

REVENUE CYCLE STRATEGIST

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• coding Q&A •

Capturing Transitional Care and Chronic Care Management Appropriately

By Jennifer Swindle

Although these services are provided automatically for the health and well-being of patients, they also should be coded and reported to obtain appropriate payment.

What is the difference between coding for transitional care management and chronic care management?

Answer: While the services for transitional care management and chronic care management are very different and have very different requirements, they have one glaring similarity: They are both often-missed revenue opportunities. Transitional care management captures patients' transitions from acute care or long-term care facilities back to their homes or community living arrangements. Although these services are medically necessary and do occur, they often do not get coded, so revenues are not captured.

Transitional care management covers a 30-day period from the date of discharge and can be reported anytime patients transition from various institutional care settings to a home or community-based setting (see the exhibit at the top of page 2).

There are three required components to transitional care management.



Transitional Care Management Examples

Transitional care management can be reported anytime patients transition from various institutional care settings to a home or community-based setting.

FROM	TO ANY OF THESE SETTINGS
Inpatient acute care hospital	Patient home
Inpatient psychiatric hospital	Patient domiciliary
Long-term care hospital	A rest home
Skilled-nursing facility	Assisted living
Inpatient rehabilitation facility	
Hospital outpatient observation	
Partial hospitalization	
Partial hospitalization at a community mental health center	

Source: Salud Revenue Partners. Used with permission.

Interactive contact within two business days following discharge:

- > May be made via telephone
- > May be made by provider or clinical staff

Non face-to-face services, such as the following:

- > Review records and discharges to help determine plan of care and needs
- > Coordinate with other healthcare providers
- > Provide education for patients and/or patient caregivers
- > Assess and establish needed community services

Face-to-face visits with providers:

- > Must be completed within 14 days if patients' medical conditions are of moderate complexity
- > Must be done within 7 days if patients' medical conditions are of high complexity

If all criteria are met, the services should be reported with either code 99495 or 99496, based on complexity. Separate evaluation and management services should not be reported with face-to-face

visits, as they are included in transitional care management service charges.

However, other evaluation and management services may occur during the 30-day period that are not part of the transitional care management services and should be reported appropriately and separately.

Chronic care management also comprises services that cover 30-day periods of time and often are not supported accurately in the documentation or coded to capture revenue. These services are appropriate for

all patients who have two or more chronic conditions that put these patients at risk, that need to be managed and controlled, and that are expected to last a minimum of 12 months or until death. Chronic care management can only be reported by one provider per month, but can be reported monthly, as long as all criteria are met.

In 2017, there were significant changes to chronic care management to lessen reporting burdens and also to better capture the time spent and the complexity of services. There was one code to report prior to 2017, but three codes are utilized for this service now (see the exhibit below).

Initiation of chronic care management must be done in a face-to-face visit and is billed separately. Patients must consent to chronic care management prior to it being reported and billed. Such consent helps to ensure that patients are aware that these services will occur and be billed and that patients will have some financial responsibility for the services delivered.

Many elements are included in chronic care management, including the following:

- > Use of a certified electronic health record
- > Continuity of care with designated care team member
- > Comprehensive care management
- > Transitional care management

New Coding for Chronic Care in 2017

The number of codes for chronic care management increased from one in 2016 to three in 2017.

CPT	Clinical Staff Time	Care Planning	Billing Provider Requirements
99490	20 minutes or more	Established, implemented, revised or monitored	Ongoing oversight, direction, management, 15 minutes of work
99487	60 minutes	Established or substantially revised	Ongoing oversight, direction, management; high complexity medical decision-making, 26 minutes
99489 (add on)	Each additional 30 minutes	Establishing substantially revised	Additional 13 minutes of work

Source: Salud Revenue Partners. Used with permission.

- > Coordination with home and community-based clinical service providers
- > 24/7 access to address urgent needs
- > Enhanced communication
- > Advance consent

If the services are provided and documented, and after the initial face-to-face occurs to establish the service, these services are performed remotely, with much of the work and time spent by clinical staff.

Although more often than not, these services are already provided for the health and well-being of patients, they also should be coded and reported to obtain appropriate payment. •

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