

American Geriatrics Society 2013 Coding Update

New Transitional Care Management Services CPT Codes Adopted by CMS

The Centers for Medicare and Medicaid Services (CMS) announced that it will pay qualified healthcare professionals for coordinating Medicare beneficiaries' transitions from inpatient to outpatient settings. The new and groundbreaking policy was published in CMS' 2013 Final Rule with comment period for the Medicare Physician Fee Schedule on November 16th in the *Federal Register*. The 2013 CPT codes are the product of a multisociety team, working collaboratively in 2012 and facilitated by the AMA CPT and RUC, with strong participation by the AGS. The new CPT codes and rates are effective January 1, 2013.

The new policy is designed to reduce the frequency with which beneficiaries are readmitted to hospitals and skilled nursing facilities or need emergency department care.

Under the new policy, healthcare providers coordinating care for patients undergoing transitions of care will be responsible for communicating with all of the healthcare providers and agencies involved in a given patient's care. These clinicians will also be responsible for monitoring and reconciling patients' discharge medications with their previous regimens to lessen the likelihood of adverse drug effects during transitions. The codes cover all non-face-to-face services related to the discharge that are performed by the physician or other qualified health professional and clinical staff, during the 30 days following discharge, as well as a single face-to-face visit occurring after discharge.

The three key elements for reporting Transitional Care Management (TCM) codes are; (1) that a follow-up communication occurs within 2 business days of the discharge, (2) only moderate- or high-complexity patients with multiple comorbidities who take multiple medications, and are at high risk of readmissions would qualify, and (3) the face-to-face visit must occur within at least 14 days of discharge. The choice of which one of the two codes are based on the timing of the visit. Look for if the visit occurs within 7 days or within the 14 days, these key elements will guide you to selecting the correct TCM CPT code.

The 2013 CPT codebook provides detailed introductory instructions regarding requirements to meet the code elements and billing these services and lists several exclusionary parentheticals with the duplicative codes, which are not allowed to be billed. AGS has developed a FAQ found [here](#) on for these new services and reporting the CPT codes.

Transition Care Management CPT Codes:

99495 – Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

99496 – Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least moderate complexity during the service period

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- Face-to-face visit, within 7 calendar days of discharge

These codes are meant to report the follow-up care given to a patient once they've been discharged from a facility setting to their community setting. The facility setting may include: acute hospital, rehabilitation hospital, long-term acute care hospital, partial hospital, observation status in a hospital, or a skilled nursing facility/nursing facility. The community setting may include: the patient's home, domiciliary, rest home, or assisted living.

The TCM CPT codes can be reported by a physician or other qualified health care professional and/or licensed clinical staff under the physician's direction. The TCM codes include one face-to-face visit with the patient after discharge, and the subsequent non-face-to-face care. ***Note: If more than one face-to-face visit occurs within the reporting period, that visit is to be reported separately.***

New Complex Chronic Care Coordination CPT Codes Available

The American Medical Association (AMA) published three new codes describing complex chronic care coordination (CCCC) services. While these new CPT codes will be available for use beginning January 1, 2013, they were not included in the final 2013 Medicare Physician Fee Schedule for separate payment, as were the TCM codes.

Medicare will not compensate healthcare providers for offering CCCC services in 2013, however, private, or commercial insurers may, check with your local insurer(s) for details.

- **99487** – Complex chronic care coordination services: first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month
- **99488** – First hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month
- **99489** – Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

The intent of the complex chronic care coordination codes is to allow physicians and qualified health care professionals to report the work and time they spend on a patient's care – including non-face-to-face elements, similar to the TCM codes. The key elements for reporting CCCC are (1) overseeing, revisions, documentation, communications and implementation of a patient specific plan of care, (2) only moderate- or high-complexity patients with multiple comorbidities who take one complex or multiple medications, and are at high risk of death or functional decline would qualify, and (3) the total time of the clinical staff as directed by the physician or qualified healthcare professional during the calendar month. The choice of which one of the three codes are based on the total time of the clinical staff during the calendar month, next look to see if there were a face-to-face visit during that calendar month.

The 2013 CPT codebook provides detailed introductory instructions regarding requirements to meet the CCCC code elements and billing these services and lists several exclusionary parentheticals with the duplicative codes, which are not allowed to be billed. Additionally, the CPT codebook provides a coding tip and a total duration of staff table to assist in the appropriate code selection.

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