TRANSITIONAL CARE MANAGEMENT CHECKLIST

Patient Name_____ DOB _____

Name of TCM Qualified Healthcare Professional (QHP) Provider: _____

Discharge Date: _____ TCM End Date (29 days after day of discharge): _____

- **TCM services are for an established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute, rehabilitation and long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living).**
- **Documentation for TCM includes the timing of the initial post discharge communication with the patient or caregivers, date of the face-to-face visit, and the complexity of medical decision making. *See Check boxes below.***
- **The first face-to-face visit is part of the TCM and is not reported separately and must be documented in the patient's medical record by the QHP.**
- **Additional visits in the TCM period may be billed by the QHP according to level of care provided.**
- **Medication reconciliation and management must occur not later than the date of the face-to-face visit and must be documented in the patient's medical record.**

□ Initial Contact with patient/caregiver - Must occur w/in 2 business days after discharge
Date/Time:_____
Mode of Communication: Direct Telephone Electronic Other_____
Name of QHP Making Contact :_____
Patient/Caregiver Name: _____ Relationship to Patient: _____

Notes from Initial Contact :

□ Date of Face-To-Face Visit: _____ MDM of Face-to Face Visit: □ Moderate □ High
See page 4 of this document for details of face-to-face visit
TCM Code: □ 99495 (Must occur w/in 14 calendar days of discharge & moderate complexity MDM)
□ 99496 (Must occur w/in 7 calendar days of discharge & high complexity MDM)

□ Medication reconciliation/management performed and docuemnted in the pateint's medical record. Must be performed before face-to face visit.

QHP Signature:_____ Date:_____

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Non-Face-To-Face Services Provided by Clinical Staff Under the Direction of QHP

***Initial and date when services are performed.**

Service	Date	Date	Date	Comments
Commuication to Patient/Care giver regarding care				
Educate patient/caregiver regarding care self-management, independent living, and activities of daily living				
Assess and support treatment regimen adherence and medication management				
Identify available community and health resources				
Communication with home health agencies and other community services utilized by patient				
Facilitate access to necessary care and services				

Non-Face-To-Face Services Provided by Physician/QHP

***Initial and date when services are performed.**

Service	Date	Date	Date	Comments
Discharge records reviewed (including, test results and follow-up on any pending results or scheduled tests, and all communications with patients, caregivers, home health, DME, other physicians or healthcare professionals (eg, therapists), community services, etc.				
Communication with Patient/Care giver regarding care				
Labs Reviewed				
Diagnostic Tests Reviewed				
Communication with Other Health Care Professionls concering continuity of care				
Adjustment of Medications				
Cooridination of Home Health, DME, Therapy, Social Services				
Referrals, certifications/recertifications for services				

Additional Services/Comments

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Face-To-Face Visit Documentation - Must be docuemnted by QHP Provider

Date of Service: _____

Patient's Diagnosis/Condition (1)_____ (2)_____ (3)_____
(4)_____ (5)_____ (6)_____

Medical Decision Making Includes; # of Problems, # of Data Reviewed and Risk
(Use tables below to calculate MDM):

Problems	**Points**	**Total points**
Self-limited or minor (maximum of 2)	1	
Established problem, stable or improving	1	
Established problem, worsening	2	
New problem, with no additional work-up planned (maximum of 1)	3	
New problem, with additional work-up planned	4	

Data Reviewed – (Additionally, review non-face-to-face services provided prior to this visit – see table above)	**Points**	**Total Points**
Review or order clinical lab tests	1	
Review or order radiology test (except heart catheterization or echo)	1	
Review or order medicine test (PFTs, EKG, cardiac echo or cath)	1	
Discuss test with performing physician	1	
Independent review of image, tracing, or specimen	2	
Decision to obtain old records	1	
Review and summation of old records	2	

RISK LEVEL

Moderate Risk **Requires any ONE of these elements in ANY of the three categories listed**	• One or more chronic illness, with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem, with uncertain prognosis, e.g., lump in breast • Acute illness, with systemic symptoms • Acute complicated injury, e.g., head injury, with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies, with no identified risk factors • Deep needle, or incisional biopsies • Cardiovascular imaging studies, with contrast, with no identified risk factors, e.g., arteriogram, cardiac catheterization • Obtain fluid from body cavity, e.g., LP/thoracentesis	• Minor surgery, with identified risk factors • Elective major surgery (open, percutaneous, or endoscopic), with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids, with additives • Closed treatment of fracture or dislocation, without manipulation

TRANSITIONAL CARE MANAGEMENT CHECKLIST

Patient Name_____ DOB _____

RISK LEVEL

Risk Level	Presenting Problems	Diagnostic Procedures	Management Options Selected
High Risk **Requires any ONE of these elements in ANY of the three categories listed**	• One or more chronic illness, with severe exacerbation or progression • Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others, peritonitis, ARF • An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss	• Cardiovascular imaging, with contrast, with identified risk factors • Cardiac EP studies • Diagnostic endoscopies, with identified risk factors • Discography	• Elective major surgery (open, percutaneous, endoscopic), with identified risk factors • Emergency major surgery (open, percutaneous, endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate, or to de-escalate care because of poor prognosis

Treatment/Management

Overall MDM	Problem Points	Data Reviewed Points	Risk
99495 - Moderate Complexity	**3**	**3**	**Moderate**
99496- High Complexity	**4**	**4**	**High**

Medical decision making is defined by the E/M Services Guidelines. The medical decision making **over the period reported** is used to define the medical decision making of TCM. Documentation includes the timing of the **initial post discharge communication** with the patient or caregivers, **date of the face-to-face visit**, and the **complexity of medical decision making**.

Physicain/QHP Signature _____ Date _____

TRANSITIONAL CARE MANAGEMENT CHECKLIST

Patient Name_____ DOB _____

Tansitional Care Management Team

Name	Credentials	Signature	Initals

COMMENTS