Society Efforts Result in New Payment for Care Coordination Services

On November 1, the Centers for Medicare and Medicaid Services (CMS) released the 2013 Medicare Physician Fee Schedule final rule which sets the rates at which physicians will be reimbursed for the upcoming year. In this payment policy, CMS approved payment for two new CPT codes (99495 and 99496) to cover a 30 day period of transitional care management: the additional care coordination activities that are required in the 30 days following a complicated patient's discharge from the hospital.

Over the past year, the Society has had significant involvement in the arduous process of developing these new codes and establishing relative values for them. The Society is pleased that CMS has agreed to provide coverage for care coordination and looks forward to continuing to champion payment for these services in advocating for the interests of clinical endocrinologists in the reimbursement arena.

Until now, clinicians have often been providing this type of care coordination activity without reimbursement. These new codes will cover care coordination activities performed by physicians and their staff over the 30-day post-discharge period even when the patient is not present, a rather big change in CMS payment policy. Reimbursement for these new codes begins in January 2013.

To bill these codes, the patient must be contacted by a physician or staff within 2 days after discharge and must have a face-to-face visit with the patient within 7 days (99496) or 14 days (99495); this initial face-to-face visit is included in the payment for the codes and is not separately billable. The patient must be complicated enough to require decision making that is moderately complex (99495) or highly complex (99496). In addition, there is a list of care coordination activities that must be provided (e.g. medication reconciliation, communication with other health agencies, patient/family education, coordination of physician referrals, etc).

Only one physician will be able to report these codes, presumably the physician who is developing and implementing the care plan and is providing the care coordination services. Endocrinologists who meet the specified criteria will be able to bill these new codes.

The actual payment amounts for these codes have not yet been established by CMS, pending determination of the practice expense as well as the 2013 conversion factor. However, the physician work RVUs for the two codes have been set at 2.11 (99495) and 3.05 (99496); for comparison, a level 5 follow-up visit (99215) is assigned 2.11 physician work RVUs.

The Society will provide members with an in-depth analysis of the 2013 Medicare Physician Fee Schedule in the next edition of *Endocrine Insider*. Additional background about the transitional care management codes can be found here, beginning on p. 277; the specific requirements for billing these codes can be found on p. 316-320. Should you have questions about coverage for these services, please contact Meredith Dyer, Manager, Health Policy, at mdyer@endo-society.org.