

1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

Walter H. Krzyzewski

DOB

02/09/1955

AGE / SEX

71 yrs / Male

MRN / PATIENT ID

IM-3308671

DATE OF SERVICE

08/13/2026

PROVIDER

Adaeze O. Nwachukwu, MD

CREDENTIALS

MD, FACP

PRIMARY CARE PROVIDER

This provider

VISIT TYPE

Hospital Follow-Up — day 7 after discharge for acute decompensated heart failure

CARE SETTING

Outpatient internal medicine clinic, transitional care management visit

REFERRAL SOURCE

Hospitalist discharge referral, Mercy Central —
discharged 08/06/2026

INTERPRETER USED

No

CC CHIEF COMPLAINT

2 PRIMARY REASON FOR VISIT

"The breathing is much better than it was, but I have gained four pounds back since Sunday and my ankles are puffy again by the evening. And I have twelve bottles on the counter now — I genuinely do not know which ones I am still meant to take."

S SUBJECTIVE

3 INTERVAL HISTORY & CHRONIC DISEASE STATUS

3a PRESENTING CONCERN

Reason for visit

Transitional care management visit 7 days after a 4-day admission for acute decompensated heart failure with reduced ejection fraction. Purpose is volume reassessment, medication reconciliation after multiple inpatient changes, laboratory

review after diuretic and GDMT adjustment, and prevention of a 30-day readmission.

History of present illness

Admitted 08/02/2026 with three days of progressive exertional dyspnea, two-pillow orthopnea, paroxysmal nocturnal dyspnea and a 12 lb weight gain. Treated with intravenous furosemide with a net negative fluid balance of 6.4 L, and discharged 08/06/2026 at 194 lb on oral furosemide. Since discharge his breathing has improved substantially — he now sleeps flat with one pillow and can walk the length of his hallway without stopping, against half that distance before admission. However, home weights have risen from 194 lb at discharge to 198 lb today, with ankle edema recurring each evening and resolving partially overnight. He denies chest pain, palpitations, syncope, and dizziness. He acknowledges eating tinned soup and deli meat on three occasions since discharge, and reports that he stopped the metolazone after two days because "the discharge sheet did not say for how long."

Chronic medical conditions

Heart failure with reduced ejection fraction, LVEF 32% on the 08/03/2026 echocardiogram, down from 41% in 2024, NYHA class III at admission and now class II. Ischemic cardiomyopathy following an anterior myocardial infarction in 2016 with two drug-eluting stents to the LAD. Permanent atrial fibrillation, rate-controlled, on anticoagulation. Chronic kidney disease stage 3b. Type 2 diabetes, 18 years. Hypertension. COPD GOLD 2, ex-smoker with a 40 pack-year history, quit 2016. Gout. Benign prostatic hyperplasia.

3b SYSTEM-BASED REVIEW

Cardiovascular

Dyspnea markedly improved but not resolved; NYHA class II. Evening ankle edema recurring. Orthopnea reduced to one pillow. No PND in the past four nights. No chest pain, no palpitations, no syncope, no presyncope. No ICD in situ — primary prevention device discussion is pending the 90-day post-optimization LVEF reassessment.

Respiratory

Baseline productive morning cough, unchanged. No wheeze at present. No increase in inhaler use. No hemoptysis. Uses tiotropium daily and salbutamol rarely. Sleep apnea suspected historically but never formally tested; wife reports loud snoring and witnessed pauses.

Gastrointestinal / hepatic

Appetite reduced since discharge, roughly two-thirds of usual intake. Mild early satiety. No abdominal pain, nausea, vomiting or diarrhea. Constipation since discharge, two days without a bowel movement. No jaundice, no melena, no hematochezia. No alcohol for 10 years.

Genitourinary

Nocturia four times nightly, up from two — attributes this to evening diuretic timing. Weak stream and hesitancy from known BPH. No dysuria, no hematuria, no retention. No stone history.

Endocrine / metabolic

Home glucose 120–170 mg/dL, improved since the inpatient insulin adjustment. No hypoglycemia. Weight trend as above. No thyroid symptoms. No polyuria beyond the diuretic effect.

Neurologic

No headache, focal weakness, numbness, tremor or seizure. Reports mild word-finding difficulty since admission, which his wife attributes to poor sleep. No falls, though he describes two episodes of unsteadiness on standing quickly.

Musculoskeletal / pain

Chronic bilateral knee osteoarthritis, 3/10, stable. No gout flare in 14 months. No back pain. Mobility limited by dyspnea and knee pain, using a stick outdoors since the admission.

Mental health / sleep

Low mood since discharge, describing frustration at his loss of independence and fear of readmission. Sleep fragmented by nocturia. No anhedonia, no suicidal ideation. No prior psychiatric history. Wife reports he has become withdrawn.

3c MEDICATIONS, PREVENTIVE CARE & SOCIAL HISTORY

Medication reconciliation

Performed in full today with all bottles present — four discrepancies identified. (1) Both the pre-admission furosemide 40 mg daily and the discharge furosemide 80 mg twice daily are in the house and he has been taking the 40 mg tablets in addition on some days. (2) Metolazone 2.5 mg was prescribed as needed with no duration and has been stopped. (3) Pre-admission carvedilol 12.5 mg BID bottles remain alongside the discharge dose of 6.25 mg BID, which was reduced inpatient. (4) He has continued naproxen 500 mg twice weekly for knee pain, which was not on any list and which he did not consider a medication. Current intended regimen: furosemide 80 mg BID, sacubitril-valsartan 24/26 mg BID, carvedilol 6.25 mg BID, spironolactone 12.5 mg daily, dapagliflozin 10 mg daily, apixaban 2.5 mg BID, atorvastatin 80 mg nightly, metformin 500 mg BID, insulin glargine 22 units nightly, tiotropium, salbutamol PRN, allopurinol 200 mg daily, tamsulosin 0.4 mg nightly, potassium chloride 20 mEq daily.

Allergies

Penicillin — anaphylaxis, 1978, documented. Contrast media — mild urticaria, premedicated in 2016. No other allergies.

Recent care and hospitalizations

Admission 08/02–08/06/2026 as above. No emergency visits since discharge. Cardiology follow-up scheduled 08/20/2026. Home health nurse visited once on 08/08/2026 and recorded a weight of 195 lb. No further home visits scheduled — the order lapsed.

Preventive care and screening

Colonoscopy 2019 with two tubular adenomas removed, repeat due 2029. Lung cancer screening low-dose CT eligible given the 40 pack-year history and quit within 15 years — never performed. AAA ultrasound 2018 negative. Influenza 10/2025, COVID-19 booster 11/2025, PPSV23 2018, PCV20 not given, Tdap 2017, zoster series incomplete.

Lifestyle and health behaviors

Sodium intake the principal issue — tinned and processed foods since his wife's recent hip surgery limited her cooking. Fluid intake unrestricted and untracked. No exercise beyond household mobility. Quit smoking 2016. No alcohol. Sleeps 5 hours fragmented. Reports willingness to change diet if given specific options rather than general advice.

Functional status

Independent in ADLs. Requires assistance with shopping and heavy household tasks — his wife is 8 weeks post hip replacement and cannot currently provide this. Uses a stick outdoors. Drives short distances. Manages his own medications, which is where the errors originate. Two unsteadiness episodes on standing but no falls.

Social history / social determinants

Lives with his wife in a two-storey home; the bedroom and bathroom are upstairs and he stops twice on the stairs. Retired machinist. Fixed income — reports the sacubitril-valsartan copay at \$92 per month is "a stretch" and he has considered halving the dose to make it last, though he has not yet done so. Transport available through a daughter twice weekly. Health literacy limited by a lack of written organization rather than comprehension. No food insecurity, but no one currently cooking fresh meals in the household.

Family history

Father — myocardial infarction at 58, deceased at 62. Mother — type 2 diabetes, stroke at 77. Brother — atrial fibrillation, alive at 74. No known kidney or liver disease, no sudden cardiac death in first-degree relatives.

Pertinent negatives

Denies chest pain, resting dyspnea, PND in the past four nights, syncope, focal neurologic deficit, severe abdominal pain, melena or hematochezia, bleeding on apixaban, fever, and suicidal or homicidal ideation. No calf pain or asymmetric swelling.

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INTERNAL MEDICINE REVIEW OF SYSTEMS

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PERTINENT POSITIVES & NEGATIVES

Constitutional — fever, chills, fatigue, appetite, night sweats, weight	Positive — fatigue, reduced appetite, 4 lb weight gain since discharge. Afebrile.
HEENT — headache, vision or hearing change, congestion, dysphagia	Negative.
Cardiovascular — chest pain, palpitations, edema, DOE, dizziness, syncope	Positive — evening ankle edema, NYHA II dyspnea, orthostatic unsteadiness. No chest pain.
Respiratory — cough, wheeze, dyspnea, sputum, hemoptysis, apnea symptoms	Positive — baseline COPD cough; snoring with witnessed apneas. No hemoptysis.
Gastrointestinal — pain, nausea, diarrhea, constipation, reflux, bleeding	Positive — early satiety, constipation 2 days. No bleeding on anticoagulation.
Genitourinary — dysuria, frequency, hematuria, nocturia, prostate	Positive — nocturia x4, BPH symptoms. No dysuria or hematuria.
Musculoskeletal — joint, back, muscle pain, swelling, stiffness	Positive — knee osteoarthritis 3/10, driving the naproxen use.
Skin — rash, lesions, wounds, bruising, color change	Positive — easy bruising on apixaban, no active bleeding.
Neurologic — weakness, numbness, headache, gait change, memory	Positive — mild word-finding difficulty, unsteadiness on standing. No focal deficit.
Psychiatric — depression, anxiety, insomnia, stress, SI	Positive — low mood and readmission anxiety. PHQ-9 8. No SI.
Endocrine / metabolic — intolerance, polyuria, weight, glucose, thyroid	Positive — glucose 120–170. No hypoglycemia, no thyroid symptoms.
Hematologic — bleeding, bruising, anemia, lymphadenopathy	Positive for bruising. Hemoglobin 10.9 — anemia of CKD.

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE

97.9 °F

HEART RATE

76 bpm, irregularly irregular

OXYGEN SATURATION

94% RA

WEIGHT

198 lb (discharge 194 lb; admission 206 lb)

PAIN SCORE

3/10 — bilateral knees

BLOOD PRESSURE

104/62 mmHg

RESPIRATORY RATE

18 /min

HEIGHT

5 ft 10 in

BMI

28.4

ORTHOSTATIC VITALS

Supine 112/66 (74) → standing 94/58 (88), symptomatic lightheadedness

General appearance

Elderly man, comfortable seated, mildly dyspneic after walking from the waiting room and recovers within 90 seconds. No accessory muscle use at rest. Slightly cachectic upper body with fluid-loaded lower body. Alert and engaged. Arrived with a carrier bag of medication bottles at the clinic's request.

HEENT

Conjunctiva pale. Sclera anicteric. Oral mucosa dry. Dentition adequate. No lymphadenopathy of the head or neck. No thyromegaly.

Neck

Jugular venous pressure elevated at approximately 9 cm H₂O at 45 degrees, down from documented 14 cm on admission. Positive hepatojugular reflux. No carotid bruit. Trachea midline.

Cardiovascular

Irregularly irregular rhythm at 76. Displaced apex beat in the sixth intercostal space, anterior axillary line. Soft S3 gallop present. Grade 2/6 holosystolic murmur at the apex radiating to the axilla, consistent with functional mitral regurgitation. **Bilateral pitting edema to mid-shin, 2+**, down from 3+ to the thighs on admission. Peripheral pulses 1+ and symmetric, capillary refill 3 seconds. Extremities cool.

Pulmonary

Reduced air entry at both bases with fine inspiratory crackles in the lower third bilaterally, improved from mid-zone crackles on admission. Prolonged expiratory phase consistent with COPD. No wheeze today. Saturation 94% on room air, dropping to 91% after ambulating 25 metres.

Abdomen

Soft, mildly distended, non-tender. Bowel sounds present but reduced. Liver edge palpable 2 cm below the costal margin, smooth and mildly tender. No ascitic shifting dullness. No bruit, no mass, no hernia.

Musculoskeletal

Bilateral knee crepitus with mild effusion on the right. No warmth or erythema — no gout flare. Reduced knee flexion bilaterally. Gait slow and wide-based with a stick, no ataxia.

Skin

Multiple non-traumatic ecchymoses on both forearms, consistent with anticoagulation. Chronic venous stasis pigmentation of both lower legs. Skin intact, no ulceration, no cellulitis. Dry skin over the shins.

Neurologic

Alert and oriented to person, place and time. Mini-Cog 4/5 — recall 2/3, clock normal; borderline and confounded by sleep deprivation. Cranial nerves intact. Strength 5/5 proximally and distally. Sensation reduced to monofilament at the great toes bilaterally, consistent with diabetic neuropathy. Reflexes 1+ symmetric. No tremor. Romberg negative.

Psychiatric

Mood subdued, affect mildly constricted but reactive. Speech normal. Thought process linear with occasional word-finding pauses. Insight good — he identified the medication confusion himself. No suicidal ideation, no hopelessness.

CD CHRONIC DISEASE / RISK ASSESSMENT

6 STATUS OF CHRONIC CONDITIONS & RISK FACTORS

BLOOD PRESSURE CONTROL

104/62 with symptomatic orthostasis — at the floor for GDMT titration

DIABETES CONTROL

HbA1c 7.6%; glucose 120–170; no hypoglycemia

LIPID STATUS & ASCVD

KIDNEY FUNCTION

Secondary prevention; LDL 61 on atorvastatin 80 mg — at goal

HEART FAILURE STATUS

HFrEF, LVEF 32%, NYHA II. Incompletely decongested — JVP 9 cm, 2+ edema, S3

THYROID

TSH 2.8 — normal

ANEMIA / HEMATOLOGIC

Hemoglobin 10.9 — anemia of CKD; ferritin 68, TSAT 16% — iron deficient

MENTAL HEALTH / SUBSTANCE USE

PHQ-9 8 — mild depression, new. No substance use

MEDICATION BURDEN

14 medications with 4 reconciliation discrepancies, one high-risk NSAID, and an affordability threat to sacubitril-valsartan

eGFR 38, creatinine 1.74 — CKD 3b, up from baseline 1.52

COPD CONTROL

GOLD 2, stable. No exacerbation. Tiotropium adherent

LIVER

Mild congestive hepatopathy; ALT 46, AST 41, bilirubin 1.1

OBESITY / NUTRITION

BMI 28.4 with fluid overlay; reduced protein intake and early satiety

FALLS, COGNITION, FRAILTY

Symptomatic orthostasis, Mini-Cog 4/5, stick use — rising fall risk

PC

PREVENTIVE CARE / HEALTH MAINTENANCE

7 NEEDS & COMPLETED ITEMS

CANCER SCREENING

Colonoscopy 2019 — due 2029. Lung cancer LDCT eligible and never done

DIABETES SCREENING

Established; complication screening — retinal exam overdue since 2024

DEPRESSION & ANXIETY

PHQ-9 8, GAD-7 6 — new mild depression, monitored

INFECTIOUS DISEASE SCREENING

Not indicated

OSTEOPOROSIS SCREENING

Not previously assessed; deferred to a future visit

DENTAL, VISION & HEARING

Hearing aid needed per wife; diabetic retinal exam overdue

LIFESTYLE COUNSELING PROVIDED

Sodium and fluid targets with specific products named, daily weight protocol, activity pacing — 15 minutes

BLOOD PRESSURE

Monitored; currently limiting rather than a target

LIPID SCREENING

Current, at goal

TOBACCO, ALCOHOL, SUBSTANCE USE

Ex-smoker 2016, no relapse; no alcohol

IMMUNIZATIONS

PCV20 and RSV vaccine both indicated and offered; zoster series incomplete

FALL RISK SCREENING

Positive — orthostasis, stick use, upstairs bathroom

ADVANCE CARE PLANNING

Initiated today — 18 minutes, healthcare proxy named

8 SCORES, INTERPRETATION & COMPARISON

PHQ-2 / PHQ-9

2 / 8 — mild depression, new since admission

AUDIT-C

0

FALL RISK (TIMED UP AND GO)

16.4 seconds — elevated fall risk

STOP-BANG

5 — intermediate-high; untested OSA

KCCQ-12

44 — poor to fair health status

SOCIAL DETERMINANTS SCREENING

Positive — medication cost, caregiver capacity, meal preparation

INTERPRETATION

The dominant readmission drivers on this profile are incomplete decongestion, four medication discrepancies, a copay threat to GDMT, and the loss of both home nursing and household cooking capacity — all modifiable today.

GAD-7

6 — mild anxiety, readmission-focused

MINI-COG

4 / 5 — borderline, repeat when sleep improves

PAIN SCALE

3/10 knees

NYHA FUNCTIONAL CLASS

II (was III on admission)

MEDICATION ADHERENCE (SINGLE-ITEM)

Reports missing doses due to confusion, not intent

9 REVIEWED OR ORDERED

Routine labs (drawn today, resulted same day)

Sodium 133 mmol/L (discharge 136), potassium 5.3 mmol/L (discharge 4.4), chloride 96, bicarbonate 26, urea 68 mg/dL, creatinine 1.74 mg/dL (discharge 1.52, baseline 1.40), eGFR 38 mL/min/1.73m². Hemoglobin 10.9 g/dL, MCV 88, platelets 188 k, white cells 7.2 k. Ferritin 68 ng/mL, transferrin saturation 16% — iron deficient. Albumin 3.3 g/dL. ALT 46, AST 41, bilirubin 1.1. Magnesium 1.9.

Cardiometabolic testing

NT-proBNP 3,180 pg/mL today, against 1,940 at discharge and 9,600 on admission — rising, corroborating clinical congestion. HbA1c 7.6%. Lipids — LDL 61, HDL 38, triglycerides 158. EKG today: atrial fibrillation at 76, left bundle branch block with QRS 148 ms, unchanged from admission, no acute ischemic change.

Imaging and echocardiography

Inpatient echocardiogram 08/03/2026: LVEF 32%, severe global hypokinesis with anterior akinesis, moderate functional mitral regurgitation, moderately dilated left atrium, estimated PASP 46 mmHg, dilated IVC with reduced collapse. Chest radiograph on admission with pulmonary venous congestion and small bilateral effusions; no repeat film today, clinical assessment sufficient.

Pulmonary / sleep testing

No formal sleep study on record despite a STOP-Bang of 5 and witnessed apneas. Home sleep apnea test ordered today. Spirometry 2023: FEV₁/FVC 0.62, FEV₁ 64% predicted — GOLD 2.

Preventive screening results

Colonoscopy 2019 with two tubular adenomas. AAA ultrasound 2018 negative. No low-dose CT lung screening on record despite eligibility.

Prior records reviewed

Full discharge summary, inpatient medication administration record, daily inpatient weights, cardiology inpatient consultation, and the 08/03 echocardiogram report all reviewed line by line — this is how the four medication discrepancies were identified. Home health nurse note of 08/08/2026 also reviewed.

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ASSESSMENT

10 INTERNAL MEDICINE CLINICAL INTERPRETATION

- **Heart failure with reduced ejection fraction, LVEF 32%, NYHA class II — incompletely decongested at day 7 (I50.22).** The 4 lb regain, JVP of 9 cm, persistent S3, 2+ edema and a rising NT-proBNP from 1,940 to 3,180 together indicate residual congestion, not euvoolemia. He was discharged before full decongestion, which is the single strongest predictor of 30-day readmission in this population.
- **Four medication discrepancies identified on reconciliation** — duplicate furosemide strengths, an abandoned metolazone with no stop date, duplicate carvedilol strengths, and unreported NSAID use. The naproxen is actively harmful here: it antagonises the diuretic, worsens renal function, and raises bleeding risk on apixaban. This is a medication-safety problem masquerading as a heart-failure problem.
- **Acute-on-chronic kidney injury, CKD 3b (N18.32, N17.9).** Creatinine has risen from 1.52 to 1.74 with hyponatremia at 133 and hyperkalemia at 5.3. Multifactorial — cardiorenal physiology, NSAID exposure, and the combination of an MRA with sacubitril-valsartan. The potassium constrains, but does not prohibit, the diuretic escalation this congestion requires.
- **Symptomatic orthostatic hypotension with a rising fall risk (I95.1).** Supine to standing drop of 18/8 mmHg with symptoms, a Timed Up and Go of 16.4 seconds, a stick, and an upstairs bathroom. This constrains further GDMT titration and is itself a readmission and fracture risk.
- **Iron deficiency in heart failure (D50.9, E61.1)** — ferritin 68 with a transferrin saturation of 16% meets criteria for treatment in HFrEF irrespective of anemia, and intravenous repletion improves symptoms and quality of life.
- **Medication affordability threatening guideline-directed therapy.** He has considered halving sacubitril-valsartan over a \$92 monthly copay. Unaddressed, this predictably becomes non-adherence.
- **Untreated suspected obstructive sleep apnea (G47.33 provisional)** — STOP-Bang 5 with witnessed apneas, a plausible contributor to his atrial fibrillation burden and to the difficulty of blood pressure and volume control.
- **New mild depression (F32.0) and borderline cognition (Mini-Cog 4/5)** — both common after a heart failure admission, both likely amplified by sleep deprivation, and both relevant to self-management capacity.
- **Additional stable problems:** permanent atrial fibrillation on appropriately dose-reduced apixaban; type 2 diabetes at 7.6%; COPD GOLD 2 without exacerbation; gout in remission; BPH.
- **Preventive gaps:** lung cancer screening never performed despite clear eligibility; diabetic retinal screening 2 years overdue; PCV20, RSV and zoster vaccination outstanding.
- **Overall:** high readmission risk, driven by identifiable and modifiable factors rather than by irreversible disease progression. Manageable as an outpatient today provided decongestion is escalated with same-week laboratory surveillance.

11 INTERNAL MEDICINE MANAGEMENT BY PROBLEM

- **Decongestion:** increase furosemide to 120 mg in the morning and 80 mg at midday, with the second dose moved before 2 PM to reduce nocturia. Restart metolazone 2.5 mg, now with an explicit rule — one dose 30 minutes before the morning furosemide on Thursday and Sunday only, for two weeks, then stop. Target 2–3 lb loss weekly to a dry weight of 190 lb. Daily morning weights on a chart supplied today, with instructions to call for a 3 lb gain in two days or 5 lb in a week.
- **Stop naproxen today.** Substitute topical diclofenac gel and scheduled acetaminophen 650 mg three times daily for the knees. Explained directly why an over-the-counter tablet is doing measurable harm here. Referral to physical therapy for knee-sparing strengthening.
- **Medication safety:** all duplicate bottles collected and disposed of in the clinic today with the patient's agreement. A single-page written schedule issued. Pharmacy contacted to convert to a blister-pack weekly dispensing system. His daughter added as a second contact for the medication list with consent.
- **Potassium and renal surveillance:** hold spironolactone for 7 days given the potassium of 5.3, then resume at 12.5 mg on alternate days if the level is below 5.0. Stop the potassium chloride supplement now — it is unnecessary alongside an MRA and is contributing. Basic metabolic panel in 72 hours (08/16) and again in 7 days, arranged as a nurse-drawn appointment rather than left to the patient to book.
- **GDMT:** continue sacubitril-valsartan 24/26 mg BID and carvedilol 6.25 mg BID at current doses — no up-titration while he is orthostatic and hyperkalemic. Continue dapagliflozin 10 mg. Reassess titration at cardiology on 08/20 once volume and potassium have settled. ICD candidacy to be reassessed at 90 days of optimized therapy.
- **Affordability:** manufacturer patient assistance application for sacubitril-valsartan completed with the clinic pharmacist during the visit and submitted today. Explicitly instructed not to halve or ration doses; he agreed to call the clinic rather than self-adjust.
- **Iron deficiency:** intravenous ferric carboxymaltose 750 mg arranged in the infusion suite for 08/18/2026. Oral iron avoided — poorly absorbed in heart failure and would worsen his constipation.
- **Orthostasis and falls:** counselled on rising slowly and on compression stockings, though these are deferred until decongestion is complete. Occupational therapy home safety assessment ordered, with a specific request to evaluate a downstairs commode or bathroom access. Home health nursing reinstated at three visits weekly for weights, vitals and medication supervision — the lapsed order was the proximate cause of much of today's findings.
- **Sodium and nutrition:** 2 g sodium and 1.5 L fluid daily targets, with a written list of specific products to eliminate rather than general advice. Home-delivered heart-failure meals arranged for 8 weeks through the health plan benefit — his wife cannot currently cook and this is the real barrier. Dietitian referral placed.
- **Sleep apnea:** home sleep apnea test ordered; sleep medicine referral placed pending the result.
- **Depression and cognition:** no antidepressant today; sleep, volume and iron status are all realistic contributors that should be corrected first. Cardiac rehabilitation referral placed — it addresses mood, function and mortality together. Repeat PHQ-9 and Mini-Cog at the 4-week visit.
- **Preventive care:** PCV20 and RSV vaccine administered today. Zoster dose 2 scheduled. Low-dose CT lung cancer screening ordered with shared decision-making documented. Diabetic retinal screening booked.
- **Advance care planning:** 18-minute discussion held with the patient and his wife. Wife named healthcare proxy, forms completed and scanned. Full code confirmed at present. Discussion documented as ongoing rather than concluded.
- **Education and red flags:** written and verbal instruction on daily weights, sodium and fluid targets, the diuretic schedule, when to call, and when to attend the emergency department — resting dyspnea, chest pain, syncope, weight gain beyond thresholds, bleeding, or confusion. Teach-back completed with both the patient and his wife.

12 REASSESSMENT PLAN**Follow-up**

Nurse-drawn basic metabolic panel on 08/16/2026 and 08/20/2026 with same-day provider review of both. Home health nursing three times weekly starting 08/14. Cardiology 08/20/2026 as scheduled. Intravenous iron 08/18/2026. Provider follow-up in 7 days (08/20) for volume reassessment, weight trend review and diuretic adjustment, then at 4 weeks for GDMT titration, repeat NT-proBNP, PHQ-9 and Mini-Cog. Cardiac rehabilitation and occupational therapy within 2 weeks. Immediate emergency attendance for resting dyspnea, chest pain, syncope, confusion, or bleeding; same-day clinic call for a 3 lb gain in two days, a 5 lb gain in a week, or a drop in urine output.

TB

TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

74 minutes

COUNSELING / PREVENTIVE COUNSELING

15 minutes

CARE COORDINATION TIME

16 minutes

RECORDS REVIEW TIME

12 minutes — discharge summary and inpatient MAR

MEDICATION MANAGEMENT TIME

13 minutes — full reconciliation with bottles

ADVANCE CARE PLANNING TIME

18 minutes — patient and proxy present

E/M LEVEL

99215 — established patient, high MDM

TRANSITIONAL CARE MANAGEMENT

99496 — face-to-face within 7 days of discharge, high complexity MDM; interactive contact made 08/07/2026 within 2 business days

ADVANCE CARE PLANNING CODE

99497 — first 30 minutes, 18 minutes documented

CHRONIC CARE MANAGEMENT

Not billed — TCM period active

SCREENING CODE(S)

96127 x 2 — PHQ-9 and GAD-7

IMMUNIZATION ADMINISTRATION

90677 PCV20 · 90678 RSV · 90471, 90472 administration

PROCEDURE CODE(S)

93000 — EKG with interpretation and report

BASIS FOR BILLING

Transitional care management with high-complexity medical decision making; ACP and EKG separately identifiable and documented

PRIMARY ICD-10

I50.22 — Chronic systolic (congestive) heart failure

SECONDARY ICD-10

I25.5 ischemic cardiomyopathy · I48.21 permanent atrial fibrillation · N18.32 CKD stage 3b · N17.9 acute kidney failure · E87.5 hyperkalemia · E87.1 hyponatremia · E11.9 type 2 diabetes · J44.9 COPD · D50.9 iron deficiency anemia · I95.1 orthostatic hypotension · F32.0 mild depressive episode · Z79.01 long term anticoagulant use · Z71.89 advance care planning counseling

SO

PROVIDER SIGN-OFF

PROVIDER NAME

Adaeze O. Nwachukwu

CREDENTIALS

MD, FACP

SPECIALTY

Internal Medicine

DATE

08/13/2026

TIME

3:26 PM