[Topics in Practice Management]

CHEST

Review of Transitional Care Management and Chronic Care Management Codes for Pulmonologists

Q15 Q1 *Veronica Rivera, MD; Linda V. DeCherrie, MD; and Audrey Chun, MD*

Patients with advanced respiratory illness are often hospitalized, requiring close follow-up after discharge and also requiring care coordination outside of traditional face-to-face outpatient visits. Primary care providers and specialists often provide services outside of outpatient visits that have not been captured and reimbursed with traditional billing evaluation and management codes. Within the last 5 years, the Centers for Medicare & Medicaid added new codes to the Medicare Physician Fee Schedule that reimburse for care coordination services not paid for by traditional evaluation and management codes. Transitional care management includes the 30-day period following hospitalization in which a clinician is responsible for care of the patient postdischarge from the hospital. Chronic care management provides reimbursement for coordination of care for chronic conditions that is performed by any clinician and his or her staff on a monthly basis that is > 20 min in duration.

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Primary care providers and specialists often provide services outside of the traditional face-to-face visit that have not been captured and reimbursed with traditional billing evaluation and management (E/M) codes. More recently, the Centers for Medicare & Medicaid (CMS) added new billing codes that allow for reimbursement outside of these traditional E/M codes. Medicare began making payments on codes for transitional care management (TCM) in 2013, for chronic care management (CCM) in 2015, for advance care planning in 2016, and for complex chronic care management (CCCM), including add-on codes, in 2017. In addition, home care certifications and care plan oversight codes have been available for many years; the focus of the present discussion, however, is on codes available since 2013. Q5

The present article examines the requirements for TCM, CCM, and CCCM and reviews steps for providers to implement processes in their practice to facilitate billing for both TCM and CCM services (Table 1). Per the Medicare Physician Fee Schedule Final Rule in 2017, CMS improved care management services payment, recognized additional Current Procedural Terminology (CPT) codes, and adjusted payment for the visit during which CCM services are initiated.[1]

ABBREVIATIONS: CCCM = complex chronic care management; CCM = chronic care management; CMS = Centers for Medicare & Medicaid; CPT = Current Procedural Terminology; E/M = evaluation and management; EHR = electronic health record; TCM = transitional care management

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TABLE 1] Overview of TCM, CCM, and CCCM Activities

Variable	CPT or G Code	Code Descriptor Services Required	Who Can Deliver Services	When Codes Can Be Reported
TCM	99496	TCM services with high medical decision complexity	Physician or non-physician practitioner such as physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwife	At posthospital discharge visit within 7 d of discharge
TCM	99495	TCM services with moderate medical decision complexity	Same as TCM above	At posthospital discharge visit within 14 d of discharge
CCM	99490	CCM services of at least 20 min with the following requirements: · Multiple (two or more) chronic conditions expected to last at least 12 mo or until death of patient · Chronic conditions place patient at risk of death, acute exacerbation/decompensation, or functional decline · Comprehensive care plan established, implemented, revised, or monitored	Physician or non-physician practitioner such as physician assistant, nurse practitioner, clinical nurse specialist, and certified nurse midwife and their clinical staff such as RN, SW, and LPN. Nonclinical staff time cannot be counted	Once per calendar month
CCCM	99487	CCCM services of at least 60 min with same requirements as CCM plus moderate or high complexity medical decision-making	Same as CCM above	Once per calendar month
Add-on to CCM initiating visit	G0506	CCM initiating visit that includes extensive assessment and CCM care planning outside of usual effort from face-to-face visit	Physician or nonphysician practitioner such as physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwife	At time of in-person visit when providing care plan. Can be billed only once

CCCM = complex chronic care management; CCM = chronic care management; LPN = licensed practical nurse; RN = registered nurse; SW = social worker; TCM = transitional care management.

TCM Overview

TCM refers to the 30-day period following a transition back to the community, usually after discharge from a hospital but it can also include discharge from another facility such as a skilled nursing facility for a subacute rehabilitation stay. This 30-day period begins on the day of discharge and lasts the following 29 days.[2] During this period, the health-care provider who reports a TCM code takes responsibility for the beneficiary's care, and the beneficiary must have medical and/or psychosocial issues that require moderate or high complexity medical decision-making.

There are three components to TCM.[3] The first is an interactive contact, initiated by clinical staff such as a nurse, nurse practitioner, or a physician, which requires that the patient be contacted within two business days of discharge. In the event that the patient cannot be reached, there must be at least two documented attempts in the first 2 days. However, continued attempts should be made until contact is successful. Second, there should be provision of non-face-to-face services such as follow-up on pending tests, review of discharge information, education to patient and family, or placing referrals for community resources. These services can be provided by clinical staff under direction of a physician. Last, a face-to-face visit with a clinician within 14 days of discharge must occur.

The two CPT codes used to report TCM are 99495 for moderate medical complexity requiring a face-to-face visit within 14 days and 99496 for high medical complexity requiring a face-to-face visit within 7 days of discharge.[3] Only one qualified practitioner may report

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