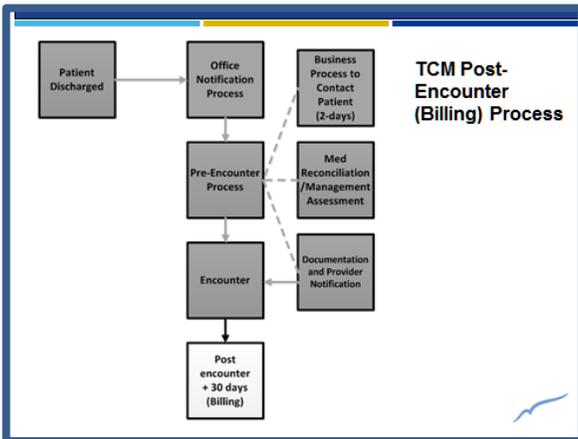


### Considerations:

- How will the medical provider know this is a transitional care encounter
- Proper selection of TCM code

How are you going to ensure the TCM codes are selected by a medical provider during the initial face-to-face encounter?

## Operationalization of the TCM Codes: Workflow



### Considerations:

- The TCM code cannot be billed for 30-days from date of discharge
- Need to ensure patient did not return to the hospital
- Need to ensure only one provider bills for the services

How are you going to hold the billing process for 30 days on transitional based encounters?