**Transitional care management services change in 2013**

By Debra Lansey

The 2013 Medicare physician fee schedule rule changes increase payments to internists by 4% to 5% over last year, an estimated total payment of more than $11 billion. The bulk of this increase (3%) comes from the new transitional care management codes.

Non-face-to-face transitional care management services are now being covered and reimbursed in certain circumstances. New Current Procedural Terminology (CPT) codes allow physicians to report their transitional care management services, including the non-face-to-face time they and their clinical staff spend on patient cases. Prior to Jan. 1, only the face-to-face portion of care was considered for reimbursement.

Several codes were under consideration for the 2013 Medicare fee schedule. Two of the codes, CPT codes 99495 and 99496, appear in the 2013 CPT book. These were described in detail in the November/December 2012 *ACP Internist.*

ACP and other specialty societies had long advocated this coding and payment enhancement. The result is a revolutionary acceptance of the continuum of care that exists for patients who were recently discharged from inpatient facilities. Adding these services to the Medicare fee schedule is a critical move forward in the reimbursement of the cognitive services provided in primary care.

The 2013 fee schedule relative values for the new codes are:

- **99495,** transitional care management services with face-to-face visit within 14 days of discharge: 2.11 work Relative Value Units (RVUs)
- **99496,** transitional care management services with face-to-face visit within 7 days of discharge: 3.05 work RVUs

In the final rule, CMS adopted the CPT codes but implemented some modifications for use in the Medicare program. This means that physicians may have two sets of coding rules for the transition care management codes: the CPT rules and the CMS rules. The table shows the differences in the coding rules.

CMS officials believe that the adopted CPT transitional care management codes are defined broadly enough to incorporate treatment of chronic conditions, such as Alzheimer's disease, diabetes, and HIV, and the planning services involved in cancer survival after discharge.

However, CMS will consider adoption of the complex care coordination codes (99487-99489) developed by the CPT Editorial Board as it continues to explore payment for primary care services in future rulemaking.

ACP will continue to advocate for coverage of these important services and will inform its members of any changes to related Medicare or other payer policies.

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### Differences in transition care management (TCM) coding rules

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Medicare Coding</th>
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<tbody>
<tr>
<td>99495</td>
<td>Transitional care management services with face-to-face visit within 14 days of discharge</td>
<td>99495-TCM services</td>
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The reporting physician or nonphysician provider must have an established relationship with the patient. "Established patient" means a visit in the past three years.

#### When should billing occur?

- **Within 30 days of patient discharge**
- **After conclusion of the service (after the 30-day post-discharge period)**

#### Who can bill TCM?

- **MD, DO, NP, PA, CNS, CNM**
- **MD, DO, NP, PA, CNS, CNM**

#### Billing limited by medical specialty?

- No. Can be billed by primary care and other specialties.
- No. Can be billed by primary care and other specialties.

#### Limited to certain diagnoses?

- No
- No

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**CPITIPS**

The Physician Quality Reporting System (PQRS) can offer a good return on investment. While it is a voluntary program, starting this year there will be penalties for not participating.

Incentive payments, equal to 0.5% of allowed charges for services covered by the Medicare Physician Fee Schedule, ended after 2012. Now, clinicians who do not report PQRS measures in 2013 will incur a 1.5% deduction from their 2015 Medicare reimbursements. The negative adjustment will increase to 2% for future years.

Practices have several options to report quality measures. It may seem intimidating at first, but it is possible to spend a little time up front deciding the reporting method and the measures that are most applicable to a practice.

There are two principal decisions to make: what reporting method to use and whether to report individual measures or measures groups.

**Claims-based reporting.** To use claims-based reporting, clinicians can choose three or more measures. For instance, common measures for internal medicine relate to diabetes or congestive heart failure management or preventive care. Clinicians who choose this option will bill using specific codes for 12 months:

- **Individual measures.** Physicians must report on at least three measures and report at least 50% of applicable Medicare fee-for-service patients.
- **Measures groups.** Physicians must report on at least 30 patients during the 12-month period or, if fewer than 30 but more than 15, then at least 50%.

**EHR-based reporting.** To report directly from an EHR, the EHR must be PQRS-qualified. (Clinicians can ask their vendors if they qualify or check online at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013QualifiedEHRDirectVendor.pdf) Physicians who are participating in the 2012 Medicare EHR Incentive Program may satisfy the meaningful use objective to report clinical quality measures to CMS by reporting them through the PQRS-Medicare EHR Incentive Pilot, which uses specific 2012 Physician Quality Reporting EHR measure specifications.

**Registry-based reporting.** With this option, clinicians satisfactorily report on at least 80% of eligible encounters or report on a 30-patient sample (if reporting measures groups). Unlike the other options, which are tied to claim submittals, this option can be done retroactively. Additionally, the fact that only 30 patients are needed to qualify is very appealing.

ACP offers a registry tool, the PQRwizard, that allows physicians to participate using the 30-patient measures group option. The process requires identifying patients who meet the criteria (such as using the practice management system), pulling the charts and then inputting data regarding the measures group. With well-organized charts, this process can take as little as two hours. More details on each of these options, as well as how to access the PQRwizard, are online at www.acponline.org/running_practice/payment_coding/pqrs.