Chronic Care Management

The Chronic Care Management payment is offered by CMS for the care of patients who have more than two chronic conditions and who are contacted each month for complex care management. The contact must result in an aggregate of 20 minutes of time spend in counseling with the patient by telephone or in person including time spent preparing a plan of care and treatment plan.

The tutorial for SETMA’s preparation for this task includes documentation for:

1. Performed
2. Documented to meet all standards
3. Compared to exclusions such as nursing home admission, home healthcare and transitions of care charges being submitted.
4. Audited to prove that all elements of the Chronic Care Management being done.
The CCM is found at the link surround in green above. The Chronic Care Management Master template is shown next. It includes:

1. Primary and Secondary Insurance designation
2. Patient Status in regard to CCM participation
3. Primary Care Provider and Designated CCM contact
4. Time Tracing function to document time spent monthly on CCM
5. Patient’s Current Chronic Problems
6. Tracked Problems and whether or not they are currently being tracked.
7. Current Medications and whether or not they have been reconciled
8. Current Allergies
9. Referrals
10. Appointment History and Upcoming Appointments.
The CCM requires the patient to have at least two chronic conditions and documentation for each condition being tracked is required. The following is taken from the above template and shows what conditions are being tracked.

When the Diabetes button outlined in green above is clicked the following pick list will be deployed:

There are seven structured data fields for Chronic Conditions for the CCM function; they are:
1. Cardiac Disease
2. CHF
3. Depression
4. Diabetes
5. COPD/Asthma
6. Hyperlipidemia
7. Hypertension

There are several non-designated fields to be used for other chronic conditions.

When completed, each Tracked Problem will have a CCM template similar to the one below for diabetes. When the Diabetes tab above is clicked the CCM tool shown below will be deployed. For diabetes, there will be a HbA1c target with a date for that being achieved. The last three HbA1c will be document automatically. The Diabetes Consortium Data Set which includes targeted goals will be listed as is seen below and a referral tool will be deployable from this template as well.

In addition, there is a place to document the patient's expressed concerns about their diabetes care and a place to denote whether diabetes was discussed in the current CCM contact with the discussion and plan.
Time Tracking

Chronic Care Management

Patient: Larry  Q/med
DOB: 05/01/1959

Primary Insurance: 
Secondary Insurance: 

Patient Status:
Currently active in CCM?: Y  N
CCM Consent completed?: Y  N
Date Completed: Print  08/14/2015
Enrolled in NextMD?: Yes

Primary Care Provider: Holly James L
Designated CCM Contact: 

Time Tracking - Today
Date  Subject

Chronic Care Management Time Tracking

Staff: Jayne A. Nurse
Date: 09/14/2015
Start: 11:18 AM
Stop: 11:38 AM
Total: 20 mins

Subject: Phone Call
Comments: Monthly phone call with patient. Addressed concerns related to diabetes. Patient states he is feeling well and does not need anything until his office visit next week.

Be sure to click “Save” before “Close” or “Clear To Add.”