Checklist: Chronic Care Management

This checklist is intended to provide healthcare providers with a reference to use when responding to Medical Documentation Requests for Chronic Care Management (CCM) Services. It is not intended to replace published guidelines. Healthcare providers retain responsibility to submit complete and accurate documentation.

Check	Documentation Requirements
	Documentation is for the correct beneficiary.
	Documentation contains a valid and legible signature and credentials of all parties involved in patient CCM care.
	Documentation includes evidence of a comprehensive care plan being established, implemented, revised or monitored (i.e., measurable treatment goals, medication reconciliation, coordination with home/community service providers and timely receipt of all recommended preventative care services).
	Documentation includes evidence of the beneficiary having multiple (two or more) chronic conditions expected to last at least 12 months, or until death of the beneficiary.
	Documentation includes evidence that the chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
	Documentation supports total time per month spent providing chronic care management services.
	Documentation includes evidence of an initiating visit for new patients or patients not seen within one year prior to commencement of CCM.
	Documentation includes evidence of patient consent prior to initiation of CCM services. Consent may be verbal or written but must be documented in the medical record, and includes informing them about: • The availability of CCM services and applicable cost-sharing; • That only one practitioner can furnish and be paid for CCM services during a calendar month; • The right to stop CCM services at any time (effective at the end of the calendar month).
	If applicable and required, submitted documentation should include a beneficiary waiver of liability.

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