Chronic Care Management: Patient Checklist

Patient Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Conditions

*Minimum of 2 to qualify, check all that apply:*

Alzheimer’s disease and related dementia  Arthritis (Osteoarthritis & rheumatoid)

Asthma  Autism spectrum disorders

Atrial fibrillation  Cancer

Chronic Obstructive Pulmonary Disease  Depression

Diabetes  Heart failure

Hypertension  Ischemic heart disease

Osteoporosis  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CCM Service Requirements

Care Plan created and made available to patient electronically

Care Plan is uploaded to the certified EMR

Review co-payment requirement

Explain how to discontinue service

Assign a Care Coordinator

Explain that only 1 Physician can bill these services in a given month

Provide 24/7 access to care

Provide 20 minutes of non-face-to-face care management each month

Note that transitional care services, home healthcare supervision, hospice care supervision or

certain end-stage renal disease services cannot be administered the same month as CCM

services

Explain that patient information may be shared with other providers during the coordination of

care services

Annual Wellness Visit, Initial Preventive Physical Examination or Comprehensive Evaluation and

Management Visit completed

Care Plan Checklist

Problem list; expected outcome and prognosis; measurable treatment goals

Symptom management and planned interventions (including all recommended preventive care

services) Community/social services to be accessed

Plan for care coordination with other providers

Medication management (including list of current medications and allergies; reconciliation with

review of adherence and potential interactions; oversight of patient self-management)

Responsible individual for each intervention

Requirements for periodic review/revision

Patient Consent

*What to discuss at the first visit*

What the CCM service is

How to access the elements of the service

How the patient’s information will be shared among practitioners and providers

How cost-sharing (co-insurance and deductibles) applies to these services

As with other Medicare services, the patient is obligated to make a 20% copayment for CCM services (~$8/ month) and complex CCM services (~$20/month or higher if the monthly service exceeds 90 minutes). However, some of this payment may be fully or partially addressed by coinsurance (e.g., Medicaid for dual eligible beneficiaries or Medigap) and will not be required for the majority of dual eligibles. CCM was CCM: An Overview for Pharmacists March 2017 10 designed to provide Medicare QHPs the funding to invest in additional resources, including personnel and technology, needed to address the complex needs of patients with multiple chronic conditions. Explaining the value the program brings to each patient’s care may encourage them to participate.

When speaking with patients, a potential talking point related to cost-sharing is that although CCM will cost them an additional fee per month (approximately $8), CCM may help avoid the need for more costly face-to-face services in the future by proactively managing patient health, rather than only treating disease and illness.

That only one practitioner can furnish and be paid for the service during a calendar month

How to stop the service.