KNOWLEDGE • RESOURCES • TRAINING

Chronic Care Management Services

Chronic Care Management Service Summary

Initiating Visit

- ☐ Face-to-face E/M visit, AWV, or IPPE for new patients or patients who the billing practitioner hasn't seen within 1 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 & 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, environmental (re)assessment, and inventory of resources and supports.
  - ☐ Comprehensive care plan for all health issues with focus on managing chronic conditions.
- ☐ Provide patients and or caregivers with copy of the care plan.
- ☐ Electronically capture care plan information and make it available promptly both within and outside 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 their practitioners about their care by phone and through secure messaging, secure web, or other asynchronous non-face-to-face consultation methods (like email or secure electronic patient portal).

Patient Consent

- ☐ Inform patient that:
  - ☐ CCM services are available
  - ☐ They may have cost sharing responsibilities
  - ☐ Only 1 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)
- ☐ 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).

Capability Highlights:

- Chronic Care Management Services (CCM)
- Remote Patient Monitoring (RPM)
- Annual Wellness Visits (AWV)
- EMR Compatible Solution
- Weekly / Monthly Reporting
- 24/7 patient access to care and health information
- Seamless Billing Integration
- Prompt sharing and using patient health information

Sample Revenue Projections:

Example Revenue Scenario
(State of VA Medical Practice)*

- 280 Enrolled Patients
- 1st Year: $100,000
- 2nd Year and After: $90,000

Example Revenue Scenario
(State of AZ Medical Practice)*

- 224 Enrolled Patients
- 1st Year: $74,000
- 2nd Year and After: $70,000

* Figures represent average assumptions. Each new practice receives a custom revenue projection. Our goal is to assist practices enhance revenue through better patient care without excess overhead.