HCCIntelligence™ PREMIER

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# Chronic Care Management Provider Checklist

## Purpose

This resource is intended to assist home based medical care providers with effectively managing Chronic Care Management (CCM) services, inclusive of guidance on how to identify eligible patients with multiple chronic conditions, initiate appropriate visits for assessment and consent, document patient consent, record and update patient information in certified Electronic Health Record (EHR) systems, develop and maintain electronic care plans, facilitate care transitions between healthcare providers and settings, and coordinate care with home-and community-based clinical service practitioners, ensuring comprehensive and patient-centered care delivery while adhering to billing guidelines and patient consent requirements. Refer to CMS guidelines[1] for full details and requirements.

☐ **Identify patient eligibility for CCM services.**

- Eligible CCM patients will **have multiple (2 or more) chronic conditions expected to last at least 12 months** or until the patient's death.
- Identify patients who require CCM services by **using criteria suggested in CPT guidance** (like number of illnesses, number of medications, repeat admissions, or emergency department visits) or the **typical patient profile in the CPT prefatory language.**

☐ **Initiate a face-to-face Evaluation and Management (E/M) visit or Annual Wellness Visit (AWV) as an initiating visit for new patients or patients whom the billing practitioner hasn't seen within 1 year before CCM services start.**

- Assess the patient's medical, functional, and psychosocial needs.
- Make sure the patient receives timely recommended preventive services.
- Oversee the patient's medication self-management.

☐ **Provide informed consent and inform patient(s) that:**

- CCM services are available.
- They may have cost-sharing responsibilities.
- Only one practitioner can furnish and bill CCM services during a calendar month.
- They can stop the CCM services at any time (effective at the end of a calendar month).

[1] https://www.cms.gov/medicare/payment/fee-schedules/physician


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☐ **Receive verbal or written consent.**

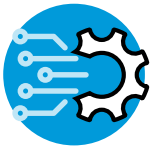
- Patient consent must be documented in the patient's medical record.

☐ **Record the patient's demographics, problems, medications, and medication allergies using certified Electronic Health Record (EHR) technology.**

- A full EHR list of problems, medications, and medication allergies must inform the care plan, care coordination, and ongoing clinical care.

☐ **Create, revise, and or monitor (per code descriptors) a person-centered, electronic care plan based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and inventory of resources and supports.**

- Make the electronic care plan information available promptly both within and outside billing practice with individuals involved in the patient's care, as appropriate.



☐ **Manage care transitions between and among healthcare providers and settings.**

- This includes referrals to other clinicians, or follow-up after an emergency department visit or after discharges from hospitals, skilled nursing facilities, or other healthcare facilities.

☐ **Execute the following:**

- Create and exchange or share a continuity of care document(s) promptly with other practitioners.
- Coordinate care with home- and community-based clinical service practitioners.
- Communicate with practitioners about the patient's psychosocial needs and functional decline and document it in the patient's medical record.

[2] Centers for Medicare & Medicaid Services/Physician Fee Schedule/Care Management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