CHRONIC CARE MANAGEMENT PROVIDER(S) CHECKLIST

- ☐ **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, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE) as an initiating visit** for new patients or patients who 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 the end of calendar month).

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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, 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 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.

- ☐ **Execute the following:**
  - ○ Create and exchange or share continuity of care document(s) promptly with other practitioners.
  - ○ 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.

Learn more about CCM and download resources at **go.CMS.gov/ccm**.

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