From Hospital to Home
Establishing a Transition of Care Program within your practice
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Disclosures
• I have no disclosures to report

Objectives
• By the conclusion of this session, the participant will be able to:
  • Identify the purpose of the Centers for Medicare and Medicaid Services’ transitional care management (TCM) services for the at-risk population.
  • Discuss patient and practice specific benefits of employing TCM within an outpatient, primary care setting.
  • Apply these methods via a case-based scenario to demonstrate compliance with TCM requirements.
The basis for Transition of Care Management (TCM)

- Discharge planning is usually not enough to provide an adequate discharge
  - Not able to address...
  - All medication errors
  - Unforeseen complications in regards to their illness
  - Retention of instructions
  - Environmental/Home conditions

A closer look at Hospital Readmissions

- 1 in 5 older adults discharged from the hospital is re-hospitalized within 30 days
- Cost of unplanned re-hospitalizations to Medicare
  - Estimated $15 billion/year
- 2003-2004 Medicare Claims were examined (n=11,855,702)
  - Almost 1/5 (19.6%) beneficiaries who had been discharged were re-hospitalized within 30 days
  - 50.2% were discharged to the community
  - No billable visit was noted between discharge and re-hospitalization

What does TCM entail?

(The watered down version)

- An interactive with the patient, family, and/or caretaker within 2 business days of discharge
- A visit with the provider within 7 or 14 calendar days of discharge
  - Timeframe depends on complexity of patient
- Keeping them out of the hospital for the 30 days post discharge
What constitutes as “Community Settings”

From a hospital setting…
• Inpatient acute/long-term care hospital
• Inpatient psychiatric hospital
• Skilled nursing facility
• Inpatient rehabilitation facility
• All psychiatric settings

To an outpatient setting…
• Patient's home
• Patient's domiciliary
• Rest home
• Assisted Living
  • NOT Skilled Nursing

Who can provide TCM Services?

Clinical Support Staff
• Obtaining Hospital Records/Discharge Summary
• Establish initial contact and establish appointment
• Medication History obtained
• Provide ongoing Patient-Specific Education

NPs, CNMs, PAs, MD/DOs
• Review of Hospital Records/Discharge Summary
• FACE to FACE encounter
• Evaluation and Management
• Medication Reconciliation completed
• Provide ongoing Patient-Specific Education

That sounds easy!
Well, it’s not…

Hank, 86yo with diabetes & CAD
• Discharged to home after being in the hospital for 6 days with sugars in the 300’s
• Ambulates with Rollator
• Received a call from his PCP within 2 days of discharge
• Seen within 10 days by his NP
• Lives life to the fullest
• Received a call from the staff three times a week to ensure his sugars were being monitored annually

Rita, 86yo with diabetes & CAD
• Discharged to home after being in the hospital for 6 days with sugars in the 300’s
• Ambulates with Rollator
• Received a call from his PCP within 2 days of discharge
• Seen within 10 days by her NP
• Gets readmitted discharge day 17
• Never heard from the office after the visit
So what happened?

We never provided any follow up for Rita!

• After the TCM visit, the work really begins!
• The NP or a clinical staff member must continue to contact and enforce the plan set and education that was provided during the TCM visit
• Each contact must be documented
  • Include the patient response to current plan
  • Include discussion of reinforcement of education provided
  • Include the current status of the patient at the time of the contact
• If there is a change in status, the clinical staff would bring it to the attention of the NP or other provider in the office

Educating your patients about TCM Services

• Did you know…
  • If you are admitted into a hospital or a rehabilitation facility, we will help you transition back to your home safely and comfortably
• How?
  • Our office will work to coordinate and manage your care for the first 30 days after you return home to help for a smooth transition
  • We will be working with you and your family and caregiver(s), as well as your other health care providers

Tell me more about this service you provide…

What does it include?

• A phone call from our clinical staff asking how you are doing and making sure your immediate needs are met
• An opportunity to allow us to help you establish that appointment with the practice – no need to worry about waiting on hold to make an appointment
  • This occurs within 1-2 weeks after your discharge to your home
• A dedicated appointment with your Nurse Practitioner to:
  • Review the information about the care you received at the hospital or rehab facility
  • Provide information to help you transition back to living at home
  • Help you with referrals or arrangement for follow-up care or community resources
  • Help you with scheduling and managing your medications
Helping to ensure program success

- Be sure your patient knows who their PCP is
  - Do they have YOUR business card in their wallet?
- Some suggestions:
  - Create a medication list that you can provide for the patient with your office information on it
  - Get to know the admitting department of your local hospital
    - Do they have your information on file? Is it correct?
  - Speak with the case management department at your local hospital

Educating your Clinical Staff

- Assign a clinical point person
  - The “lookout” person for the hospital discharges
  - Will be making the first communication within two business days
- Suggestion…
  - Give the hospital a call twice a week specifically Case Management
  - Involve the staff with the care of your patients!
    - Teach your staff how to obtain a medication history
      - Remember, YOU do the reconciliation
    - Have the staff involved in patient teaching
    - Reinforce that the clinical staff is a part of the patient’s care!

But what is defined as “Clinical Staff”

- CPT defines a clinical staff member as
  - A person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service but who does not individually report that professional service
  - Meaning, cannot be an administrator, manager, or a receptionist
  - Can be a RN, LPN, or Medical Assistant

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Preparing the office to make the initial contact…

- Have the clinical point person (or you) set some time aside for this process
- Remember, it's not just about making an appointment!
- Have the clinical hospital summary with this point person
  - Be sure it has been reviewed by YOU first
  - May want to “tie up loose ends” prior to the appointment
    - IE: Follow up XR, Labs
- Initial contact within 2 business days may be completed via:
  - Call, Fax, Secure Email, Mail
- If you are unable to reach the person within the first two business days, the patient is still eligible for TCM
  - However you must continue to document your attempts until you reach the person

Establishing the Contact

- Notification of patient discharge from hospital or SAR
- Communication to the patient and/or caregiver is made within 2 business days
  - Must be made by a Provider or clinical staff
- Inquire about their experience
  - "We saw that you were in XYZ hospital, and wanted to check in on you. What happened?"
- Establish an appointment
  - "Your Nurse Practitioner would like to see you within the next (7-14) days. Let me help you set up an appointment now."

Before you hang up!

- Received their medication & have their preferred pharmacy on file
- Have appointments made for follow up consults and/or diagnostics
- Inquire about use of community resources
  - What's for dinner tonight? (Meals on Wheels)
  - Is it going to be difficult for you to get to this appointment?
- Do they need anything?
  - Shower chair? Rolling Walker?
Preparing for the TCM Appointment

- Review the Hospitalization & Discharge Summary
  - Pre-hospitalization vs. Post-Hospitalization Medication List
  - Overall hospital course
    - Indicative of laboratory & radiological results, EKGs, consults

The TCM Appointment

- Routine evaluation provided
  - Chief Complaint, History of Present Illness and Review of Systems
  - Physical Exam
  - Review laboratory & radiological results, EKGs, consults with the patient and document this review

Provide Education and Consultation

- Discuss current disease/illness
  - Provide education about exacerbation, illness/symptom management
  - Discuss needs at home
    - Home health/community services referrals
  - Establishment or re-establishment of referral orders for community resources
    - Meals on Wheels
    - Accessible Transportation
  - Discussion with other health care providers
    - Let each provider communicate with, share of care communication, and findings and results from each communication. Document if no communication is required.
Key Documentation Components for the Visit

- CC noting this was a discharge
- HPI noting that the patient was admitted to the hospital from ABC to XYZ and discharged to home
- Note the discharge diagnosis in your HPI

Key Documentation Components for the Visit Continued…

- Review of lab work/diagnostics (XRs, EKGs), and consults
- Discuss laboratory/diagnostic results and consults
- Inform patient of benefits of keeping consultation appointment
  - You may want to add R/R/A discussed
- Latest hospital's lab work and EKG reviewed. Results consistent with previous
- Endocrine consult reviewed. Has follow up appointment with Dr. Sugar on 1/18/2019. Benefits of keeping this appointment discussed with patient.

Key Documentation Components for the Visit Continued…

- For TCM your diagnosis should template the hospital's discharge diagnoses
  - These are conditions identified during the hospital stay that either need to be monitored after discharge from the hospital and/or where resolved during the hospital course
Key Documentation Components for the Visit Continued…

**In your plan…**
- Document any and all education provided.
- Include any patient education materials given to the patient.
- May also re-enforce keeping appointments with the consulting service.
- Note the patient engagement & family presence.
- Reviewed glucometer testing, how and when to test, and glucose parameters.
- Hypo/hyperglycemia s/s and action plan discussed.
- Again, stressed on importance of follow up with endocrine.
- Counseled patient and DTR on dx, rx, medications, diet/exercise. Verbalized understanding.

Bill for the Service
(Complexity based on **ANYTIME** during 30 days)

For **moderately complex** cases:
- Seen by the NP within 14 days from discharge.
- Multiple number of possible diagnosis +/- management options.
- Moderate amount +/- complexity of data to be reviewed.
- Moderate risk of significant complications, morbidity, and/or mortality.

For **highly complex** cases:
- Seen by the NP within 7 days from discharge.
- Extensive number of possible diagnosis +/- management options.
- Extensive amount +/- complexity of data to be reviewed.
- High risk of significant complications, morbidity, and/or mortality.

In other words… If the patient met an E/M of…

- The visit meets the requirements for 99214…
  - Your visit would meet the criteria for 99210.
  - Providing your evaluation was within 14 days of a moderate complexity.
- The visit meets the requirements for 99215…
  - Your visit would meet the criteria for 99215.
  - Providing your evaluation was within 7 days of a high complexity.
- This can be billed the day of service of the TCM visit.
  - You **DO NOT** have to wait for the 30 day mark.
What if the patient requires an evaluation?

- Bring them on in!
- The goal is to keep the person out of the hospital!
- Patient may be evaluated and managed during this period
  - An appropriate E/M CPT code will be applied (99214 vs. 99215)

But what if the person...

Is re-admitted…
- You cannot bill for TCM
- Must be changed to E/M
  - 99214 vs. 99215

Seen in the Emergency Room…
- TCM may still be used

Dies…
- Must be changed to E/M
  - 99214 vs. 99215

Coding and Billing

- CPT 99495
  - TCM 14 day discharge - for moderately complex cases seen within 14 days
    - ~ $166.50 MD/DO or "incident-to" reimbursement
    - ~ $141.53 NP reimbursement
- CPT 99496
  - TCM 7 day discharge - for highly complex cases seen within 7 days
    - ~ $234.97 MD/DO or "incident-to" reimbursement
    - ~ $199.72 NP reimbursement
Comparing Apples to Apples

TCM for moderately complexed patient
- CPT 99495
- NP reimbursed ~ $141.53
- Review of outside records
- Medication reconciliation
- Providing education about illness & management
- Continued follow up for 30 days

E/M for moderately complexed patient
- CPT 99214
- NP reimbursed ~ $93.74
- Review of outside records
- Medication reconciliation
- Providing education about illness & management
- Follow up "PRN"

Let's take a look…

- Jean, an 86yo female with a PMHx of DM2, HLD, HTN, and mild CAD presented to the hospital for shortness of breath stating “this is the big one!”
- Her evaluation ruled out any cardiac issues, but was found to have a left lower lobe pneumonia

During the admission process…

- She made it known to the admitting clerk that her PCP was the NP “Margaret” but works with Dr. Robinson at “Your Health Matters” in Forest Hills
- She can’t remember her last name
- Case Management is working on her discharge from day one and is planning on being discharged on Tuesday
  - “I am too busy to be sick! I have Bingo on Thursday, and I’m going to beat Maryanne this time... Luck will not strike her twice!”
Jean is discharged back into the community

- Tuesday morning comes around and Jean is discharged on “paper” at 11am, but was not able to get a ride home until 6pm when her daughter got home from work
- She is happy to be home!

- Your office was sent the discharge summary via fax on Tuesday at 3pm
- You want to start TCM in your practice, have “buy in” by the manager, but the doctor has “no desire” to do this…
- So you are spearheading this effort!

NP Margaret hits the ground running!

- The office manager receives all faxes as is on “alert” to provide all hospital discharges to the NP
  - Margaret sees that Jean was admitted for SOB and diagnosed with LLL PN
  - NP Margaret is excited and really want this TCM to work!
  - She believes in her patients and wants the best for them
- Prior to the call, the NP reviews the discharge summary and plan

Starting the TCM Process for Jean

- NP Margaret makes the call
  - She makes the call Wednesday, but there was no answer
  - She left a message
  - And DOCUMENTS THE ATTEMPT
  - She made another call on Thursday
    - She got Jean on the phone!
    - And boy, did Jean have a lot to say…
During the phone conversation, the NP should…

- Discuss hospital course
- CXR follow up was ordered
- Follow up with Pulmonary
- Illness/Symptom Management
  - How is the feeling?
  - How are her ADLs?
- Provide education about illness/symptom management
  - What to be concerned
- Inquires about her medication
  - Did she pick it up & taking it as prescribed?
  - Is she still taking her other medication?
- Establish a follow up appointment
  - Transfers them to the receptionist for an appointment *within 14 calendar days from discharge*

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7 vs. 14 day follow up

- Remember…
  - Based on complexity of the case *
    ANYTIME* during the 30-days
  - Think… How would you code this person if it was not TCM?
- It’s based on…
  - *Number* of possible diagnosis +/− management options
  - *Amount* +/− complexity of data to be reviewed
  - *Risk* of significant complications, morbidity, and/or mortality

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FAQ…

- Can this patient come in before the 7 day or 14 day mark?
  - YES, as long as it meets the calendar day requirement
  - 10 calendar days post discharge for a 14 days requirement is acceptable
- Can this post-discharge visit be a *house call*?
  - Yes, but only the TCM code applies
Jean comes in for her visit!

- Perform medication reconciliation
- Review the hospitalization documents
- Review the labs/diagnostics
  - Follow up on any outstanding follow up needed
- Discuss consultation with Pulmonary
- Perform an examination
- Reinforce education about illness/symptom management
- CPT code is 99495
  - Moderate complexity
- Diagnostic must match the discharge diagnoses
  - LLL PN
  - Shortness of Breath
  - MI/CAD
  - DM2, controlled
  - HTN

A week later…

Are we done yet?

- Check in every few days
  - Can be done by NP or their clinical staff
- Reinforce the education
  - Illness/Symptom Management
- Make sure she has everything she needs
- Did Jean ever see the Pulmonary team?
- Did Jean ever go for that CXR?

A week later…

- Jean is seen in the office by her physician colleague Dr. Robinson
- Provided with a nebulizer treatment in the office and given a burst of steroids
- Jean isn’t happy that her NP took a Saturday off to go to a NP conference in NYC…
  - But she is happy she can breathe better!
Does Jean still qualify for TCM?

- Absolutely!
  - Can be billed as a routine office visit at the appropriate CPT level
- What if this was a house call?
  - Can still be billed as a routine visit at the appropriate CPT level
- What if she went to the ER?
  - As long as she was not admitted...

FAQs...

- What is the patient discharged on a weekend?
  - The clock starts the next business day
- What if the patient is discharged after business hours?
  - The clock starts the next business day with the notification of discharge
- Can I bill for End of Life Discussions?
  - YES
  - Billing for HCP Out of Hospital, DNR, and/or MOLST form is possible
  - Document the conversation as separate and distinct
  - 25 modifier is required

In Summary...

- TCM may be used for all Medicare patients for hospital follow up
- Initial contact must be within 2 business days during “normal” business hours
  - Excluding weekends, holidays
  - Based on the timing of the receipt of discharge notification/summary
- Initial visit of 7 vs 14 days based on complexity anytime within 30 days
  - Remember, the 7 vs 14 are calendar days from hospital discharge
- Document your heart out!
- Keep in touch for the full 30 days
Helpful Resources

- CMS Transitional Management Services

- Transitional Care Management Documentation Checklist

- Transitional Care Management 30-Day Worksheet
  - https://familymedicine.med.uky.edu/sites/default/files/TCM30day.pdf

- FAQ on TCM