PEOPLES HEALTH
A UnitedHealthcare Company

CCM Checklist

Enhancing Patient Outcomes Through Chronic Care Management Services

CMS recognizes chronic care management (CCM) as a critical primary care service that contributes to better patient health and care. Review the CMS Medicare Learning Network (MLN) Chronic Care Management Services booklet for more information. It provides background on payable CCM service codes, names eligible billing practitioners and patients, and details the Medicare Physician Fee Schedule (PFS) billing requirements.

The following checklist, excerpted from the MLN booklet, offers valuable tips for providing and managing CCM services.

Initiating Visit

☐ Conduct a face-to-face E/M visit, AWV or IPPE for new patients or patients not seen within one year before CCM services start.

Structured Recording of Patient Health Information Using Certified EHR Technology

☐ Record the patient's demographics, problems, medications and medication allergies using certified EHR technology. A full EHR list of problems, medications and medication allergies must inform the care plan, care coordination and ongoing clinical care.

24/7 Access and Continuity of Care

☐ Provide 24/7 access to physicians or other qualified practitioners or clinical staff, including providing patients or caregivers with a way to contact health care practitioners in the practice to discuss urgent needs no matter the time of day or day of week.

☐ Provide continuity of care with a designated practitioner or member of the care team with whom the patient can get successive routine appointments.

Comprehensive Care Management

☐ 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

Comprehensive Care Plan

☐ 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, as well as an inventory of resources and supports.

- Comprehensive care plan for all health issues with focus on managing chronic conditions

☐ Provide patients and/or caregivers with a copy of the care plan.

☐ Electronically capture care plan information and make it available promptly both within and outside the billing practice with individuals involved in the patient's care, as appropriate.

Manage Care Transitions

- ☐ Manage care transitions between and among health care providers and settings, including referrals to other clinicians, or follow-up after an emergency department visit or after discharges from hospitals, skilled nursing facilities or other health care facilities.
- ☐ Create and exchange or share continuity of care document(s) promptly with other practitioners.

Home- and Community-Based Care Coordination

- ☐ Coordinate care with home- and community-based clinical service practitioners.
- ☐ Communicate with home- and community-based practitioners about the patient's psychosocial needs and functional decline, and document it in the patient's medical record.

Enhanced Communication Opportunities

- ☐ Provide patients and caregivers enhanced opportunities to communicate with practitioners about the patient's care by phone and through secure messaging, secure web or other asynchronous non-face-to-face consultation methods (like email or a secure electronic patient portal).

Patient Consent

- ☐ Inform patient that:
    - CCM services are available
    - They may have cost-sharing responsibilities
    - Only one practitioner can furnish and bill CCM services during a calendar month
- ☐ The patient can stop the CCM services at any time (effective the end of the calendar month).
- ☐ Document in patient's medical record that you explained the required information and whether they accepted or declined services.

Medical Decision-Making

- ☐ Complex CCM services require and include moderate to high complexity medical decision-making (by the physician or other billing provider).