Transitional Care Management 30-Day Worksheet

Patient name: _____ DOB: _____

D/C physician: _____ D/C date: _____

Records requested: Records received: Reviewed:

Diagnoses on discharge:	
Date of interactive contact (2 business days post D/C):	☐ Phone ☐ Email ☐ Direct ☐ Other
Date of 7-day or 14-day, face-to-face visit:	
Family and/or caretaker present at visit:	
Medications on discharge	**Medication changes/adjustments**
Diagnostic tests reviewed/disposition:	
Disease/illness education:	
Home health/community services discussion/referrals:	
Establishment or re-establishment of referral orders for community resources:	
Discussion with other health care providers:	
Assessment and support of treatment regimen adherence:	
Appointments coordinated with:	
Education for self-management, independent living, and activities of daily living:	

TCM.January 2013

SUBMIT BILLING 30 DAYS POST DISCHARGE.

Physician completes colored areas
Staff completes remainder

Medical Decision Making			
DIAGNOSIS and MANAGEMENT	**QTY**	**POINTS**	**TOTAL**
Self-limited or minor — stable, improv, or prog as expected		1	=
Established prob — stable, improving		1	=
Established prob — worsening		2	=
New prob — no further workup planned		3	=
New prob — additional workup planned		4	=
DIAGNOSIS and MANAGEMENT TOTALS			=

DATA REVIEWED	
Review/order of clinical lab tests (80000 code series)	1
Review/order of radiology tests (70000 code series)	1
Review/order of medicine tests (90000 code series)	1
Discuss test w/performing or interpreting physician	1
Decision to obtain old records or history from someone other than patient	1
Review and summary of old records and/or ***obtaining*** history from someone other than pt and/or discussion w/another provider **with documentation of findings**	2
Independent visualization of actual image, tracing, or specimen **(not simply review of report)**	2
DATA REVIEWED TOTAL	

TABLE OF RISK		
Moderate	Presenting Problem	1+ chronic ill w/milk exac, prog, or tx side effects, 2+ stable chronic ill, Undx new prob with uncertain prog (lump in breast), Acute ill w/systemic symp (pyeloephritis, Pneumonitis, colitis), Acute comp injury (head inj w/brief loss of consciousness)
	Diag Procedure Ordered	Physiologic tests under stress, Diag endos w/no identified risk, Deep needle or inc bx, Cardio imag w/cont, no identified risk, Obtain fluid from body cavity (lumbar puncture, thoracentesis)
	Mgmt Options	Minor sx w identified risk, Elec major sx (open, perc, endos) w/no identified risk, Rx drug mgmt, Therapeutic nuclear medicine, IV fluids w/additives, Closed treatment of fx or dislocation w/o manipulation
High	Presenting Problem	1+ chr ill w/severe exac, prog, tx side effects; Acute/chr ill or inj posing threat to life/bodily func (trauma, MI, pulm emb, sev resp dist, prog sev rheum arth, psych ill w/pot threat to self or others, renal fail); Sz, TIA, weakness, sens loss
	Diag Procedure Ordered	Cardio img w/cont and risk; Cardio electrophysiological tests; Diag endoscopies w/identified risk factors; Discography
	Mgmt Options	Elective major sx (open, perc, endo w/risk); Emerg major sx; Parenteral cont subs; Rx therapy w/intensive monitoring for toxicity; Decision not to resuscitate or to de-escalate care because of poor prognosis

(2 of 3 elements must be met or exceeded for a level of decision making)

MDM:	SF	Low	Mod	High
DX MGMT Options	0-1	2	3	4+
Data	0-1	2	3	4+
Risk	Minimal	Low	Moderate	High

NOTES:

Physician signature: _____

Staff signature: _____

Staff signature: _____

Staff signature: _____

SUBMIT BILLING 30 DAYS POST DISCHARGE.

Physician completes colored areas
Staff completes remainder