Improving Transitions of Care: What Can My Practice Do?

Approximately one in five Medicare beneficiaries in the United States is readmitted to the hospital within 30 days of discharge; up to 76% of these readmissions may be preventable. A common reason for readmissions is the absence of timely follow-up appointments with primary care providers to assist patients with new diagnoses, medications, and treatments.

Do you have a process to see patients recently discharged from the hospital?

Here are a few simple steps to ensure timely follow-up:

- **Adjust schedules** to allow for more timely follow-up appointments
- Front desk or scheduling staff **ask patients** if they’ve been recently discharged
- Proactively **contact a hospital** when your patients are admitted and discharged
- **Open a telephone line** for hospital discharge planners and providers to use for scheduling hospital discharge related appointments
- **Modify your automated phone system** to include a message about having patients notify the receptionist if they have been recently discharged from the hospital

The consequences of poor transitions between the hospital and community are prominent in quality and cost of care discussions. The Centers for Medicare & Medicaid Services (CMS) has asked communities to improve patient care transitions to make them safer and more efficient. *HealthInsight* is working with our community partners, such as hospitals, outpatient clinics, home health agencies, and extended care facilities, to improve communication and coordination across health settings.

To receive information or ask questions about improving care transitions, please call Larry Garrett at (801) 892-6665 or Janet Tennison at (801) 892-6604.

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Improving Transitions of Care: New Reimbursement Opportunities

Identifying patients recently discharged from hospitals or skilled nursing facilities and providing timely ongoing care reduces hospital readmissions. The Centers for Medicare & Medicaid Services (CMS) announced that they will begin paying physicians for coordinating Medicare beneficiaries’ care transitions following discharge to their homes or assisted living facilities effective January 1, 2013.

The new payment plan

- Acknowledges that effective care transitions require care coordination
- Is intended to help prevent re-hospitalizations and emergency department visits during the first 30 days post-discharge

Payment will be made utilizing two new CPT codes for “Transitional Care Management” (TCM) services.

The 2013 Physician Fee Schedule includes payment for the two new CPT codes: 99495 and 99496

- Medical providers will be reimbursed $134.67 and $197.58 for codes 99495 and 99496, for facility based settings and $163.91 and $230.90, for physician office settings.
- The codes may only be billed at the conclusion of the service period (at least 30 days post discharge).
- Both codes require communication with the patient and/or caregiver within 2 business days of discharge, and a face-to-face visit with the patient within a defined time period.
- Medication reconciliation and management must occur no later than the date of the face-to-face visit.

CPT 99495 requires a face-to-face visit within 14 calendar days of discharge and is designed for patients for whom medical decision making is of at least moderate complexity during the service period.

CPT 99496 requires a face-to-face visit within 7 calendar days of discharge and is designed for patients who require medical decision making of high complexity. The non-face-to-face care management services may be performed by the provider and/or licensed clinical staff under his or her direction, but the provider must perform the face-to-face visit.

Practitioners should understand that proper documentation is required. For example, it will be necessary to document the initial post-discharge communication, the date of the face-to-face visit, and the complexity of the medical decision making. Prior to using these codes, healthcare professionals should review all appropriate CPT instructions and discuss the implications of their use with their medical billing staff.