IEHP UM Subcommittee Approved Authorization Guideline			
Guideline	Transitional Care Medicine	**Guideline #**	UM_OTH 13
		Original Effective Date	May 9, 2018
Section	Other	**Revision Date**	8/11/2021

COVERAGE POLICY

Members with complex medical conditions or in need of complex care coordination may qualify for in-home wrap around services depending on the health literacy, co-morbidities and physical capability of the Member (Naylor et al 1999 and Hirschman et al 2015).

I. A Member must have pre-approved authorization to receive Transitional Care Medicine (TCM) services.
   A. IEHP Adjusted Clinical Group (ACG) risk scoring as per the Johns Hopkins model will direct initial level of care. Levels of care are divided into Tiers. Members do not change levels of care (Tier) once assigned.
   B. The lowest level of care is Tier 1 and the highest level of care in the first 90 days is Tier 3. Tier 4 is a longitudinal tier reserved for Members who qualify and are in need of additional time to transition (see section III).
   C. Changing level of care (changing Tiers) may be possible only with IEHP Medical Director approval. A Member will typically remain in the assigned Tier for the duration of care for up to 90 days.
   D. Initial services are authorized for up to 90 days; Members may be discharged prior to the 90th day. Members must be assessed for additional assistance beyond 90 days.
   E. Members requiring additional assistance beyond 90 days must be reassessed for eligibility for the Longitudinal tier weekly case rate, also known as Tier 4, by a Medical Director (see section III).

II. Transitional Care Medicine Approved Criteria
   A. For Members to qualify for Transitional Care Medicine Services, two of the following must be met:
      1. 3 or more admissions in 2 consecutive months in the last 6 months
      2. 4 or more Emergency Department Visits in the past 60 days
      3. Custodial care discharges to home where the Member had a length of stay at the facility for ≥ 30 days
      4. Polypharmacy of 6 or more medications with poor health literacy.
      5. Newly established on supplemental O2 with 2 or more high risk co-morbidities (as listed below in II.A.8)
      6. Newly established as dependent on medical equipment and discharged from an acute facility in the last 14 days (e.g., ventilators/TPN/ home infusion)
      7. Advanced stage malignancy not enrolled in a Palliative or Hospice program
      8. **High Risk Conditions**. Members with an ACG Probability for Persistent High Utilization (PPHU) score of ≥0.6 and at least one of the following complex co-morbid condition with high risk for readmission (DHCS 2004, CCR 2018).
         a. Congestive Heart Failure or recent myocardial infarction

b. Chronic Obstructive Pulmonary Disease
c. Chronic Pancreatitis
d. Advanced liver cirrhosis
e. Sickle Cell anemia
f. Poorly controlled Diabetes, Type I or II (HgA1c >9%) with an additional co-morbidity as listed in II.A.8. (i.e., diabetes plus an additional diagnosis)
g. End Stage Renal Disease, newly established on dialysis (peritoneal/ hemodialysis)
h. Cerebrovascular event or neurologic disease and not enrolled in a Palliative Care or Hospice program (diagnoses include multiple sclerosis, quadriplegia, amyotrophic lateral sclerosis)
i. Behavioral Health diagnoses marked with poor functioning (requires professional assistance to remain in the community).
    1. This does not include Members with severe persistent mental illness who are County Department of Behavioral Health "Tier 3" patients.

9. Discharged to home with a new PICC/Foley catheter/ gastrostomy tube and without an established PCP or if there is no follow up appointment within 7 days of discharge. A Member is considered to not have an established PCP if there has been no PCP visit in the last 12 months.
10. Member discharged to home who refused transfer to a Skilled Nursing Facility (SNF) when the discharging healthcare team has recommended SNF.
11. Homelessness with medical co-morbidities not enrolled in IEHP intensive care management services

B. All other cases require Medical Director approval.

III. Members who require additional assistance beyond the 90 days as listed above may qualify for a TCM Longitudinal Tier (Tier 4) which is a month to month level of care.
A. All requests for extensions of care in a TCM program require Medical Director approval.
B. The Member is currently receiving Charter TCM services and met criteria as listed above in section II.
C. Longitudinal Tier criteria (may qualify if any two of the following are met):
    1. 2 or more documented Emergency Department diversions or visits in the last 30 days while receiving TCM services.
    2. Presence of co-morbid uncontrolled significant mental health disorder (e.g. Bipolar disorder, Schizophrenia) marked with poor functioning but able to remain in the community with assistance
    3. Homelessness with medical co-morbidities pending intensive care management services (ICMS)
    4. Complex co-morbid conditions (see section II.A.8 above) with an acute decline (prolonged hospitalization or intensive care unit stay) while receiving TCM services.
D. The Member meeting this criteria will be authorized to receive additional TCM services for up to 90 days
E. Review of Tier 4 criteria to be performed by Medical Director every 90 days

COVERAGE LIMITATIONS AND EXCLUSIONS

1. TCM services are not line of business specific; Medi-Cal and Dual Choice Members can be eligible.

ADDITIONAL INFORMATION

Transitional Care Medicine (TCM) services are short term, high intensity, face-to-face healthcare services provided to a Member as they transition from one level of care to the home or community setting. TCM Services are provided in the home or in a home-like environment.

The primary goal of the transitional care medicine program is to provide support to Members to ensure a smooth transition between healthcare settings and Providers. An additional benefit is to help the Member avoid readmission to the acute care setting. The TCM Provider will ensure that medical needs are met and that care coordination is successful. Improved Member outcomes and decreased healthcare costs through increased Member education and disease insight (medical literacy) are considerations of the program.

Services provided by a Transitional Care Medicine team include, but are not limited to (CMS 2016):

1. Ensure a safe transition from the acute setting to the community (home or home-like environment)
2. Review of hospital discharge information with Member
3. Review of medication lists and schedules (medication reconciliation)
4. Support for treatment regimen adherence and medication compliance
5. Interact with Primary Care providers (PCPs) & Specialists regarding post discharge follow-up
6. Educate caregivers and family members regarding diagnosis and management
7. Care coordination with IEHP Team Members for referrals to community resources and Providers
8. Assist the Member is accessing needed care, services and resources

CLINICAL/REGULATORY RESOURCE

Medicare and Medi-Cal both require that efforts be made to prevent acute care readmission and further disability and/or promote improvement.

DEFINITION OF TERMS

1. **ACG PPHU** – Johns Hopkins Adjusted Clinical Groups Probability for Persistent High Utilization – a risk score which helps to identify Members at high risk for readmission or visits to the Emergency Department
2. **Health Literacy** -- the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions [11].
3. **Tiers**

Transition of Care (TCM) Program Tiers and Rates

Member with TCM < 90 Days		
ACG Tier	CPT Codes	Description of Care
Tier 1	99341	Nurse visits every other week and as needed; 24/7 access to Nurses; assigned CM and SW as needed. Member understands and is compliant with care and has follow-up with PCP and Specialist
Tier 2	99342	Nurse visits 1x per week and as needed; 24/7 access to Nurses; assigned CM and SW as needed. Member requires ongoing education about disease process and medications
Tier 3	99343	Nurse visits at least 2x per week; 24/7 access to Nurses; assigned CM and SW for coordination of community resources; Member with high

		risk of re-admission or ED visits; multiple medical co-morbidities; requires extensive education regarding diagnoses and plan of care
Member with TCM ≥ 90 Days – Longitudinal tier 90 additional days of care (weekly case rate with Medical Director approval)		
Tier 4	99345	Member seen on an as needed basis depending on medical complexities and understanding of disease process

*MD/NP available for triage and acute changes for all Members

4. **Transitional Care** - the care patients receive as they move between health care settings and providers [5]

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