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Chronic Care & Transitional Care

These May Not Be The Codes You Are Looking For…

BY CINDY PARMAN, CPC, CPC-H, RCC

Care management is an emerging concept that refers to a set of evidence-based, integrated clinical care activities that are tailored to the individual patient and ensure each patient has his or her own coordinated plan of care and services.[1] The care plan may include multiple medical conditions managed by different medical specialists and is designed to optimize the patient's health and quality of life by generating, planning, organizing, and administering medical care and services. The care plan may include prevention, treatment, and management of illnesses, and the preservation of the patient's mental and physical well-being.

There are procedure codes to report care management services, providing that all documentation requirements are met. It is important to note that while these are billable procedure codes, not all insurers reimburse for these services. Two types of care management services are included in the current code set:

1. Transitional care management services
2. Chronic care management services.

Transitional Care Management Services

Transitional Care Management (TCM) codes were created in 2013 and are used to report services provided to patients transitioning from the inpatient hospital setting to the community setting. The Centers for Medicare & Medicaid Services (CMS) adds that the services must be required by the beneficiary, which means there must be documentation of medical necessity.[2] TCM begins at the date of hospital discharge when the healthcare professional accepts the care of the patient post-discharge without a gap and continues for the next 29 days. These services include:

One (1) face-to-face visit performed within specified time frames. This initial face-to-face visit is part of the TCM service and not separately billed. Additional medically necessary patient visits provided on subsequent dates may be coded and reported separately as established patient visits (codes **99211-99215**).

TCM services can be charged for both new patients and established patients, providing that all criteria are met.

An interactive contact with the patient or caregiver within two business days of discharge. This contact may be direct (face-to-face), by telephone, or by electronic means. The healthcare professional who bills for TCM takes responsibility for the patient's total care. According to CMS, healthcare professionals who can furnish TCM services include physicians, certified nurse-midwives, clinical nurse specialists, nurse practitioners, and physician assistants.

The healthcare provider who performs TCM bills for the service directly; this is not considered to be an "incident-to" service that can be performed by a nonphysician practitioner and billed in the name of a physician. For Medicare purposes, if attempts to communicate with the patient have been unsuccessful within two business days of discharge, providers must continue their attempts to communicate until successful. A successful attempt requires a direct exchange of information and appropriate medical direction by clinical staff with the beneficiary and/or caregiver and not merely delivery of a voicemail or email without response from the patient or caregiver. If there is no successful interactive contact, TCM codes cannot be charged.

Medication reconciliation and management must occur no later than the date of the face-to-face visit. TCM medication reconciliation requires that the medications on discharge be reconciled with the medications that the patient was taking prior to hospital admission. The nurse can obtain the medication information, but the physician must review this data and order any changes, additions, or deletions to the medication list.[3]

Non-face-to-face services performed by the physician or other qualified healthcare professional and/or licensed clinical staff under his/her direction. The physician or qualified nonphysician healthcare professional may be required to:

- Obtain and review discharge information.
- Determine the need for follow-up of any pending diagnostic tests.
- Interact directly with other specialists who will assume or re-assume patient care for non-oncology medical conditions.
- Establish or re-establish referrals.
- Arrange for community resources.
- Assist with scheduling for all necessary visits to other medical professionals.
- Educate the patient, family, and/or caregivers on the transitional care plan.

Table 1. TCM Procedure Codes*

TCM CODE	COMMUNICATION	MEDICAL DECISION MAKING	FACE-TO-FACE VISIT
99495	Direct contact within 2 business days	Moderate complexity	Within 14 days
99496	Direct contact within 2 business days	High complexity	Within 7 days

* Medical decision making is defined by the evaluation and management services guidelines. Documentation must support that the patient has medical and/or psychosocial problems that require moderate or high complexity medical decision making. In addition, the claim for TCM services must include diagnosis codes for all medical conditions managed as part of this care.

Services provided by clinical staff include:

- Monitoring communications from community services or agencies used by the patient.
- Providing assessment and support for treatment regimen adherence and medication management.
- Reinforcing patient and caregiver education.
- Facilitating access to care and services needed to ensure transitional care plan compliance.

Key to charging for TCM is that the physician must be able to address any needed coordination of care performed by other medical disciplines and community service agencies. By reporting the TCM codes, the provider agrees to oversee the management and coordination of services for all medical conditions, psychosocial needs, and support for activities of daily living (ADLs) by providing first contact and continuous access. Only one individual may report these services and then only once per patient within 30 days of discharge. Remember that if an oncologist provides TCM services, it means that the physician and staff are responsible for continuous access for all patient medical conditions—not just the hematology/oncology concern. The physician who performs and bills TCM will manage all medical conditions and all patient medications. For example:[4]

On the day after discharge, the physician speaks with the wife, who is concerned that the patient remains confused. The physician reviews the medication regimen and instructs the wife to discontinue one of the psychoactive medications. The wife is counseled about avoidance of anticholnergic over-the-counter (OTC) medications.

The clinical staff nurse contacts the hospital to obtain the discharge summary to find out who attended the patient during the hospitalization, and which home-health agency received the referral. The physician calls the hospitalist and the consultants to clarify the indications for the medications.

The patient comes to the office 3 days later, at which time the physician has received and reviewed additional records, makes further adjustments to the medication regimen, including tapering anti-diabetic medications that are no longer necessary with resolution of the stressors. Care goals are reviewed (resuscitation status, glycemic control, and lipid goals in a patient with limited life expectancy). Additional diagnostic/monitoring tests are ordered. The nurse care-manager calls the wife several days later to follow up, and the patient is managed for 30 days with additional nurse calls to monitor progress in resolution of the delirium and blood glucose testing.

When all criteria are met, the date of the first face-to-face visit and the extent of documented medical decision making are used to select the TCM procedure code (see Table 1, above).

Because the TCM services will occur over a period of 30 days, medical record documentation must include all face-to-face and non-face-to-face services. Supporting information should include documentation

of the timing of the initial post-discharge communication with the patient or caregivers, date of the face-to-face visit, and the complexity of medical decision making.[5] The date of service for TCM is the last date of the 30-day service period, unless there is an individual insurance payer policy to the contrary. The place of service reported by the billing provider will correspond to the place of service where the required face-to-face visit occurred (e.g., physician's office, patient's home, etc.). Also, while the same provider can bill for both the hospital discharge and TCM, seeing the patient on the day of discharge does not meet the requirements for the follow-up face-to-face visit.

Chronic Care Management

While TCM codes are billed only once per patient per hospital discharge, other procedure codes describe Chronic Care Management (CCM) or Complex Chronic Care Management (CCCM). Similar to the TCM codes, the physician or other qualified healthcare professional oversees, manages, and coordinates care for all medical conditions. Approximately two-thirds of Medicare beneficiaries have two or more chronic conditions and one-third have four or more chronic conditions.[6]

Remember: the patient will be liable for any coinsurance and/or deductibles associated with chronic care management services. As a result, the patient must complete an informed consent for CCM services prior to initiating the service. The patient must specifically acknowledge in writing that:

- The provider has explained the nature of CCM, including how CCM may be accessed.
- Only one provider at a time may furnish CCM for the patient.
- The patient's health information will be shared with other providers for care coordination purposes.
- The patient may stop CCM services at any time by revoking consent (effective at the end of the current calendar month).
- The patient will be responsible for any coinsurance and deductible amounts associated with these services.

While CMS strongly recommends that a provider furnish an annual wellness visit (AWV) or an initial preventive physical exam (IPPE) for each patient receiving CCM, there are no prerequisite services required to bill for CCM at this time.

Chronic care management services are appropriate for patients with medical and/or psychosocial needs that require establishing, implementing, revising, or monitoring a care plan. These patients have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months or until the death of the patient. In addition, these conditions place the patient at significant risk of death, acute exacerbation, decompensation, or functional decline.

CMS maintains a Chronic Conditions Warehouse (CCW) to provide researchers with beneficiary, claims, and assessment data that includes information on 22 specified chronic conditions.[7] This warehouse may not constitute an exclusive list of chronic medical conditions, and CMS has not provided a definition of which medical conditions are required for CCM reimbursement. In addition, while cancer is listed as a chronic medical condition, providers should ensure that they can manage all patient medical conditions prior to billing chronic care management services.

The CCM code can be reported when at least 20 minutes of clinical staff time (including face-to-face and non-face-to-face time) is spent in care management activities during a calendar month. Because this physician-directed service may result in staff time that occurs after hours, CMS states that this service requires general supervision rather than direct supervision. The code for this service is:

- **99490.** At least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month. Multiple chronic conditions, expected to last at least 12 months or until the death of the patient, places the patient at significant risk of death, acute exacerbation, decompensation, or functional decline, with a comprehensive care plan established, implemented, revised, or monitored.

(Note: Chronic care management services of less than 20 minutes duration in a calendar month are not reported separately. In addition, clinical staff time cannot be counted toward the monthly total when the physician or other qualified healthcare professional reports a professional service on the same day.)

The plan of care must be documented and shared with the patient and/or caregiver. This care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment and includes all health problems. It generally includes:

- A problem list.
- Expected outcome and prognosis.
- Measurable treatment goals for all medical concerns.
- Symptom management.
- Planned interventions.
- Medication management.
- Community and/or social services.
- How the services of agencies and specialists that are not connected with the practice will be directed/coordinated.
- Identification of the individuals responsible for each intervention.
- Requirements for periodic review and any necessary revisions of the care plan.
- A list of current practitioners and suppliers that are regularly involved in providing medical care to the patient and address all health issues (not just chronic conditions).

CCM is reported only once each calendar month and only reported by the single physician or other qualified healthcare professional who assumes the care management role for the individual patient.[8] If there is a month where the 20-minute minimum time requirement is not met, chronic care management cannot be billed for that calendar month. Activities performed by clinical staff generally include:

- Education, communication, and engagement of the patient and family in the care plan.
- Communication with agencies and community services used by the patient.
- Collection of health outcomes data and registry documentation.

Table 2. Time-Based Codes for Complex Chronic Care Management*

CCCM CODE	DEFINITION
99487	Complex chronic care management services, for multiple chronic conditions expected to last at least 12 months, placing the patient at risk of death, acute exacerbation, decompensation, or functional decline. Requires the establishment of a comprehensive care plan, with moderate or high medical decision making, 60 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.
+99489	Each additional 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.

* Medical decision making is defined by the evaluation and management services guidelines.

- Assessment and support for treatment regimen adherence and medication management.
- Facilitating access to necessary care and services.
- Ongoing review of patient status.
- Maintenance of a comprehensive care plan.

In addition to these requirements, the practice or program that performs CCM must have the following capabilities:

- Provide 24/7 access to physicians or other qualified healthcare professionals or clinical staff, including providing patients and/or caregivers with a means to make contact with healthcare professionals to address urgent needs—regardless of the time of day or day of week.
- Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
- Provide timely access and management for follow-up after an emergency department visit or facility discharge.
- Utilize an electronic health record (EHR) system so that care providers have timely access to clinical information:
  - The patient's demographics, problems, medications, and medication allergies, which must be included in structured clinical summary records using certified EHR technology.
  - The patient's care plan must be available electronically at all times to anyone within the practice or program providing the CCM service. Specifically, all clinical staff whose time is counted toward the monthly maximum must have electronic access to the care plan.
  - The care plan must be electronically shared outside the program or practice as appropriate.
- Use a standardized methodology to identify patients who require care management services.
- Have an internal care management process and/or function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner.
- Use a form and format in the medical record that is standardized within the practice or program.
- Be able to engage and educate patients and caregivers, as well as coordinate care among all service professionals, as appropriate for each patient.
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care. This can be accomplished through telephone, secure messaging, secure Internet connection, or other asynchronous non-face-to-face consultation methods that comply with HIPAA (Health Insurance Portability and Accountability Act).

Effective January 1, 2015, CMS established a payment for procedure code **99490**, and noted that payment for CCM is only one part of a multifaceted initiative to improve Medicare beneficiaries' access to primary care.[9] By providing CCM reimbursement, payers are also establishing a bridge between fee-for-service and value-based reimbursement.

Complex Chronic Care Management

CCCM services are provided during a calendar month that includes all criteria for CCM services, as well as the establishment or substantial revision of a comprehensive care plan; medical, functional, and/or psychosocial problems requiring medical decision making of moderate or high complexity; and clinical staff care management services of at least 60 minutes. If the care plan is unchanged or requires only minimal changes, CCCM cannot be charged.

The program or practice will identify patients who require CCCM services through practice- or program-specific algorithms or other published algorithms that recognize multiple illnesses, multiple medication use, inability to perform activities of daily living, requirement for a caregiver, multiple emergency department visits, and/or multiple hospital admissions. Typical patients:

- Are treated with three or more prescription medications.
- Receive other types of therapeutic interventions (e.g., physical therapy, occupational therapy).
- Have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months or until the death of the patient.
- Have chronic conditions that place the patient at a significant risk of death,

Table 3. Criteria for Assigning Time-Based CCCM Codes

TOTAL DURATION OF STAFF CARE	CCCM CODES
Less than 60 minutes	Not reported separately
60 minutes to 89 minutes	Code 99487
90 minutes to 119 minutes	Code 99487 + 99489 x 1
120 minutes or more	Code 99487 + 99489 x 2 + 99489 for each additional 30 minutes

acute exacerbation, decompensation, or functional decline.
- Require the coordination of a number of specialties and services.
- Are unable to perform ADLs.
- May have cognitive impairment, resulting in poor adherence to the treatment plan without substantial assistance.
- May have psychiatric and medical comorbidities.
- Have social support requirements or difficulty with access to care.

There are two time-based codes for these services (see Table 2, page 15). Table 3, above, can help providers assign these time-based codes.

While Medicare currently reimburses for chronic care management, CCCM services have a bundled status under the Medicare Physician Fee Schedule.

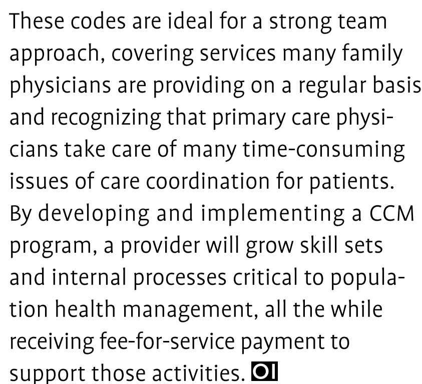
Other Considerations

Research studies continue to demonstrate that care management reduces the total cost of care for patients with chronic diseases and improves overall patient health. In a May 2015 Fact Sheet, CMS states:[10]

The Centers for Medicare & Medicaid Services (CMS) recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals as well as reduced spending.

Last, there are a number of other services that are considered to be inclusive to care management; a comprehensive list is located in the CPT® Manual, and includes procedures such as:

- Care plan oversight
- Prolonged services without direct patient contact
- Anticoagulant management
- Medical team conferences
- Education and training
- Telephone services
- ESRD (end stage renal disease) services
- Online medical evaluations
- Preparation of special reports
- Data analysis
- Medication therapy management services.



These codes are ideal for a strong team approach, covering services many family physicians are providing on a regular basis and recognizing that primary care physicians take care of many time-consuming issues of care coordination for patients. By developing and implementing a CCM program, a provider will grow skill sets and internal processes critical to population health management, all the while receiving fee-for-service payment to support those activities. OI

Cindy Parman, CPC, CPC-H, RCC, is a principal at Coding Strategies, Inc., Powder Springs, Ga.

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