Transitional Care Management

The case for incorporating automated patient communications

Medicare’s billing codes for Transitional Care Management (99495/99496) highlight the importance of timely post-discharge contact with patients by provider offices, and timely face-to-face follow up and evaluation by TCM providers. Incorporating automated patient communications can facilitate efficient and effective handoffs, and support a consistent track of care to help providers earn TCM reimbursements and avoid hospital readmission penalties.

LOWER COSTS

- 78% of hospitals were penalized in 2015 to the tune of $428M in total readmission penalties.
- Identified risk groups receiving transitional care experienced a reduction in readmission rates of 20% and a cost savings per case of approximately $500.

HIGHER REIMBURSEMENTS

- CMS estimates that primary care physicians will receive, on average, a 7% increase in Medicare payments because of the new TCM code.
- Total TCM revenue per year with 1,122 qualified patients estimated at $217,600.
- Average per patient estimated at $193.94.

MEAN TOTAL COST SAVINGS PER MEDICARE BENEFICIARY

- $3000* AT 6 MONTHS
- $5000* AT 12 MONTHS

*Costs of hospital readmissions, ED visits, unscheduled physician visits, visiting nurses, and interventions.

TCM CODE REIMBURSEMENTS AND COMMUNICATION CRITERIA

- CPT 99495: 7 DAYS POST-DISCHARGE
  - MEAN REIMBURSEMENT: $162.14
- CPT 99496: 14 DAYS POST-DISCHARGE
  - MEAN REIMBURSEMENT: $228.80

AUTOMATED PATIENT COMMUNICATIONS TO SUPPORT TCM AND BEYOND

- CONNECT
  - Automated outbound call connects patient to a live resource for discussion and scheduling.
  - Automated, documented attempts continue throughout 90-day period.
- REMIND
  - Text message or outbound call reminds patient of upcoming face-to-face visit.
  - Prompting patient to confirm or cancel triggers immediate follow up by scheduling when necessary.
- SURVEY
  - Simple automated survey assesses how patient is doing, heads off serious issues.
  - Reminds patient to contact provider with any concerns; promotes proper care utilization.
- ENGAGE
  - Post TCM, continue to engage patients to close gaps in care and reduce patient churn.
  - Personalized automated communications promote screenings, immunizations, and wellness visits when due.

Incorporating automated patient communications can help you overcome a key challenge of effective Transition Care Management: doing TCM at scale without having to hire the additional staff just to make manual follow-up calls.

The smart use of technology can help drive efficiency in patient outreach by adding scale and capacity, not cost.

To learn more about reducing readmissions and capturing TCM revenue, check out the Six Communication Best Practices for Transitional Care Management:

- LISTEN to the webinar
- DOWNLOAD the white paper

About West Healthcare

West helps healthcare providers, payers, employers, pharmacy organizations, and ACOs optimize communications, drive better member activation, and lower the overall cost of delivering care. Whether you want to increase immunization and screening rates, reduce hospital re-admissions for members with chronic disease, or improve the member experience and operational efficiency in your access centers, the West Engagement Center™ is the communication linchpin for engaging and activating member populations across the entire care continuum.

SOURCES
- Kaiser Family Foundation
- CMS, Health Affairs, The New England Journal of Medicine
- Healthcare Information and Management Systems Society (HIMSS)

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