Coding Today
With a Look to Tomorrow:
Transition Care Management and Beyond

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Spartanburg Regional Healthcare System
Staff Physician
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Declarations
• No unapproved medication uses
• No financial relationships to report
• Interpretations of the TCM Codes are mine
  and not those of Spartanburg Regional
  Healthcare System. Ultimately, questions
  relating to complete understanding of these
  codes should be directed to me or your local
  Medicare Administrative Contractor
  (Palmetto GBA).

Objectives
• State the importance of care coordination and
  understand how to begin this in the hospital setting
• Name components specific to the two different
  Transition Care Management (TCM) codes for 2013
• Understand processes needed to successfully
  implement these in your practices
• Understand the basic key components of medical
decision making and how that relates to these
  codes

Complex patients need care
coordination
• Chronic disease burden affects multiple organ
  systems and debilitates
  – Complicates surgical cases, both planned and unplanned
  – Orthopedic procedures
    – Healing and rehabilitation is difficult
  – General surgical procedures, especially with general
    anesthesia
  – Routine infections can become more difficult to treat
  – Diabetes
  – Vascular disease
• Transition Care Management codes are not limited
to just multi-chronic disease patients

Lack of coordination leads to
costly care
• Higher re-admission rates
  – 90% are unplanned (AHRQ), usually related to poor
care coordination and continuity
    • <50% see a provider prior to the readmission
    • Medication mismanagement is second leader associated with
      readmits
• When admitted, more costly care with
  prolonged LOS
  – Preventable re-admissions could save $12B/ year
  – In DRG payment world, less chance for profit
  – Heart disease and Stroke lead the way, Diabetes #2

2013 update:
Transition Care Management
• One potential solution to prevent
  readmissions
  – Hospital penalty of up to 3% of Medicare payments
    in 2015
  – TCM codes set to apply mostly to primary care
    practices to help cover the non face-to-face
    services they offer
  – For TCM codes to be successfully used, we need
    partnerships: Hospital – Hospital based physician
    – and primary care physician working as team
How do we coordinate care?

- Begins in the hospital before discharge
  - Out of hospital services aligned with the patient’s needs
    - Home health, rehab services, outpatient ancillary follow-up with dietitians/counseling, etc.
    - Medication reconciliation and education of proper compliance and reasons for medication use
    - Education of the disease(s) and how they caused the hospitalization and self-directed modifications that can be embraced to keep disease state in check
  - The Team is key to re-admission reduction and patient quality of life optimization
  - Relay of the information to outside entities is key

Discharge encounter

- Inclusions for physician/NPP on unit/floor that day
  - The face-to-face examination
  - Review of the hospital course, and discharge instructions
  - Medication reconciliation
  - Paperwork preparation/form fill-out
  - Discharge summary dictation
- Time for completion of this is additive and must be documented

The discharge from hospital

- Discharge summary
  - Must be completed timely
  - Even observation services!!
  - Must be succinct but complete
    - Abbreviated as compared to the admit note
    - Some "musts"
      - Pertinent tests that were negative or positive
        - A1c of 6.4 means something as does an ECHO of 22% EF
      - Procedures re-stated with findings
        - EGD with stricture, etc.
      - Medication list with med changes from admit summarized
        - If meds changed for sake of formulary, consider reverting to admitt medication if class of drug or clinical effect not different
      - Needed follow-up tests, office visits, or other appointments
        - “recheck potassium at cv in 1wk and get a fu ECHO in 4wks”

Discharge care billable codes

- Inpatient care services
  - 99238 (<30 minutes of time involved)
  - 99239 (>30 minutes of time involved)
- Observation (outpatient) care services
  - 99217 observation discharge (no time)
  - 99234-99236 admit/discharge same day
- Nursing home admission is separately billable even if performed on the same day
  - 99304-99306 (01/2006)

TCM Service: 99495/99496

- Provided to patients discharged from
  - Inpatient or Observation status hospital care
  - Skilled Nursing Facilities
  - Partial Hospitalization programs
- NOT to be used
  - Unless physician or NPP accepts the care of the patient post-discharge without a gap and accepts responsibility for patient’s care
  - By surgeons in post-hospital global surgical period (90d)
  - By hospitalists who do a one-time fu visit
  - By RHC and FQHCs
  - In hospital → Hospital or hospital → SNF transfer
- Established or new patients qualify
- Place of service 11 (office), 12 (pt home), 13 (assisted living)

TCM Service: 99495/99496

- Time period is 30 days (date of discharge and for next 29 days)
- Additional E/M visits outside of the one required are billed separately, even if <30d
- Documentation needs:
  - Date of discharge
  - Date of dialogue to secure/confirm appointment
  - Minimal content to address hospital course
    - Disease status, medication compliance, fu interim access
  - Subsequent correspondence
  - The E/M note associated with the fu care
  - Medication reconciliation completed no later than initial office visit
2013 update:
Transition Care Management
• 99495
  - Communication (direct contact, telephone, electronic) with the
    patient/caregiver (includes home health agencies) within 2 business
    days by staff
  - Discuss caretaker education, care management, ADLs
  - Assess for support and treatment adherence
  - Identify available community health resources
  - Assist in access to care and other services as needed by family
  - Non face-to-face services provided by physician, or other qualified
    healthcare provider
  - Discharge summary review
  - Lab f/u issues
  - Contact other providers of care to coordinate healthcare delivery
  - Educational outreach
  - MDM of moderate complexity during the service period
  - Face-to-face visit within 2 business days of discharge

• 99496
  - Communication (direct contact, telephone, electronic) with the
    patient/caregiver (includes home health agencies) within 2 business
    days by staff
  - Discuss caretaker education, care management, ADLs
  - Assess for support and treatment adherence
  - Identify available community health resources
  - Assist in access to care and other services as needed by family
  - Non face-to-face services provided by physician, or other qualified
    healthcare provider
  - Discharge summary review
  - Lab f/u issues
  - Contact other providers of care to coordinate healthcare delivery
  - Educational outreach
  - MDM of high complexity during the service period
  - Face-to-face visit within 7 calendar days of discharge
  - Same rules for billing as for 99495

What is Medical Decision Making?
• ……of Moderate nature?
  – 99214, 99203, 99284, level 2 admission codes

• ……of High nature?
  – 99215, 99205, 99285, level 3 admission codes

The Third Key Component
• History
• Examination

• Medical Decision Making
  – Diagnoses managed (number and type)
  – Data reviewed to manage diagnoses of visit
  – Risk associated with the management plan

<table>
<thead>
<tr>
<th>TABULATION OF DECISION MAKING ELEMENTS</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> Diagnoses/Management Options</td>
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</tr>
<tr>
<td>Minimal (0)</td>
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</tr>
<tr>
<td>Low (1)</td>
<td>Low (1)</td>
</tr>
<tr>
<td>Moderate (2)</td>
<td>Moderate (2)</td>
</tr>
<tr>
<td>High (3)</td>
<td>High (3)</td>
</tr>
<tr>
<td><strong>B</strong> Amount/Complexity of Data</td>
<td><strong>B</strong> Amount/Complexity of Data</td>
</tr>
<tr>
<td>Minimal/Low (0)</td>
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</tr>
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<td><strong>C</strong> Highest Risk (from any category in table)</td>
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</tr>
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</tr>
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</tr>
</tbody>
</table>

(Choose the column with at least 2 elements. Otherwise, pick the middle column of the three columns with 1 element)
### For MDM calculation on diagnosis

- **Maximum point total is “4”**
  - If 4 is maximum, then the maximum MDM is being met ("High")
  - If 3 is achieved, then "moderate"
  - If 2 is achieved, then "low"
  - If 1 is achieved, then "minimal"

<table>
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<tr>
<th>Types of Problems</th>
<th>Number x points = subtotal</th>
</tr>
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<tbody>
<tr>
<td>Self limited, minor</td>
<td>(max = 2) 1</td>
</tr>
<tr>
<td>Est. problem, stable or improved</td>
<td>1</td>
</tr>
<tr>
<td>Est. problem, medical adjustment needed</td>
<td>2</td>
</tr>
<tr>
<td>New problem*, no work-up planned</td>
<td>3</td>
</tr>
<tr>
<td>New problem*, further work-up planned</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Number of Diagnoses or Treatment Options

<table>
<thead>
<tr>
<th>Categories of Data Reviewed</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order and/or review clinical lab tests (CPT 8xxxx series)</td>
<td>1</td>
</tr>
<tr>
<td>Order and/or review tests from radiology section (nuclear med., Xray—not echo/cath) (CPT 7xxxx series)</td>
<td>1</td>
</tr>
<tr>
<td>Order and/or review tests from medicine section (EKG, EMG, echo, dopplers, cath, PFT, audiometry, etc.) (CPT 9xxxx series)</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records or decide to obtain history from other caregivers/family, or discuss tests with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarize old records by updating chart or taking history from someone other than patient (nurse at NH, interpreter, children)</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing, or specimen</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>
For MDM calculation on risk
• “Highest box wins”
  – Moderate or High is our focus

### RISK FACTORS—SELECT HIGHEST IN CATEGORY

<table>
<thead>
<tr>
<th>LEVEL OF RISK</th>
<th>PRESENTING PROBLEM</th>
<th>PROCEDURES ORDERED</th>
<th>MANAGEMENT OPTIONS CHosen</th>
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<tbody>
<tr>
<td>Minimal</td>
<td>1 chronic unstable  + 1 chronic stable illness</td>
<td>Physiologic tests w/o stress, Endoscopies w/o risk factors</td>
<td>OTC meds, Minor surgery w/o risk factors, Physical/Occupation Therapy</td>
</tr>
<tr>
<td>Low</td>
<td>1 chronic unstable illness, + 1 chronic stable illness</td>
<td>Imaging studies w/ contrast, CV imaging studies with risk factors</td>
<td>Minor surgery w/ risk factors, Prescription drug management, Closed Rx of skeletal injury</td>
</tr>
<tr>
<td>Moderate</td>
<td>1 chronic unstable illness, + 1 chronic stable illness, New prob w/ uncertain prognosis</td>
<td>CV imaging studies with risk factors, Cardiac EPS tests</td>
<td>Elective major surgery with risk factors, Emergency major surgery</td>
</tr>
<tr>
<td>High</td>
<td>1 chronic unstable illness, + 1 chronic stable illness, New prob w/ uncertain prognosis</td>
<td>Cardiac EPS tests, Discography</td>
<td>Elective major surgery with risk factors, Emergency major surgery</td>
</tr>
</tbody>
</table>

### TABULATION OF DECISION MAKING ELEMENTS

#### A
Diagnoses/Management Options
- Minimal: 0-1
- Low: 2
- Moderate: 3
- High: 4

#### B
Amount/Complexity of Data
- Minimal: 0-1
- Low: 2
- Moderate: 3
- High: 4

#### C
Highest Risk (from any category in table)
- Minimal: 0-1
- Low: 2
- Moderate: 3
- High: 4

Medical Decision Making
- Straight-forward
- Low: Moderate
- High: Moderate

### USC 2010 Pediatric Update

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<tr>
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<td>Low: Moderate</td>
</tr>
<tr>
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</tr>
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</table>
Moderate (Detailed) Medical Decision Making (MDM)

- IF you manage a prescription, **AND**
- There are three chronic, stable problems **OR**
- There are two chronic problems, 1 in need of medical management **OR**
- There is one new problem, with no further work-up planned

THEN, there is **MODERATE** MDM

High (Comprehensive) Medical Decision Making (MDM)

- IF you manage a patient with three medical conditions and one is out of control **OR**
- You manage two medical conditions and **both** are out of control **OR**
- You manage a new problem and other diagnostics (CT, MRI, etc.) are needed to fully care for the patient **AND**
- The illness(s) are such as acute kidney injury, suicidal gesture/threats, seizure, TIA, weakness, or acute MS change

THEN

That decision making falls in line with **HIGH** MDM

2013 update: Transition Care Management

- Documentation will be key
  - Have relationship with IP physician so notification can occur
  - Note the discharge date (be notified of admit?)
  - Note the service(s) rendered/recommendations made
  - The “A/P” for the diagnoses covered
    - Moderate MDM: need 1 new disease (to provider), or 2 diseases, one in need of management
    - High MDM: need 2 with both diseases needing attention and some degree of urgency in getting in to be seen within 7 days (COPD, bleeding complication, cardiac event with new NYHA Class IV, etc.)
    - Not mandated, but watch the time: 40 or 50 minutes of “intra-service” time
    - Bill the ICD-9 code linked to the CPT
  - These billing metrics run parallel with components of ACA

2013 update: Transition Care Management

- Billing should coincide NOT with the date of the face-to-face service but with the end of the 30 day period that services were delivered
- The place of service is the physician’s office most often (POS 11)
- Only ONE provider can bill per patient

2013 update: Transition Care Management

- Reimbursement
  - 99495: 2.11 wRVU ($153)
  - 99496: 3.05 wRVU ($217)

- Complex Chronic Care Coordination Codes
  - 99487, 99488, 99489
    - Once per month codes for home or assisted living care coordination services
    - CMS **chose not to fund for 2013**

Closing

- The work most of us has been doing is finally being reimbursed
- We need to fine-tune our staff to help with in-office coordination to make sure all of the TCM metrics are being met
Thank you!

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  - NUlmer@ProtimeLLC.com
  - nick.ulmer@prtcnet.com