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Reducing Readmissions and Optimizing Patient Outcomes With Transitional and Chronic Care Management Codes

By Katherine Kay Brown & Lorraine Buck

The transformation to value-based healthcare reimbursement is well under way, with the most important factor being maximized value through achieving the best patient outcomes at the lowest cost. Provider success with newer reimbursement models such as bundled payments and medical homes, along with reimbursement penalty programs such as the Hospital Readmission Reduction Program (HRRP), are contingent on managing care transitions between acute care and the ambulatory setting by providing close patient follow-up.

Nationally, 1 in 5 Medicare beneficiaries are readmitted within 30 days of discharge, with the majority (76%) due to inadequate coordination of discharge and a lack of timely follow-up with a clinician after discharge. However, Corazon believes that addressing these complex issues remains easier said than done, for multiple reasons such as incomplete hand-offs, discharge plans not being communicated clearly with post-acute care providers, a shortage of primary care physicians (PCPs), and patients' noncompliance with showing up to scheduled appointments. And unfortunately, these readmissions due to the healthcare system's inability to bridge from the acute care setting into the community add up — costing Medicare approximately $24 billion annually. Corazon strongly recommends addressing the operational causes of readmissions as a first step in reducing the incidence of these events.

To assist with securing prompt post-discharge provider access, in January 2013, Medicare introduced two CPT codes [99495 and 99496] that reimburse providers and their staff to seamlessly transition more complex patients back into the community. The Transitional Care Management (TCM) Code is unique in that it reimburses for non-face-to-face services that are crucial to coordinating care. It also defines time periods within which services are to be provided in order to benefit the patient: for instance, contact with the patient within two days of discharge and an office visit within two weeks.

Payable services include communication (telephonic or electronic) with the patient, family, or community service (i.e., home health) used by the patient for the purposes of directing or facilitating access to care or supporting self-management and adherence to treatment through education. Other non-face-to-face services include reviewing discharge information and any pending diagnostic tests and treatment and arranging for additional clinical services through referrals and interactions with qualified healthcare professionals.

In essence, TCM payments provide additional revenue for each patient discharge (based on medical complexity) as long as the provider accomplishes the metrics outlined by Medicare. Paying for time-consuming care coordination services should certainly incentivize physician offices to allocate resources to patients at risk for readmission. And indeed, clinical, operational, and financial hospital benefits arise from a reduction in 30-day readmissions.

Chronic illnesses such as heart failure, chronic obstructive pulmonary disease, and other diagnoses have 30-day readmission rates one-third higher than for other acute conditions. Chronic diseases account for $3 out of every $4 spent on healthcare. These patients are clinically more complex, requiring the coordination of multiple specialists and services, as well as education in order to understand and adhere to a more multifaceted plan of care. As of 2015, Medicare began to recognize care management of chronically ill patients, and beginning in January 2017, multiple Chronic Care Management (CCM) CPT codes (99490, 99487, and 99489) have been made available based on patient complexity and the time required to coordinate care.

For patients to qualify for CCM, they must have multiple [two or more] chronic conditions that are expected to last least 12 months, place patients at risk for death, acute exacerbation/decompensation, or functional decline. To bill for CCM code, offices must create and maintain a comprehensive plan of care that includes at least 20 minutes of clinical staff time per month, which justifies the monthly Medicare reimbursement starting at $42. Similar to reimbursing for TCM codes, certain metrics must be met for CCM payment, including an initial preventative physician examination visit, 24/7 access to care and continuity of care, a comprehensive plan of care, management of care transitions among all providers, and community-based care coordination.

Although the TCM and CCM billing codes have been in effect for a few years, their use is only now becoming more common, as the requirements for billing were thus far viewed as confusing with overlap between them. The metrics were not clearly defined and many smaller offices did not feel they had the resources to provide this level of service. But, by understanding which non-face-to-face coordination activities for TCM can be completed by licensed clinical staff members (vs. the physician), an internal medicine office can efficiently provide this service and generate a 3-4% increase in payments. Practices with high numbers of chronically ill patients can potentially

increase payment by a minimum of $504/patient per year *(See Table 1).* Financial rewards of offering between-visit care coordination will also result with the continued focus on reimbursing for patient outcomes, penalizing for readmissions, and paying for bundled services.

Table 1. TCM Codes and Accompanying Reimbursement

Code	Description	Reimbursement
99490	Chronic Care Management Services	$42
99487	Complex Chronic Care Management Services	$88
99489	Each Additional 30 Minutes	$44
99495	Transition Care Management – Moderate Complexity	$164
99496	Transition Care Management – High Complexity	$231

Source: www.cms.gov/Medicare

Corazon has found that acute care hospitals and health systems that create strong partnerships with physician offices and post-acute care organizations are able to successfully coordinate care along a disease path (heart failure), or particular intervention (open heart surgery). We advise hospital care management departments to not only establish immediate contact post-discharge, but also maintain this contact with the patient whether telephonically or through home health and community services that provide direct care. Only then can this post-acute care approach be optimized.

Often, staff completing this type of patient follow-up is integrated in physician offices in order to directly communicate patient needs to the physician and receive guidance. According to Medicare guidelines, physicians or their qualified healthcare professionals must oversee and direct care coordination, but *are* able to subcontract these services.

Once the commitment to providing care management services is made, staff and physicians must understand the metrics of both programs (TCM/CCM) to prevent inaccurate billing. Detailed requirements can be found on www.cms.gov, but before initiating these programs the following questions must be answered:

- What patients are appropriate / eligible for these services?
- What are the required care coordination services / metrics for payment?
- Who can provide these services?
- Which services must be face-to-face?
- What is the required timing for these services?
- What tools must be developed to assist staff in coordinating care?
- What documentation is required for billing?

While seemingly simple, these questions can result in answers that require long and/or complex shifts in policies, procedures, and/or overall care approaches, which can be daunting at first. Implementing these services requires a strong foundation of cooperation between the hospital and physician office, along with clear standards for each patient path. Understanding initial planning steps and subsequent tasks for implementation will be key to reaping the benefits of such an effort.

Medicare's shift to value-based care is supported by the development of TCM codes to assist in immediately transitioning patients from an inpatient stay to home; CCM codes to encourage management of chronically ill patients on an ongoing basis. Together, the use of these codes will provide enhanced care management of these patients to assist with 'right-sizing' healthcare resources, a requirement of today, especially amid the focus on bundled payment. Likewise, reducing 30-day returns to the hospital will help to minimize losses associated with readmission penalties.

Whether alone or in partnership with acute care hospitals, post-acute facilities, and home health providers, physician offices can embrace value-based care by improving health outcomes and patient satisfaction, ensuring care continuity, and reducing unnecessary healthcare costs.

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