TABLE 11: Summary of CY 2017 Chronic Care Management Service Elements and Billing Requirements

Initiating Visit- Initiation during an AWV, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of chronic care management (CCM) services.
Structured Recording of Patient Information Using Certified EHR Technology – Structured recording of demographics, problems, medications and medication allergies using certified EHR technology. A full list of problems, medications and medication allergies in the EHR 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 health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week. • Continuity of care with a designated member of the care team with whom the beneficiary is able to schedule successive routine appointments.
Comprehensive Care Management- Care management for chronic conditions including systematic assessment of the beneficiary's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.
Comprehensive Care Plan • Creation, revision and/or monitoring (as per code descriptors) of an electronic patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues. • Must at least electronically capture care plan information, and make this information available timely within and outside the billing practice as appropriate. Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the beneficiary's care. • A copy of the plan of care must be given to the patient and/or caregiver.
Management of Care Transitions • Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. • Create and exchange/transmit continuity of care document(s) timely with other practitioners and providers.
Home- and Community-Based Care Coordination • Coordination with home and community based clinical service providers. • Communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record.
Enhanced Communication Opportunities- Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.
Beneficiary Consent • Inform the beneficiary of the availability of CCM services; that only one practitioner can furnish and be paid for these services during a calendar month; and of their right to stop the CCM services at any time (effective at the end of the calendar month). • Document in the beneficiary's medical record that the required information was explained and whether the beneficiary accepted or declined the services.
Medical Decision-Making- Complex CCM services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner).