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***Preventing Rehospitalization***
*Our patients are 35% less likely to be hospitalized compared to national home health averages.*
Source: HHQI 2012 avg

*Locally Owned and Operated*

# How a 7% Raise for Doctors May Help Hospitals Reduce Readmissions

2013 will be the first full calendar year that Medicare is penalizing hospitals for certain readmissions. There are a number of post-discharge variables that affect hospital readmission rates. Highlighting this fact is a recent study published in the *Journal of the American Medical Association*.[1] Researchers gathered data on 30,136 Medicare patients with hospital discharges to examine the effects of following up with a local doctor. Patients in the lowest quartile of early follow-up compliance proved 15% more likely to be readmitted to the hospital. Only modest improvements in compliance reversed this hazard ratio. It was found that early follow-up compliance was highly dependent on the hospital, statistically speaking. Hospitals with the best physician follow-up rates also had readmission and mortality rates that were 10 to 14% lower. This suggests the opportunity to affect post-discharge variables and that improving these variables can yield major benefits in terms of patient health and readmission numbers. This is where helping doctors get better reimbursement from Medicare comes into play.

2013 is also the first year that Medicare is accepting two new billing codes for Transitional Care Management. CMS predicts these codes will increase family practitioner revenues by 7%, but almost any physician providing the service can bill these new codes. The fact of the matter is that a handful of doctors will seize the opportunity and increase their revenues much more than 7% while most doctors will not utilize these codes in 2013 due to their newness. These codes pay doctors and non-physician practitioners (NPPs) an attractively-increased fee for coordinating care after discharge from a hospital or skilled nursing facility to the community. The codes are intended to incentivize doctors to connect with recently-discharged patients, perform medication reconciliation, and provide any non-face-to-face care coordination found necessary after returning home. The new transitional care management codes allow a doctor's staff to perform initial communications and the follow-up non-face-to-face care coordination. **In Illinois the new code CPT 99495 pays $157 and the higher-level code CPT 99496 pays $222.**

As part of ABLE Home Health's focus on having the lowest readmission rates possible, we are working diligently to encourage patients to follow up with their physician after discharge. In addition, ABLE Home Health has a Transitional Care Management Billing help sheet designed to help doctors fully participate in the incentive to provide more transitional care and help hospitals reduce readmissions. The billing help sheet is a two-page document explaining the ins and outs of participating in the new Transitional Care Management billing. Many doctors are already performing these services essentially for free. ABLE Home Health will help doctors get paid for the work they are doing. Doctors need simply call, fax, or email to request that the billing help sheet be delivered with our compliments.

## The Nurse You Know

Rather than rotating several nurses through one home, ABLE Home Health assigns one nurse to each patient and sends that nurse for each visit. We find this not only facilitates continuity of care; it also increases your patient's peace of mind.

**Please tell your patients about ABLE Home Health.**

## Reference

1. Hernandez A, Greiner M, Fonarow G, et al. Relationship between early physician follow-up and 30-day re-admission among Medicare beneficiaries hospitalized for heart failure. Journal of the American Medical Association. 2010; 303 (17): 1716-1722.

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