Transitional care management (TCM)

Hospital costs exceed $24 billion for Medicare patients readmitted within 30 days of discharge

26.9% of readmissions are potentially preventable

Preventing hospital readmissions can lead to better patient outcomes and lower costs

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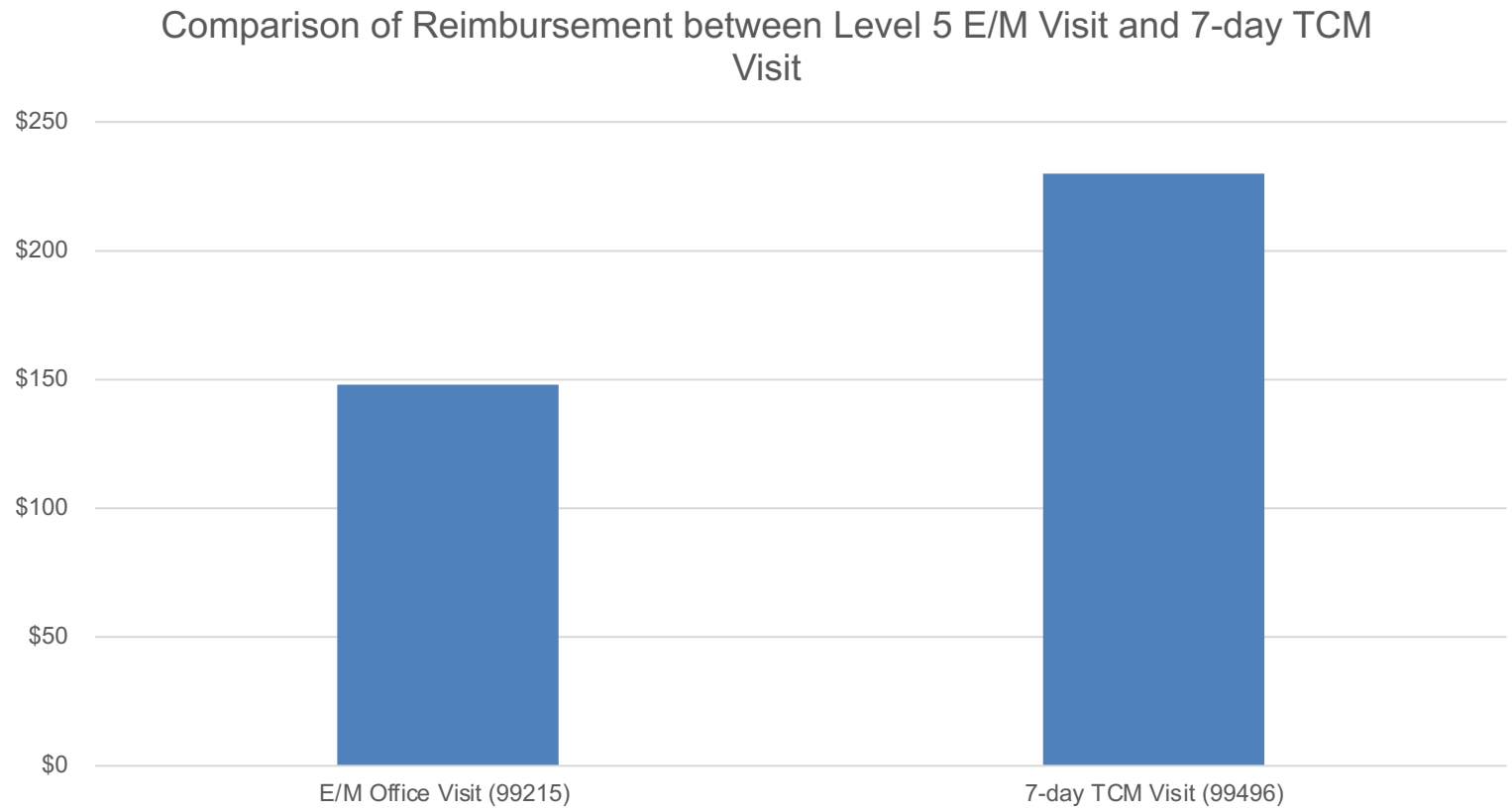
1. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb172-Conditions-Readmissions-Payer.pdf
2. https://www.medicareadvocacy.org/reducing-hospital-readmissions-by-addressing-the-causes/

The **Transitions of Care** visit aims to prevent readmissions by **improving care coordination** and closing **gaps in care** for patients as they transition from hospital or post-acute care to home

TCM Benefits
Doctors, Patients, and ACOs

- **Practice**
  - Strengthen the provider/patient partnership
  - Create a sustainable revenue stream for the practice
- **Patients**
  - Close care gaps during transitions
  - Keep patients out of the hospital
  - Enhance provider/patient relationship
- **ACO**
  - Reduce readmissions

TCMs Provide Increased FFS Reimbursement



Reimbursement Ranges Based on the 2020 Physician Fee Schedule Non-Facility Price and Non-Facility Limiting Charge
99496: $226.05-$346.10
99215: $136.12- $210.25
https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=3&H1=99215&M=1

TCM Sample Workflow: Team Based Approach

	Patient Identification/Interactive Contact	Non-face-to-face Services	Face-to-Face Services	After the Visit
RN/MA	**Practice receives a notification** that a patient has been discharged from an inpatient setting	RN/MA calls the patient to determine whether the patient needs a TCM visit and **completes non face-to-face interaction**. Schedules visit as appropriate (or transfers to scheduler). Document encounter in EHR template.	RN completes initial portion of the visit and **identifies "red flags" for the PCP**. RN/MA meet with the patient after the PCP face-to-face and **enrolls patient in care management or other community resources**. Document encounter in EHR template.	RN/MA **follows** up with the patient regarding any **identified gaps and referrals**.
PCP			PCP completes face-to-face services for the patient, **addressing issues that will help to prevent the readmission**. PCP identifies if the patient may benefit from care management and provides referrals to other services. Document encourage in EHR template.	
Biller				Bill for TCM visit

What patients are eligible for TCMs?

TCM services are furnished following the beneficiary's discharge from one of these inpatient hospital settings:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center

Following discharge from one of the above settings, the beneficiary must be returned to his or her community setting, such as:

- Home
- Domiciliary
- Rest home
- Assisted living

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

Components of the TCM

Interactive contact within 2 business days

- The contact may be via telephone, e-mail, or face-to-face.

Certain non-face-to-face services

- Review need for or follow-up on pending diagnostic tests and treatments
- Interact with other health care professionals who will assume or reassume care of the beneficiary's system-specific problems
- Provide education to the beneficiary, family, guardian, and/or caregiver
- Establish or re-establish referrals and arrange for needed community resources
- Assist in scheduling required follow-up with community providers and services

Face-to-face visit

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

There are two types of TCMs

99495	TCM with moderate medical decision complexity with a face-to-face visit within 14 calendar days of discharge
99496	TCM with high medical decision complexity with a face-to-face visit within seven calendar days of discharge

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

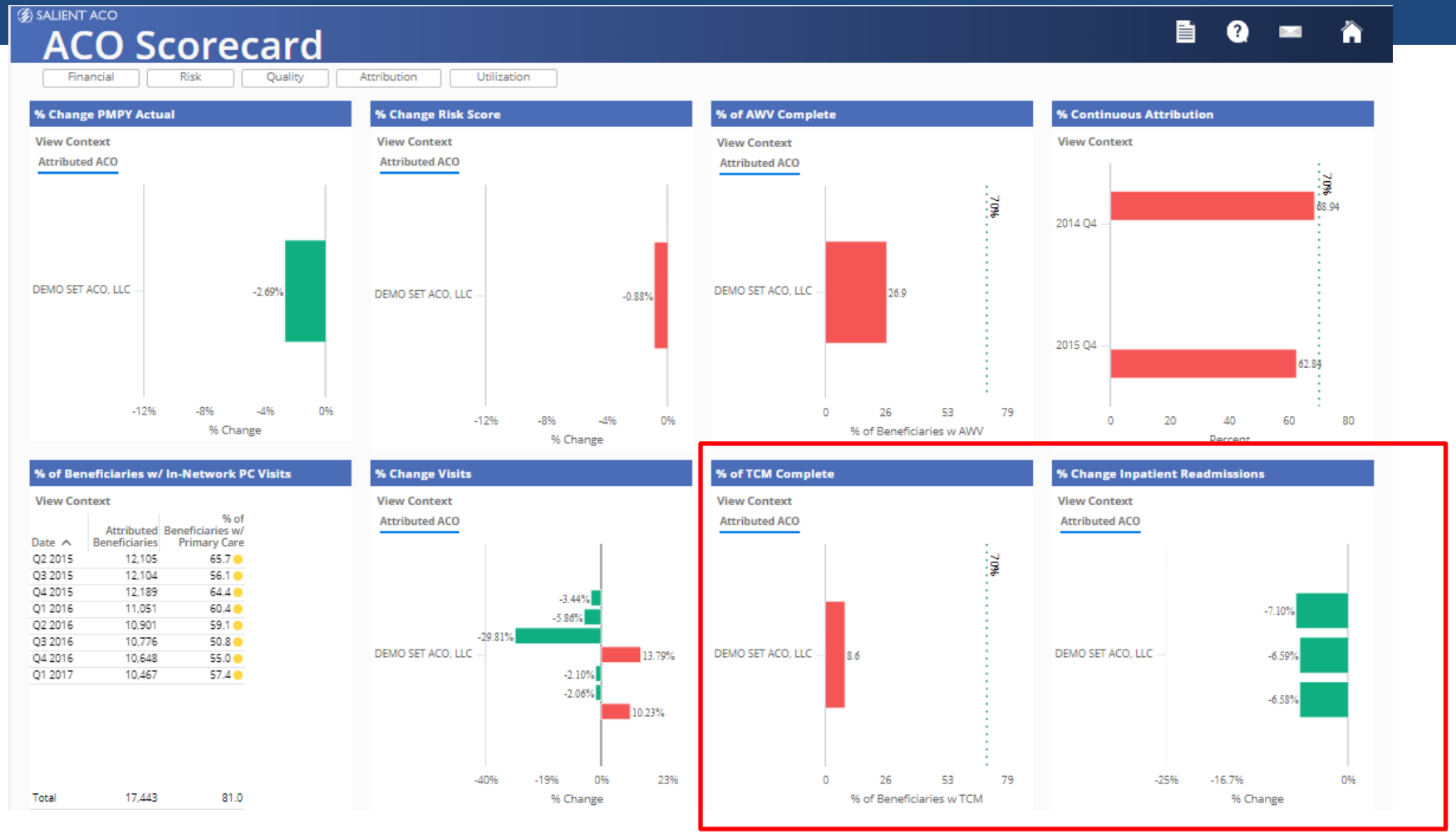
Patient identification for TCMs

The key to the success of the TCM initiative is for a practice to be able to **identify patients immediately** after they have been discharged, so that the practice can **perform outreach within 2 business days**.

This can be accomplished through:

- Connection with a **Health Information Exchange** or vendor that provides these notifications
- Discharge planners providing **fax/phone/secure email notifications** to the practice
- Access to **hospital EHR** by the practice

Using Data to Assess the Salient Trickle-Down Effect



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Using Data to Assess the Salient Trickle-Down Effect

View Context

Episode Type

Episode Type	Avg PAC Cost	PAC Claim Services Record Count	PAC Claim Diagnosis Record Count	PAC Claim Procedures Record Count	Percent of Episode 30 Day IP Readmissions	TCM Count	TCM Possible Count	Unique Episode PAC Count
SNF	11,761.42	13,780	33,239	40,042	0.00	50	804	527
IP DISCHARGE	11,465.58	58,048	129,551	156,266	12.00	248	3,949	2,192
Episode TCM - 2 of 2								
No EP TCM	11,915.84	52,251	116,263	140,616	12.47	0	3,949	1,956
Has EP TCM	7,733.76	5,797	13,288	15,650	8.05	248	0	236
OBS ENC	7,820.36	74,393	157,075	193,908	0.00	113	6,244	2,953
ER	6,272.39	83,293	157,663	206,175	0.00	158	5,464	3,646