Transitions of Care Visits – A New, Multidisciplinary, Reimbursable Service Model

Preventing hospital readmissions has become a priority for patients, payers, and providers over the past several years. The Affordable Care Act includes provisions for reduced reimbursement to healthcare systems for preventable readmissions. In response, many healthcare systems have developed and implemented new programs focused on the transition from the hospital to home.

Medicare has created a new method for reimbursement of transition-related activities. Effective January 1, 2013 new Healthcare Common Procedure Coding System (HCPCS) codes for Transitional Care Management (TCM) services (Table 1) may be used to bill physician and “qualified non-physician providers” care management following discharge from an inpatient hospital setting, observation setting, or skilled nursing facility. These codes provide higher rates of reimbursement and bundle face-to-face and non-face-to-face coordinated activities into one billing code. This service includes care management services furnished by clinical staff members or office-based case managers under the supervision of the outpatient physician or qualified non-physician practitioner. While non-face-to-face care may be furnished by qualified health care professionals, the patient must be seen face-to-face by the Medicare recognized qualified provider.

Table 1: Billing Codes for Transitional Care Management (TCM) Visits

<table>
<thead>
<tr>
<th>Visit Type</th>
<th>Timing (calendar days)</th>
<th>HCPCS Code</th>
<th>Complexity</th>
<th>Claim Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transitional Care Management</td>
<td>Within 7 days of discharge</td>
<td>99496</td>
<td>High</td>
<td>30 days from discharge</td>
</tr>
<tr>
<td>Transitional Care Management</td>
<td>Within 14 days of discharge</td>
<td>99495</td>
<td>Moderate</td>
<td>30 days from discharge</td>
</tr>
</tbody>
</table>
The required components for both TCM visits are:\textsuperscript{1-3}

- Communication (direct contact, telephone, or electronic) with patient or caregiver within 2 business days of discharge
- Medical decision making of at least moderate complexity during the service period
- Face-to-face visit within specific calendar days of discharge noted in Table 1 above

Other components of transitional care included, but not required are: \textsuperscript{1-3}

- Educating caregivers
- Managing medications
- Obtaining and reviewing discharge information
- Reviewing pending diagnostic tests and treatments
- Communicating with other health care providers (e.g. specialists)
- Establishing referrals and arrange needed community resources
- Assisting in scheduling any required follow-up with other providers and services

These new TCM reimbursement codes offer a new opportunity for cognitive reimbursement for pharmacists as a part of a multidisciplinary team. While the claim must be submitted under a Medicare recognized provider, these codes provide higher Relative Value Units (RVUs) and subsequently high reimbursement rates to reflect the involvement of multiple providers. Pharmacists may provide the non-face-to-face care and coordination components of these visits. In addition, they may be involved in the face-to-face visit and assist the Medicare recognized provider in medical decision making through services such as medication reconciliation.

One unique aspect of the TCM codes is that the date of service on the claim must be the 30\textsuperscript{th} day post discharge, not the date of the clinic visit. If the patient is re-admitted before the 30\textsuperscript{th} day, the code will be converted to the appropriate level evaluation and management (E&M code) for the service provided. The 2012 Medicare payment for the TCM visit within 7 days of discharge is approximately $231 and $164 for those within 14 days. To determine the specific fee schedule for your geographic area, please visit http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx.

Our practice has implemented a new multidisciplinary hospital follow-up clinic that is pharmacist led. We utilized the Institute for Healthcare Improvement’s (IHI) State Action on Avoidable Rehospitalizations (STAAR) guide as a framework for our intervention.\textsuperscript{4} This guide assists in identifying areas for improvement and provides a detailed checklist of suggested visit components. In our practice, patients receive an initial phone call from a care manager within 2 days of their discharge. An appointment is scheduled with the clinical pharmacist and a physician within 14 days of discharge. During the hospital follow-up visit, the clinical pharmacist practitioner completes a thorough review of systems, medication reconciliation, and addresses barriers to care such as cost of medications and transportation. The physician provides an advanced physical exam. The physician and pharmacist then work together to furnish a plan of care, identify warning signs, and plan follow-up with primary care and specialists. Finally, the pharmacist reviews changes to the plan with the patient and caregiver using the Teach Back method and provides the patient with an updated and reconciled medication list.
References


