

ENHANCED REIMBURSEMENT FOR TRANSITIONAL CARE MANAGEMENT



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Unlike in other service professions, a phrase such as “Thanks for flying with

us—we hope to see you again soon” is *not* a desired sentiment in hospital medicine. From a disease-management and health-system-management perspective, seeing a patient back for readmission to the hospital is a failure. Preventable hospital readmissions account for a significant amount of unnecessary medical costs, with Medicare spending an estimated \$17 billion annually on readmissions. These events are also distressing for patients and families.

Fortunately, Medicare has adopted payment codes to support clinicians as they manage patient transitions from hospital or skilled nursing facility to home, a critical time for readmission risk. These transitions are difficult. Patients and caregivers are thrust into managing complex tasks such as wound care, medication administration, physical therapy, and coordinating follow-up tests—often without a clear system to address questions or complications. It’s easy for things to fall through the cracks and lead to a complication resulting in readmission.

Hospitals do their best to leverage discharge planning with patients to help. But the process often feels rushed to many families, and it is ill-equipped to address questions that arise after leaving the hospital. Plus, there is no mechanism to manage complications once the patient is out the door.

Enter the primary care team. Its value in these transitions cannot be overstated. Yet assuming patient responsibility post-discharge is time-consuming and challenging. Outpatient clinicians must get up to speed in a timely fashion on the discharge plan and inpatient results, and coordinate follow-up for new

diagnoses and medication reconciliation.

Medicare has TCM payment codes. In 2013 Medicare adopted transitional care management (TCM) payment codes in recognition of the intensive coordination required of outpatient physicians in managing transitions. The codes enhance reimbursement for these tasks. To qualify for TCM billing, the services must satisfy a number of requirements:

- ✦ Contact the beneficiary within two days of discharge
- ✦ Perform certain non-face-to-face services such as reviewing the discharge summary and medications, and providing coordination and education to patient and caregivers
- ✦ Visit face-to-face with the beneficiary within 7 to 14 days of discharge

Patients who receive TCM services have better outcomes. Since the codes were implemented in 2013, analysis has shown that patients who have TCM following hospitalization have lower total healthcare cost and mortality compared with those who do not receive these services. They are nearly four times less likely to readmit within 30 days. When CMS looked at the one in five patients that experienced readmissions, more than half had no TCM services or contact with their primary care team post discharge. It’s clear TCM makes a difference. Yet these services are infrequently billed, to the tune of only 7% of eligible discharges being associated with TCM services.

USFHP reimburses for TCM services. US Family Health Plan reimburses its network providers for TCM services, as the Centers for Medicare and Medicaid (CMS) does for Medicare patients. We encourage all our network partners to participate in this important work on behalf of our members to optimize their post-hospital outcomes.

USFHP Care Managers help bridge the gap. At US Family Health Plan, our dedicated team of care managers (nurses and social workers and led by the

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ENHANCED REIMBURSEMENT – CONTINUED

medical director team) strives to assist all patients during a transition of care. We are trained to help coordinate TCM services by monitoring hospital discharges and contacting patients within the two-day CMS requirement. If your practice does not already have similar processes in place, USFHP

would be happy to connect you to our care managers to add additional support.

Together, we can work to reduce the 76% of readmissions that are deemed preventable each year. We look forward to continued teamwork as we care for our region's military families.

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