Medicare Program Supports Practices and Patients in Managing Chronic Illnesses

Chronic Care Management (CCM) is recognized as a critical primary care service that contributes to better patient health and care. It focuses on engaging patients with 2 or more chronic conditions in their own care and helping them make informed decisions about their health.

What is CCM?
CCM is care coordination provided outside of regular office visits for patients with multiple chronic conditions. Practitioners can bill for CCM when there is at least 20 minutes of clinical staff time—directed by a physician or other qualified health care professional—spent on managing and coordinating care for eligible patients in one calendar month.

The following activities count toward the minimum monthly service time for CCM:

- Providing care coordination outside of regular office visits by phone or email
- Sharing a patient's health information with their other health care providers
- Providing referrals, facilitating follow-ups, and other transitional care management activities
- Coordinating and documenting home- and community-based services in the patient's medical record

Getting Started With CCM
Here are a few tips to help you get started with implementing CCM in your practice:

- Watch this video to understand the elements of CCM, its benefits for patients and practices, and how to deliver it in your own practice.
- Print this flyer to use as a tool to discuss CCM with eligible patients who may benefit from its services.
- Learn about billing and other requirements to begin delivering CCM in your practice.
- Discuss CCM with your clinical staff, who can deliver these services under a billing provider, saving time and resources. This may be a more efficient, cost-saving approach for many practices.