CHEST Topics in Practice Management

Transitional Care Management Reimbursement to Reduce COPD Readmission

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Reducing preventable readmissions for COPD is an important national health policy goal. Thus far, Centers for Medicare & Medicaid Services (CMS) policies focused on incentivizing improvements in inpatient quality have had variable success. In its 2013 physician-payment rule, CMS announced new payments that reimburse ambulatory care providers for timely posthospital visits and transitional care management services. CMS hopes that posthospital transitional care and services will substitute for readmission, but the evidence supporting this hypothesis is mixed. In this article, we discuss ways for ambulatory pulmonologists to leverage transitional care management payments to enhance access for their patients with COPD while minimizing the risk of a paradoxic increase in readmission rates. ***CHEST 2014; 145(1):149–155***

Abbreviations: CMS = Centers for Medicare & Medicaid Services; CPT = current procedural terminology; FTF = face-to-face; NFTF = non-face-to-face; SES = socioeconomic status; TCM = transitional care management

Twenty-one percent of all patients with COPD are readmitted within 30 days of discharge,[1,2] and costs for these readmissions are 18% higher than for initial stays.[1] This high prevalence and cost make COPD an important target of Centers for Medicare and Medicaid Services (CMS) policies designed to reduce readmissions. Thus far, the CMS strategy for reducing readmissions has focused primarily on incentivizing improvements in inpatient care and discharge planning. For example, the Hospital Readmission Reduction Program penalizes hospitals with higher than expected rates of readmission for specified conditions. These inpatient-focused strategies have not produced consistent reductions in readmissions.[3]

One reason is that readmissions for many conditions, including COPD, are influenced by social and medical factors that are not immediately modifiable in the inpatient setting, such as income,[1] insurance,[4] and coexisting mental health diagnoses.[5] In addition, patients may already perceive hospital care for conditions such as COPD as more accessible and of higher quality than ambulatory care.[6] Therefore, initiatives that improve inpatient quality without making complementary improvements in ambulatory care could paradoxically drive patients further toward inpatient care and increase hospital readmissions.

In its 2013 physician-payment rule, CMS announced new payment codes (99495 and 99496) that incentivize ambulatory care providers to participate in transitional care management (TCM).[7] To bill for these payments, ambulatory physicians must provide three key services. First, they must make contact with patients within 2 days of hospital discharge. Second, they must have a face-to-face (FTF) visit with moderate or high complexity patients within 7 days to 14 days of discharge. Third, and perhaps most importantly, they must provide indicated care coordination services, although not necessarily in a FTF setting, during the 30 days after discharge (Table 1). The TCM codes are not restricted to any particular diagnostic category; however, they are restricted to patients discharged to home and may not be applied for patients discharged to a postacute care facility. TCM payments range from $164 to $231, up to $91 more than office visit

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Table 1—*Non-Face-to-Face Services Required for Transitional Care Management*[a]

Non-Face-to-Face Services
Provided by the physician or other qualified provider
Obtaining and reviewing the discharge information
Reviewing need for or follow-up on pending diagnostic tests and treatments
Interaction with other qualified health-care professionals who will assume or reassume care of the patient's system-specific problems
Education of patient, family, guardian, and/or caregiver
Establishment or reestablishment of referrals and arranging for needed community resources
Assistance in scheduling any required follow-up with community providers and services
Provided by clinical staff
Communication with the patient and/or caregiver within 2 business days of discharge
Communication with home-health agencies and other community services used by the patient
Patient/caretaker education to support self management and activities of daily living
Assessment and support for treatment regimen adherence and medication management
Identification of available community and health resources
Facilitating access to care and services needed by the patient and/or family

[a]In addition to these non-face-to-face services, transitional care management requires a face-to-face visit and medication reconciliation within specified time frames.

reimbursement ($73 to $143). There is no restriction on the use of additional office visits (ie, evaluation and management services) provided during the 30-day transitional service period. The majority of the TCM payments are expected to go to primary care providers, increasing their Medicare reimbursements by approximately 7%.[8] However, TCM payments are not limited to primary care providers because of the belief of CMS that pulmonology, cardiology, or other specialty offices may sometimes serve as patients' medical homes and provide those patients with the best transitional care.

Rather than restricting TCM payments to a particular type of physician, CMS has opted to use a "first claim" system. CMS will pay the first (and only the first) physician or qualified nonphysician provider submitting a claim during the 30-day postdischarge transitional window. For example, a patient admitted with advanced COPD may identify his pulmonology office as his ambulatory medical home. The inpatient team would then be expected to notify the pulmonologist of the patient's discharge, and the pulmonologist would then be in the best position to provide and submit the first claim for TCM services. In instances where a patient sees the same physician in the hospital and for follow-up, that physician is permitted to bill for both hospital discharge and care transition services.

CMS does not directly incentivize ambulatory care providers to keep their patients out of the hospital. Instead, CMS hopes that TCM payments will "provide better incentives to ensure that these patients are seen in a physician's office rather than be at risk for readmission."[7] This statement, and the policy itself, contains an assumption: Increasing posthospital ambulatory care, in the form of visits and certain non-face-to-face (NFTF) transitional services, will lead to a reduction in readmission rates. While some studies suggest that timely ambulatory care and NFTF services can serve as a substitute for readmission,[9-11] others studies have found that patients who received more intensive posthospital ambulatory care (including both office visits[12] and NFTF services such as telemonitoring,[13] proactive telephone follow-up,[14] or enhanced communication between inpatient and ambulatory providers[15]) had unchanged or higher rates of hospital readmission. In reality, increases in posthospital ambulatory care driven by TCM payments will likely have dual effects.[16] When TCM care prevents serious medical errors, through activities such as medication reconciliation,[17] or allows patients to access care they would have otherwise sought in the hospital, it will lead to a reduction in readmissions. However, enhanced access may actually facilitate an increase in readmissions. Because TCM payments are restricted to patients with moderate or high complexity, ambulatory providers will selectively be caring for the sickest patients early in their posthospital recovery. Just as any screening test may lead to closer surveillance and higher rates of intervention, increased transitional care could lead to a greater number of referrals from ambulatory physicians back to the hospital. Whether the specific bundle of postdischarge services that this new payment mechanism incentivizes will reduce readmissions is an important question for future research and evaluation.

TCM payments will directly reimburse pulmonologists for improving access and providing more care coordination services to patients with COPD during the posthospital transition. However, to prevent COPD readmissions, pulmonologists will also need to leverage additional revenue from TCM payments to take steps beyond the services the TCM payments directly incentivize. In this article, we suggest ways in which pulmonology practices can leverage the TCM payments to improve care for patient with COPDwhile minimizing the risk of a paradoxical increase in readmissions.

Leveraging TCM Payments to Reduce Hospital Readmissions for COPD

Improving Access

Several published studies have highlighted difficulties that patients currently face in obtaining posthospital