PROVIDER MEMO

To: Santa Clara Family Health Plan Primary Care Providers

From: Laurie Nakahira, Chief Medical Officer

Date: October 21, 2021

Subject: Importance of Transitional Care Management for Cal MediConnect Members

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Dear valued provider,

Centers for Medicare & Medicaid Services (CMS) recommends covered Transitional Care Management (TCM) services for Medicare beneficiaries to address the hand-off period between the inpatient and community setting during those 30 days after discharge. After a hospitalization or other inpatient facility stay, the patient may be dealing with a medical crisis, new diagnosis, or change in medication therapy. Medication reconciliation is an integral part of patient safety and can limit adverse drug interaction, especially when patients are on multiple prescription medications. Healthcare Professionals who may furnish and bill TCM services include Physician (any specialist), Nurse Practitioner (NP), and Physician Assistant (PA).

Payable TCM Codes used to report TCM services are:

99495	moderate medical complexity requiring a face-to-face visit within 14 days of discharge
99496	high medical complexity requiring a face-to-face visit within 7 days of discharge

Requirements & Components for TCM

- Contact the member within ***2 business days following a discharge*** by telephone, email, or a face-to-face visit. Attempts to communicate should continue after the first two attempts in the required business days until successful.
- Conduct a follow-up visit ***within 7 or 14 days of discharge***. The **face-to-face visit** is part of the TCM service and should not be reported separately.
- Obtain and review discharge information.
- Medication reconciliation and management provided **no later than the date of the face-to-face visit.** Review the need or follow up on tests/treatments. Establish or re-establish referrals with community providers and services, if necessary.
- Assist in scheduling follow-up visits with providers and services, if necessary.

How can SCFHP help?

SCFHP will continue notifying Primary Care Providers with discharge information in an SBAR format upon the completion of conducting post-discharge follow up outreach.