TCM Documentation and Flow Sheet

TCM Requirements for Post-Discharge Contact Deadlines:

2 days post discharge date ____/____/_____
7 days post discharge date ____/____/_____
14 days post discharge date ____/____/_____

Note: To ensure all required documentation to support TCM services is completed, and so that none of these 4 pages get lost, reproduce this form on the front and back of 11x17 paper and fold it in half to 8 1/2 x 11 booklet size.

Patient Name: _____

Patient DOB: ____/_____/_____ **Discharge Date/Day:**____/_____/_____ ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

Patient's Physician: _____

Reason for Admission: _____

Contact Information: ☐ Patient ☐ Caregiver Name:_____ Relationship: _____

Preferred method of contact: ☐ phone ☐ cell ☐ text ☐ e-mail

Phone: Home: (_____)_____
Cell: (_____)_____
Work: (_____)_____

E-mail address (if applicable): _____

Is Home Health Involved? ☐No ☐ Yes — if yes, please include home health contact information:

Contact person: _____ Company name:_____
Phone: (_____)_____ Fax: (_____)_____
E-mail (if applicable): _____

Discharge Information:

Diagnosis(es) at discharge: _____
Discharging physician (name and phone #): _____

Discharge Information Obtained:

Discharge summary: Date rec'd: _____/_____/_____
Copies of discharge instructions: Date rec'd: _____/_____/_____
Most recent diagnostic test results: Test name: _____ Date rec'd: _____/_____/_____
Test name: _____ Date rec'd: _____/_____/_____
Test name: _____ Date rec'd: _____/_____/_____

Patient Current Location:

☐ Home ☐ Family member home ☐ Non-family member home ☐ Assisted living facility ☐ Rest home
☐ Other: _____

Initial Communication Post-Discharge:

First 2 attempts must be within 2 business days of discharge (see discharge date at top of page).
Continue attempting to reach the patient, even if the attempts during the first 2 days are unsuccessful.

1st attempt: Date: ___/___/____ Time: ____:_____ □ am □ pm Method: ☐ call ☐ fax ☐ e-mail ☐ mail Initial: _____

2nd attempt: Date: ___/___/____ Time: ____:_____ □ am □ pm Method: ☐ call ☐ fax ☐ e-mail ☐ mail Initial: _____

Add'l attempts: Date: ___/___/____ Time: ____:_____ □ am □ pm Method: ☐ call ☐ fax ☐ e-mail ☐ mail Initial: _____
Date: ___/___/____ Time: ____:_____ □ am □ pm Method: ☐ call ☐ fax ☐ e-mail ☐ mail Initial: _____
Date: ___/___/____ Time: ____:_____ □ am □ pm Method: ☐ call ☐ fax ☐ e-mail ☐ mail Initial: _____
Date: ___/___/____ Time: ____:_____ □ am □ pm Method: ☐ call ☐ fax ☐ e-mail ☐ mail Initial: _____

*** Once you reach patient or caregiver go to page 2.*

Patient Name: _____ DOB: ____/____/_____ Discharge Date: ____/____/_____

Initial Communication Post-Discharge section continued ...

Disposition: _____
_____
_____
_____
_____ initial: _____ date: _____

Summary of nursing/licensed clinical staff member's discussion with patient/caregiver during initial post-discharge communication:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____ initial: _____ date: _____

First Face-to-Face Follow-up Visit:

First face-to-face follow-up visit must be no longer than 14-days post-discharge to qualify for TCM.

Review progress notes in patient's record for information:

First face-to-face visit occurred on: Date: ____/____/_____ Time: _____:_____ □ am □ pm
Location of visit: ☐ Office ☐ Home ☐ Rest Home ☐ Other_____
Number of calendar* days since discharge: ☐ 7 or fewer ☐ 8-14 ☐ 15 or more
Medication reconciliation performed? ☐ No ☐ Yes (If yes, date: ____/____/_____)
Level of medical decision-making : ☐ High ☐ Moderate ☐ Low/Straightforward
Face-to-face visit performed by (provider name and credentials): _____
Progress notes signed by the treating provider for the above date of service? ☐ Yes ☐ No

** Calendar days include weekends and holidays.*

Summary of recommendations: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____ initial: _____ date: _____

Patient Name: _____ DOB: ____/____/_____ Discharge Date: ____/____/_____

Additional Non-Face-to-Face Services:

Examples of Additional Non-Face-to-Face Services

Review discharge information:
- Document provider name, date and findings.
- Pending diagnostic tests and treatments: Document if nothing pending or list of pending tests and treatments, action recommended for each, dates and results received for each.

Communication with other providers involved in patient's care:
- List each provider communicated with, date of each communication, and findings and results from each communication. Document if no communication required.

Education: (*patient, family, guardian, and/or caregiver*):
- Date of education, who was educated (and if applicable their relationship with the patient), who provided education, topic of education, results and follow-up. Document if no education required.

Community resource arrangement(s):
- Document resources required, who arranged each resource, date each resource arranged, result of each resource. Document if none needed.

Assess and support treatment regimen adherence and medication management:
- Document date, topic, result and name of staff providing support. Document if none needed.

Additional non-face-to-face services provided within 30 days post-discharge must be performed by licensed clinical staff members, or personally performed by physician or qualified NPP. ***Initial and date each entry below, including licensure initials.***

Patient Non-Face-to-Face Services Documentation Record:	**Initial and Date Each Entry:**

Patient Name: ____ DOB: ____/____/______ Discharge Date: ____/____/______

Additional Non-Face-to-Face Services section continued ...

Patient Non-Face-to-Face Services Documentation Record: **Initial and Date Each Entry:**

Note: ***The person who signs below and closes this document has NO bearing on whose name the TCM services should be billed under.*** *CMS states that TCM services should be billed under the physician or NPP who actually provides the mandatory face-to-face encounter. Ideally, to ensure continuity of care, it would also be the same person, but this is not required.*

TCM 30-Day-Period Closure:

Date range included in this document: Start date: ____/____/______ End date: ____/____/______

Document reviewed and closed by: ____ ____/____/_____

Physician or NPP Signature and Licensure Date