CBR201704:

Transitional Care Management

Webinar Questions & Answers

June 21, 2017
3:00 p.m. ET
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INTRODUCTION

These questions are excerpted from the CBR201704: Transitional Care Management (TCM) webinar presented on Wednesday, June 21, 2017. You have the option to view the entire recording of the comparative billing report (CBR), listen to the audio-only version or view the webinar text. You may also open a PDF of the slides or select a specific section of the webinar. All of these options are available from the CBR website page titled CBR201704 Webinar (https://www.cbrinfo.net/cbr201704-webinar).

The CBR project has made every reasonable effort to ensure the accuracy of the information and web links provided in the CBR materials at the time of publication; however, Medicare policy changes frequently, so the information and links within the material may change without further notice. It is the responsibility of the provider to remain up-to-date with Medicare program requirements.

CBR materials are prepared as a service to the public and are not intended to grant rights or impose obligations. The information provided in the CBR is only intended to be a general summary. It does not supersede or alter the coverage and documentation policies outlined in the Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and National Coverage Determinations (NCDs) for the Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs). All coverage and documentation policies are located on the Centers for Medicare & Medicaid Services (CMS) website on the page titled Medicare Coverage Database (https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

Please refer any specific questions you may have to the MAC or DME MAC for your region. We encourage providers to review the specific statutes, regulations, and other interpretive material for a full and accurate statement of their contents. A listing of all MACs can be accessed from the website of CMS at the following link: Review Contractor Directory – Interactive Map (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).
Q. **Can I receive continuing education units (CEUs) for attending a CBR webinar?**

A. CMS does not offer CEUs for attending CBR webinars at this time, but you may receive CEUs from some other organizations. For information related to CEUs, select this link: [Continuing Education Credits](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Continuing-Education.html).

Q. **Am I being audited because of my CBR results?**

A. No. The CBR team does not perform any audits of claims nor have access to medical records of beneficiaries. We do recommend, however, that providers conduct self-audits to identify any possible coverage and/or coding errors. If you would like additional information on beginning an audit process, please visit our CBR website page at the link titled [Self-Audit Help](http://www.cbrinfo.net/self-audit-help.html).

Q. **Does anyone else have access to my CBR letter?**

A. No. Each CBR is private and is sent only to the individual provider. It is not shared with the general public. Although each CBR is not available to anyone other than the provider, CMS is made aware of the recipients and the data used may be shared with CMS at their request.

Q. **What date range was used for this CBR? The beginning and end date for the analysis would be helpful for providers in performing their self audit.**

A. This CBR includes claims with dates of service from January 1, 2016 to December 31, 2016.

Q. **Is there a website link to the information that was presented?**

A. Yes. A recording of the CBR201704 webinar and the slides are currently available on the CBR website. A webinar handout and a question and answer document are also available on our CBR website at the link [CBR201704 Webinar](https://www.cbrinfo.net/cbr201704-webinar).
Q. How do I know the information in the CBR is correct? Some of the information in the report does not appear to be accurate in accordance with guidelines with Noridian Medicare.

A. The information provided in CBR201704 is based on Medicare guidelines for TCM services. If you have specific questions about your CBR, our Help Desk is available to assist you Monday – Friday from 9:00 a.m. to 5:00 p.m. ET. You may contact us via telephone at 1-800-771-4430 or via email at cbrsupport@eglobaltech.com. For assistance with questions about your specific claims, documentation requirements and/or billing and coding, please contact the Medicare Administrative Contractor, or MAC, for your geographic area. The Centers for Medicare and Medicaid Services (CMS) has produced the following document to answer some of the questions you may have about TCM: Frequently Asked Questions about Billing the Medicare Physician Fee Schedule for Transitional Care Management Services (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf).

CLINICAL AND BILLING

Q. What are CMS’ reasons for creating TCM billing codes?

A. TCM codes were added in 2013 to pay for services not previously reimbursed such as phone calls, arranging support, facilitating access to needed services and education of the patient and/or caregiver. The Medicare Learning Network® (MLN) provides additional guidance in an article found at the web link, Transitional Care Management (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf).

Q. Should the date of service be reported as the date of the face-to-face visit or as day 30 of the TCM service?

A. The date of service should be reported as the same date the face-to-face visit is furnished.
Q. Can we bill for TCM if a patient is discharged from a hospital to a skilled nursing facility (SNF)?
A. According to the Federal Register, TCM “services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient’s community setting (home, domiciliary, rest home, or assisted living).” For detailed information, select the following web link: Federal Register/Volume 77, No. 222 (The Comprehensive Primary Care (CPC) Initiative) (https://www.federalregister.gov/).

Q. Initially, when the TCM codes came out, the date of service (DOS) had to be 30 days from the discharge date in order for Medicare to pay. When did the DOS change?
A. As stated in the Federal Register, effective January 1, 2016, the date of service is now the date of the face-to-face visit: “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.” Providers will need to track the beneficiary until the 30 days are completed in order to ensure the beneficiary has not been re-admitted or is not deceased. To find this change, select the following web link: Federal Register/Volume 80, No. 220, (CCM and TCM Services) (https://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf).

Q. If a patient has been hospitalized for surgery and develops medical complications that extend the hospital stay, would that patient be eligible for TCM?
A. Since a review of the patient’s clinical records is necessary to answer this question, and we do not have access to any beneficiary’s medical information, we cannot respond to your question. Please contact your MAC for further guidance. You can find your MAC on the CMS website link at Review Contractor Directory-Interactive Map (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).
Q. If the provider seeing the patient for TCM care is the same provider who discharged the patient, is it still necessary to document the discharge summary?

A. Yes. Documentation must support the level of service of the face-to-face visit. The MLN® article titled Transitional Care Management Services states: “At a minimum, you must document this information in the beneficiary’s medical record:

- Date the beneficiary was discharged
- Date you made an interactive contact with the beneficiary and/or caregiver
- Date you furnished the face-to-face visit
- The complexity of medical decision making (moderate or high)"

More information is available at the following link: Transitional Care Management Services.

Q. Can we bill an E/M at the same time as the TCM? We have billed these in the past and the claims were paid.

A. During the 30-day TCM period, other significantly, separately identifiable medically necessary E/M services may be billed; however, there are some services that may not be reported with TCM CPT® codes 99495 and 99496, such as care plan oversight services, end-stage renal disease (CPT® 90951-90970), chronic care management and home health or hospice supervision (HCPCS G0181, G0182). A complete list of services that cannot be billed with TCM is found in the Current Procedural Terminology (CPT®) Professional codebook, available from the American Medical Association at the web link: AMA Store.

Q. When documenting services provided during the TCM face-to-face visit, is there a preferred format for the actual list of performed services?

A. There is no preferred format for documenting TCM services; however, there are minimum requirements for documentation: the date the beneficiary was discharged, the date you made an interactive contact with the beneficiary and/or caregiver, the date you furnished the face-to-face visit and the complexity of medical decision making (moderate or high) with supporting documentation. There are several TCM worksheets available online to assist providers with documenting and billing these services. To see an example of a worksheet, select this link: American Academy of Family Physicians-Transitional Care Management 30-Day Worksheet.
Q. Can transitional care management (TCM) be billed for one-day admissions or observation?

A. According to the MLN® publication titled Transitional Care Management, “TCM services are furnished following the beneficiary’s discharge from one of these inpatient hospital settings:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center”

For detailed information, select the following web link, Transitional Care Management (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf).

Q. Does a medical assistant qualify as someone that is a “licensed professional” who can make initial contact with the beneficiary within 48 hours of the date of discharge?

A. Per the MLN® publication regarding initial contact: “An interactive contact must be made with the beneficiary and/or caregiver, as appropriate, within 2 business days following the beneficiary’s discharge to the community setting. The contact may be via telephone, email, or face-to-face. It can be made by you or clinical staff who have the capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care.” More information about interactive contact is available at the link titled Transitional Care Management (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf).

Q. Who determines moderate or high complexity when a patient is in the hospital prior to discharge?

A. The provider furnishing the TCM services and face-to-face visit should determine the medical decision making complexity.
Q. How is TCM billed for a Federally Qualified Health Center (FQHC) and a Rural Health Center (RHC)?

A. According to the Medicare Benefit Policy Manual, “TCM services can be billed as a stand-alone visit if it is the only medical service provided on that day with a RHC or FQHC practitioner and it meets the TCM billing requirements. If it is furnished on the same day as another visit, only one visit can be billed.” For detailed guidelines related to RHCs and FQHCs, select the following web link: Medicare Benefit Policy Manual, Chapter 13, Section 110.4 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf).

Q. Can the interactive contact also be the non-face-to-face service (i.e. phone call to patient addressing patient status and assisting in scheduling required follow-up with community providers/services), or must the interactive contact and non-face-to-face service be two separate activities?

A. The interactive contact may be included in the non-face-to-face services; however, there must be a face-to-face visit within seven or 14 days to meet the requirements of TCM services. The use of a telecommunications system can substitute for an in-person encounter for eligible telehealth services.

Q. What clarification can you provide for comparing CPT® codes 99495 and 99496? When we have sicker patients, we have more visits to the hospital compared to other physician practices that have less sick patients.

A. CPT® code 99495 requires a face-to-face visit by a licensed provider within 14 days of discharge. The medical decision making must be of at least moderate complexity. CPT® code 99496 requires a face-to-face visit by a licensed provider within 7 days of discharge with high complexity decision making. Additional medically necessary evaluation and management services may also be provided and billed during the TCM period; however, there are coding limitations. Some services may not be reported during the TCM period, as they are considered an inherent component of TCM services. This information can be found in the CPT® 2016 Professional Manual, which is available from the American Medical Association at this website: AMA Store (https://commerce.ama-assn.org/store/).
Q. **Is there a minimum stay required for TCM prior to the discharge date?**

A. There are no minimum stay requirements for TCM prior to discharge.

Q. **After meeting the TCM requirements, a patient is readmitted to the hospital during the 30-day TCM window. The first hospital admission was from May 1-3, 2017 (Discharged May 3, 2017). The second hospital admission was from May 15-20, 2017 (Discharged May 20, 2017). Would TCM start on May 3 and end June 18th? In this case, would the TCM service span from the first hospital discharge date to day 30 from second hospital discharge?**

A. Yes. The Medicare FAQs state “TCM services can still be reported as long as the services described by the code are furnished by the practitioner during the 30-day period, including the time following the second discharge. Alternatively, the practitioner can bill for TCM services following the second discharge for a full 30-day period as long as no other provider bills the service for the first discharge. CPT® guidance for TCM services states that only one individual may report TCM services and only once per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within 30 days.” FAQs are located at the web link, [Frequently Asked Questions about Billing the Medicare Physician Fee Schedule for Transitional Care Management Services](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf).

Q. **Can you explain the gap in care between the two-day phone call and physician visit?**

A. There should be no gap in care when TCM services are being provided. The initial contact must occur within two days and the face-to-face visit must occur within 7 days for CPT® 99496 and 14 days for CPT® 99495. The initial contact and the face-to-face visit may occur at the same time.
Q. What day is used for counting the 7th and 14th day? Is day 1 the day of discharge or do you starting counting the day post discharge. This is not related to the 30 days of coverage for following the patient.
A. Day 1 is the discharge date.

Q. Can a specialist bill these TCM codes?
A. Any physician or NPP that provides these services may bill TCM.

Q. Do we bill the E/M code for the 7-14 day face-to-face as well as the TCM code?
A. No. The face-to-face E/M is inherent in the TCM codes. However, if another medically necessary E/M is needed during the TCM period you may bill an additional E/M. The documentation should support the medical necessity and the level of the code that is billed.

Q. Can we bill TCM if the hospital has not billed their discharge?
A. The claims payment system does not have logic to account for all Medicare billing requirements. It is the provider's responsibility to remain in compliance with all requirements when filing claims with Medicare.

Q. Do we have to put the date of the telephone contact in the progress note or is it ok to have it in a separate telephone encounter?
A. The date has to be documented in the record. There is no specific guidance on where it has to be documented.

Q. Will Medicare request money back if it’s determined that our claims were billed inappropriately?
A. If you believe you have billed claims inappropriately, you should conduct a self-audit and disclose this information to your MAC. Please contact your MAC for appropriate steps to take to correct your claims. Contact information for your MAC can be found at Review Contractor Directory – Interactive Map. 

REPORT SPECIFICS

Q. **Medicare did not change their policy until 4/2016, so doesn't that make the first four months of reporting inaccurate?**

A. According to the *Federal Register*, updated TCM regulations were effective January 1, 2016. Since CBR201704 covered TCM services rendered from January 1, 2016 to December 31, 2016, our report is accurate. To find this information, select the following web link: [Federal Register/Volume 80, No. 220](https://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf).

Q. **Can you explain Table 4? I'm confused about the difference between services with CPT 99496 and total number of services.**

A. Table 4 is the provider’s *Percentage of Services Billed with CPT® Code 99496*. In this study, two codes were used, CPT® 99495 and 99496. The total services are the sum of services on both the codes. CPT® code 99496 requires medical decision making of high complexity and a face-to-face visit within 7 days of discharge. The analysis is designed to compare each provider’s usage of the higher level TCM code to that of his/her peers. Our sample shows that the mock provider’s value is 64 percent, while the state’s is 49 percent and the national rate is 48 percent. This means the provider’s rate is *Significantly Higher* than the state and the nation. To view percentages for each state and the nation, select the following web link: [CBR201704 Statistical Debriefing](https://www.cbrinfo.net/cbr201704-statistical-debriefing).

Q. **Are state and national data available for those of us who aren't eligible for a CBR but would still like to do a self analysis and compare against the data used in the CBR?**

A. To review the data on TCM for each state and the nation, please select the following web link: [CBR201704 Statistical Debriefing](https://www.cbrinfo.net/cbr201704-statistical-debriefing). In addition, we recommend that providers review representative samples of their claims on a regular basis to ensure proper coding, billing and documentation. If you need assistance with beginning your own self-audit process, please select the following web link: [Self-Audit Help](http://www.cbrinfo.net/self-audit-help.html).
Q. How do I find out what patient is attributed to the column "service without discharge" so we may audit our own records to determine what transpired and if there was a true error made?
A. In order to ensure that personal health information is not compromised, we are not at liberty to disclose the names or numbers of the Medicare beneficiaries receiving these services.

Q. Is the statistical analysis in the CBR really reasonable for all providers?
A. Please be aware that no statistical analysis can account for all of the variations seen in an individual provider’s practice. This analysis serves as a starting point for self-analysis to ensure that your billing/referral practices are correct and in line with Medicare guidelines for CPT® codes 99495 and 99496. Remember, the CBR is informational only and allows a provider to see places where his/her billing pattern is different than his/her peers.
REFERENCES

CBR201704 Webinar (https://www.cbrinfo.net/cbr201704-webinar)


Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html)

Frequently Asked Questions about Billing the Medicare Physician Fee Schedule for Transitional Care Management Services (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf)


AMA Store (https://commerce.ama-assn.org/store/)


CBR201704 Statistical Debriefing (https://www.cbrinfo.net/cbr201704-statistical-debriefing)