

Comparative Billing Report



Comparative Billing Report Program
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May 22, 2017

CBR#: CBR201704

Topic: Transitional Care Management

NPI#: 1111111111

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Questions: Contact CBR Support

www.cbrinfo.net

(800) 771-4430 / M-F 9 am – 5 pm ET

cbrsupport@eglobaltech.com

Write to the return address above

Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with eGlobalTech, a professional services firm, to develop Comparative Billing Reports (CBRs).

What is a CBR?

- A CBR is an educational tool that reflects your billing patterns compared to peer patterns for the same services in your state and nationwide.

Why did I get a CBR?

- You received this CBR because your billing patterns differ from your peers in your state or across the nation. Receiving this CBR is not an indication or precursor to an audit.
- Factors such as region, subspecialty, and patient acuity can be factors in differences in billing patterns. These factors are not evident in claims data reviewed for this report.

What should I do with this CBR?

- Read the report in its entirety. We hope the report assists you in identifying opportunities for improvement, or helps you validate your current billing patterns.
- Contact your Medicare Administrative Contractor for specific billing or coding questions, and to ensure you are meeting Medicare standards for your jurisdiction.

Do I need to reply to explain my utilization?

- No reply is necessary, as this report is for educational purposes.

REMINDER: If you have changed your mailing address or contact information and have not notified the National Plan and Provider Enumeration System (NPPES) and/or CMS' provider enrollment contractor via the internet or the appropriate Medicare enrollment application, please take time to review and update the system. You can update your National Provider Identifier (NPI) contact information in NPPES at <https://nppes.cms.hhs.gov/NPPES>. If you have forgotten your User ID and/or password or need assistance, contact the NPI Enumerator at (800) 465-3203 or email customerservice@npienumerator.com.

Sincerely,

Frank Gorton
CBR-Program Director
eGlobalTech

Enclosure

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Comparative Billing Report (CBR): NPI 1111111111

Transitional Care Management

Introduction

CBR201704 focuses on providers of Transitional Care Management (TCM) using Current Procedural Terminology (CPT®) codes 99495 and 99496. Data analysis reveals that Medicare spending on TCM services has increased over 200 percent from 2013 to 2016. TCM is also included in the *Office of Inspector General's (OIG) 2017 Work Plan*. The OIG will be reviewing claims to determine if payments were made in accordance with Medicare requirements.

The goal of this CBR is to educate providers on proper billing of TCM services and to inform them of changes since the codes were first initiated. The Centers for Medicare & Medicaid Services (CMS) introduced the two codes in 2013. The codes were created to pay for services such as phone calls, arranging support, facilitating access to needed services and education of the patient and/or caregiver. Previously, Medicare did not reimburse for these types of services.

CMS also added TCM codes in an effort to reduce hospital readmissions and increase the quality of patient care. CMS estimated that about two-thirds of all hospital discharges would be eligible for TCM services. As a result, TCM payments would be available to family practice physicians, internal medicine providers, pediatric physicians, as well as gerontologists, nurse practitioners and physician assistants.

Coverage and Documentation Overview

This portion of the CBR offers a broad look at the coverage and documentation requirements to ensure compliance with Medicare guidelines. **The information provided does not supersede or alter the coverage and documentation policies, as outlined by the Medicare Administrative Contractors' (MACs) Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the MAC for your region.

TCM begins on the day the beneficiary is discharged from an inpatient setting to a community setting. The provider's responsibility for the beneficiary's care starts on the date of discharge and continues for 29 days.

According to the CPT® definitions of TCM services, communication (interactive contact) must occur within two business days of discharge with both codes. CPT® 99495 requires medical decision making of at least moderate complexity and a face-to-face visit within 14 days. CPT®

code 99496 requires medical decision making of high complexity and a face-to-face visit within 7 days. Management of medication can be provided with the initial interactive contact but must occur no later than the date of the face-to-face visit.

TCM services are payable to one provider only during the 30-day TCM period. The claim should be billed with the date of the face-to-face visit. A physician or a non-physician practitioner (NPP) such as a physician assistant, nurse practitioner or clinical nurse specialist, must perform the face-to-face visit. Medicare requires communication with the patient to be direct, by telephone or electronic. This includes telehealth services using a telecommunications system. Should an additional evaluation and management (E/M) service be warranted, this service may be billed in addition to the TCM service; however, documentation must support medical necessity. The discharging physician may also bill for TCM services, but the face-to-face visit may not be provided on the date of discharge. Providers should not bill TCM services if they are still within the global period of services already provided.

Clinical staff may provide other services needed that are non-face-to-face; however, “incident to” rules apply for the physician or NPP. Some of these services include identifying community resources, assisting the beneficiary with accessing care and services, scheduling follow-up with providers and providing education to the beneficiary or caregiver.

According to the *Medicare Learning Network* publication titled **Transitional Care Management Services**, “When you report CPT® codes 99495 and 99496 for Medicare payment, you may not also report these codes during the TCM period:

- Care Plan Oversight Services
- Home health or hospice supervision: HCPCS codes G0181 and G0182
- End-Stage Renal Disease services: CPT® codes 90951-90970”

This list is not all inclusive.

If a beneficiary is readmitted within the 30-day TCM period, a second TCM service may be billed if the services provided in the code have been furnished and no other provider has billed for the first 30 days. If two providers bill for TCM services during the same 30 days, the provider that submits a claim first will be reimbursed and the second provider’s claim will be denied. If a beneficiary dies during the 30-day period, TCM services should not be billed; however the provider can bill for face-to-face visits using E/M codes.

Methods & Results

This report is an analysis of Medicare Part B claims. The recipients of this report are rendering providers as indicated on the claim. The data was extracted from the Integrated Data Repository (IDR) based on the latest version of the claim as of April 6, 2017 and includes claims with dates of service from January 1, 2016 to December 31, 2016. All providers with allowed charges for the procedure codes included in the study were analyzed. The list of codes used and the corresponding descriptions are included in Table 1.

Table 1: Transitional Care Management CPT® Codes and Abbreviated Descriptions

CPT® Code	Description
99495	Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two 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	Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; Medical decision making of at high complexity during the service period; Face-to-face visit within 7 calendar days of discharge

CPT® codes and descriptors are copyright 2016 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

There are a total of approximately 62,000 providers nationwide who have allowed charges for these two codes. Those who received the CBR were significantly higher than one of their peer groups on at least one of the measurements studied and also were above the 75th percentile in allowed charges (\$3,500) and beneficiary count (17).

Table 2 provides a summary of your utilization of the procedure codes included in this CBR. The total allowed charges, allowed services and distinct beneficiary count are included for each procedure code. In addition, an overall “Total” row is included. Your percentages and averages, denoted in Tables 3 through 6, are calculated from your utilization of the procedure codes summarized in Table 2, using the formulas that follow.

Table 2: Summary of Your Utilization of CPT® Codes 99495, 99496
January 1, 2016 – December 31, 2016

CPT® Code	Allowed Charges	Allowed Services	Beneficiary Count
99495	\$3,867	24	23
99496	\$9,771	43	33
Total	\$13,638	67	53

Please note that the totals may not be equal to the sum of the rows due to rounding. Also, the numbers of beneficiaries are unduplicated counts for each row and the total. A beneficiary receiving both CPT® codes within this time period would be counted in the beneficiary count in each applicable row; however, this beneficiary would be counted only once in the total row.

Metrics were calculated from your utilization and for each of the following peer groups:

- The **state** peer group is defined as all rendering Medicare providers located in the individual rendering provider's state (as determined by NPPES) with claims of allowed charges for the procedure codes included in this study
- The **national** peer group is defined as all rendering Medicare providers in the nation with claims of allowed charges for the procedure codes included in this study

Your metrics were compared to your state (NY) and the nation, using either the chi-square or t-test at the alpha value of 0.05. There are four possible outcomes for the comparisons between the provider and the peer groups:

- Significantly Higher - Provider's value is higher than the peer value and the statistical test confirms significance
- Higher - Provider's value is higher than the peer value, but the statistical test does not confirm significance
- Does Not Exceed - Provider's value is not higher than the peer value
- N/A - Provider does not have sufficient data for comparison

It is important to note that significance is based on the total number of charges, services, or beneficiaries and the variability of those values.

Percentage of Services without Corresponding Discharge Record

As detailed above, TCM services should be billed within 7 or 14 days of the discharge date. For this analysis, discharge dates submitted in Medicare Part A were selected if they were billed within 30 days of a TCM service. This measure was designed to identify TCM services which do not have a corresponding discharge record. The percentage of services without corresponding discharge records is calculated as follows:

$$\left(\frac{\text{Number of Services without a Corresponding Discharge Record}}{\text{Total Number of Services}} \right) \times 100$$

Table 3 provides a statistical analysis of the percentage of services without a corresponding discharge record. Your percentage is compared to that of your state and the nation.

Table 3: Percentage of Services without Corresponding Discharge Record
January 1, 2016 – December 31, 2016

Services Without Discharge	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State's Percent	National Percent	Comparison with the National Percent
13	67	19%	22%	Does Not Exceed	24%	Does Not Exceed

A chi-square test was used in this analysis, alpha = 0.05.

Percentage of Services Billed with CPT® Code 99496

CPT® code 99496 is the higher level TCM code that requires medical decision making of high complexity, while CPT® code 99495 requires medical decision making of at least moderate complexity. This analysis is designed to compare each provider's usage of the higher level TCM code to that of his/her peers. The percentage of services billed with CPT® Code 99496 is calculated as follows:

$$\left(\frac{\text{Number of Services Billed with CPT® Code 99496}}{\text{Total Number of Services}} \right) \times 100$$

Table 4 provides a statistical analysis of the percentage of services billed with CPT® Code 99496. Your percentage is compared to that of your state and the nation.

Table 4: Percentage of Services Billed CPT® Code 99496
January 1, 2016 – December 31, 2016

Services With CPT® 99496	Total Number of Services	Your Percent	Your State's Percent	Comparison with Your State's Percent	National Percent	Comparison with the National Percent
43	67	64%	49%	Significantly Higher	48%	Significantly Higher

A chi-square test was used in this analysis, alpha = 0.05.

Percentage of CPT® Code 99495 Services Billed After 14 Days of Discharge Date

As detailed in the Coverage and Documentation section, use of CPT® code 99495 requires medical decision making of at least moderate complexity and a face-to-face visit within 14 days of discharge; and the claim should be billed on the date of the face-to-face visit. This metric provides the percentage of CPT® code 99495 claims that are billed after 14 days of the discharge date. This measure is only calculated on TCM services where a discharge date has been identified within 30 days prior to the TCM service. TCM services where a discharge date has not been identified from the Medicare Part A claims database are excluded from this analysis. The percentage of CPT® Code 99495 services billed after 14 days of the discharge date is calculated as follows:

$$\left(\frac{\text{Number of CPT® 99495 Services Billed After 14 Days of Discharge Date}}{\text{Total Number of Services Billed with CPT® Code 99495}} \right) \times 100$$

Table 5 provides a statistical analysis of the percentage of CPT® Code 99495 services billed after 14 days of the discharge date. Your percentage is compared to that of your state and the nation.

Table 5: Percentage of CPT® Code 99495 Billed After 14 days of Discharge Date
January 1, 2016 – December 31, 2016

Services Billed After 14 Days	Total Number of CPT® 99495 Services *	Your Percent	Your State's Percent	Comparison with Your State's Percent	National Percent	Comparison with the National Percent
11	19	58%	26%	Higher	28%	Significantly Higher

A chi-square test was used in this analysis, alpha = 0.05.

* Excludes services without a corresponding discharge record

Percentage of CPT® Code 99496 Services Billed After 7 Days of Discharge Date

Use of CPT® code 99496 requires medical decision making of high complexity and a face-to-face visit within 7 days of discharge; and the claim should be billed on the date of the face-to-face visit. This metric provides the percentage of CPT® code 99496 claims that are billed after 7 days of the discharge date. This measure is only calculated on TCM services where a discharge date has been identified within 30 days prior to the TCM service. TCM services where a discharge date has not been identified from the Medicare Part A claims database are excluded from this analysis. The percentage of CPT® Code 99496 services billed after 7 days of the discharge date is calculated as follows:

$$\left(\frac{\text{Number of CPT}^{\circledR} \text{ 99496 Services Billed After 7 Days of Discharge Date}}{\text{Total Number of Services Billed with CPT}^{\circledR} \text{ Code 99496}} \right) \times 100$$

Table 6 provides a statistical analysis of the percentage of CPT[®] Code 99496 services billed after 7 days of the discharge date. Your percentage is compared to that of your state and the nation.

Table 6: Percentage of CPT[®] Code 99496 Services Billed After 7 Days of Discharge Date
January 1, 2016 – December 31, 2016

Services Billed After 7 Days	Total Number of CPT [®] 99496 Services *	Your Percent	Your State's Percent	Comparison with Your State's Percent	National Percent	Comparison with the National Percent
23	35	66%	28%	Significantly Higher	33%	Significantly Higher

A chi-square test was used in this analysis, alpha = 0.05.

* Excludes services without a corresponding discharge record

References & Resources

The coverage and documentation guidelines for Transitional Care Management (TCM) Services are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at <http://www.cbrinfo.net/cbr201704-recommended-links>.

Centers for Medicare & Medicaid Services:

- Physician Fee Schedule Search
- *Medicare Learning Network*
 - Transitional Care Management Services - December 2016

Federal Register:

- Volume 77, No. 222

Medicare Administrative Contractors (MACs):

- Nорidian Healthcare Solutions
 - Transitional Care Management, January 2017

Maine Quality Counts:

- New CMS Primary Care Transitional Care Management Services & Billing Codes: What Practices Need to Know

University of Pennsylvania School of Nursing New Courtland Center for Transitions and Health:

- Transitional Care Model

BioMed Central:

- Project Achieve-Using Implementation Research to Guide the Evaluation of Transitional Care Effectiveness

American College of Physicians (ACP):

- What Practices Need to Know about Transition Care Management Codes

American Medical Association (AMA):

- *CPT® 2016 Professional Edition*

The Next Steps

We encourage you to check with your MAC to ensure that you are meeting the Medicare standards for your jurisdiction. Please use the above references and resources as a guide.

You are invited to join us for the CBR201704 webinar on June 21, 2017 from 3:00-4:00 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201704-webinar>.

If you are unable to attend, you may access a recording of the CBR201704 webinar five business days following the event at <http://www.cbrinfo.net/cbr201704-webinar>.

If you have any questions or suggestions related to this CBR, please contact the CBR Support Help Desk via email at CBRsupport@eglobaltech.com or via telephone at (800) 771-4430.

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