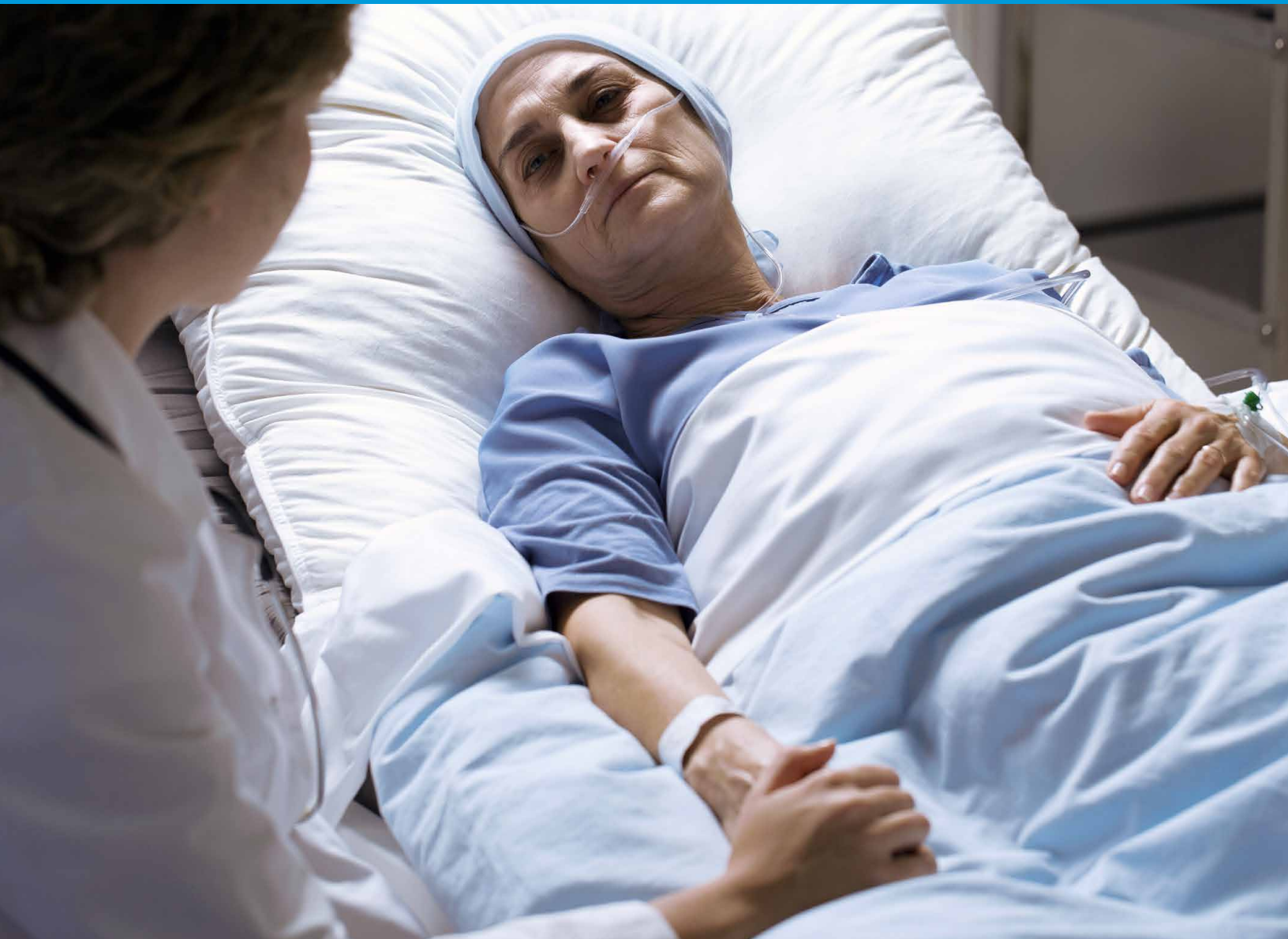


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Chronic Care Management (CCM) Toolkit



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This resource was developed utilizing Centers for Medicare & Medicaid Services (CMS) guidelines and requirements and can be referenced for further details.

What is Chronic Care Management (CCM)?

Chronic Care Management (CCM) is an essential aspect of primary care that enhances patient outcomes and satisfaction. The Centers for Medicare & Medicaid Services (CMS) acknowledges the time and effort required to deliver CCM services and has established dedicated billing codes to compensate providers for the additional support they offer between appointments. These services help Medicare, and dually eligible (Medicare and Medicaid) patients stay on track with their treatments and health goals.

CCM billing codes apply to services provided to patients with two or more chronic conditions that pose a significant risk of death, acute exacerbation, decompensation, or functional decline. With over two-thirds of Medicare beneficiaries managing multiple chronic conditions, many patients can benefit from CCM, including the ongoing support provided between visits.

By implementing CCM, providers can offer more coordinated, patient-centered care that improves health outcomes and enhances patient satisfaction. This toolkit offers resources for healthcare professionals, patients and professional organizations, and community groups. It includes guidance on getting started, fact sheets outlining CCM requirements, and educational materials to share with patients.

CCM involves care coordination outside of regular office visits for patients with two or more chronic conditions expected to last at least 12 months or until the patient's death. These conditions must also place the patient at significant risk of death, acute exacerbation, decompensation, or functional decline.

According to the Centers for Medicare & Medicaid Services (CMS), one in four adults, including 70% of Medicare beneficiaries, have multiple chronic conditions, making them eligible for CCM services. Medicare began reimbursing CCM separately under the Physician Fee Schedule (PFS) in 2015. Practitioners can bill for CCM monthly when at least 20 minutes of non-face-to-face care coordination is provided by clinical staff under the direction of a physician or other qualified healthcare professional for a Medicare patient with multiple chronic conditions.

Starting Your Practice with CCM

CCM allows you to provide the coordinated care your patients need and deserve while also supporting the growth and sustainability of your practice and enhancing patient satisfaction. Comprehensive guidance on implementing or expanding CCM services—including eligibility criteria, covered services, billing requirements, time allocation, and payment details.

Eligibility

Patients eligible for separately payable CCM services include Medicare beneficiaries and dually eligible individuals (Medicare and Medicaid) who have two or more chronic conditions expected to last at least 12 months or until the patient's death. These conditions must also place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. These are the sole diagnostic criteria for CCM eligibility.

Examples of chronic conditions that may qualify include but are not limited to: Alzheimer's disease and related dementias, arthritis, asthma, atrial fibrillation, autism spectrum disorders, cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD), depression, substance use disorders, diabetes, hypertension, and infectious diseases such as HIV/AIDS.

CCM services may be billed by*:

- Physicians and certain Non-Physician Practitioners (Physician Assistants, Clinical Nurse Specialists, Nurse Practitioners, and Certified Nurse Midwives)
- While services may be provided by a clinical staff person, the service must be billed under Physicians and certain Non-Physician Practitioners

**Only one physician, NPP, RHC or FQHC, and one hospital, can bill CCM for a patient during a calendar month.*

Many activities can count toward the minimum monthly service time to bill for CCM.

CCM involves providing patient care outside of in-person visits, such as through phone calls or secure email. It includes care coordination activities that go beyond traditional face-to-face encounters, such as telephone communication, reviewing medical records and test results, offering self-management education and support, and exchanging health information with other healthcare professionals. Some face-to-face interactions with patients or other providers may also be part of CCM.

Key components of CCM include:

- Sharing the patient's health information: Ensuring other healthcare providers have access to the patient's electronic health plan.
- Managing care transitions: Coordinating referrals and follow-ups after hospital discharge.
- Collaborating with home- and community-based service providers: Documenting these interactions in the patient's medical record.

Note: In special circumstances, Chronic Care Management (CCM) and Transitional Care Management (TCM) services can be billed during the same month as long as there is no overlap in services.

The following is a sample of actions that are required to bill for CCM:

- **Obtaining patient consent:** Secure the patient's verbal or written agreement to receive CCM services after explaining any applicable cost-sharing, their right to discontinue services at any time, and that only one practitioner or hospital can provide CCM services per calendar month. Document this consent in the patient's medical record.
- **Developing and managing a Comprehensive Care Plan:** Create, implement, revise, or monitor an electronic care plan that tracks the patient's health conditions. Share the plan with the patient or their caregiver as appropriate. For complex CCM, the care plan must be newly established or significantly updated. Ensure relevant healthcare providers have access to the plan as needed.
- **Ensuring continuity of care:** Assign a designated care team member to coordinate the patient's care, schedule appointments, and provide ongoing support in managing their chronic conditions.

- **Utilizing certified Electronic Health Records (EHRs):** Record key patient data, including demographics, medical conditions, medications, and medication allergies.
- **Providing 24/7 patient access:** Ensure the patient has a way to contact your practice at any time for urgent care management needs.

Speaking With Staff About CCM

The following information is intended to help healthcare providers and practices educate their staff about CCM services. It does not replace official guidance on delivering CCM services or seeking reimbursement.

What Is CCM?

CCM involves providing care management and coordination services to patients with two or more chronic conditions.

Examples of chronic conditions include, but are not limited to:

- Alzheimer’s disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Hypertension
- Infectious diseases such as HIV/AIDS
- Substance Use Disorders

What do we need to do to furnish and bill for CCM?

To be eligible to bill for CCM services, the clinician’s practice must meet specific requirements. While it may take time and effort to fully implement these changes, they will help improve the care you provide.

By offering CCM services, practices can deliver comprehensive care management that focuses on managing chronic conditions and ensuring patients receive all recommended preventive services, helping them better manage their health.

For each patient receiving CCM services, the clinician will create a comprehensive assessment and care plan that addresses all health issues, including medical and psychosocial aspects, with a special emphasis on chronic conditions. The practice will also:

- **Engage and educate the patient:** Develop and share the care plan with the patient (and any caregivers).
- **Review and update the care plan:** Periodically assess and revise the plan as needed.
- **Provide person-centered care:** Tailor care to the individual’s specific needs.
- **Collaborate with home- and community-based services:** Work with providers such as adult day health programs, personal care workers, home-delivered meal services, etc.
- **Educate the patient:** Provide tools to help patients manage their chronic conditions and medications.
- **Medication reconciliation:** Ensure the patient’s medication list is accurate, especially when prescribed by other healthcare providers, and ensure the patient has access to medications after care transitions.
- **Manage care transitions:** Share relevant information with the practice and other providers and follow up with the patient after referrals or hospital discharges.
- **Use standardized technology:** Employ certified EHR systems to document patient information (demographics, medical conditions, medications, allergies) and share information in a timely manner with other healthcare providers.
- **Provide continuous care:**
 - 24/7 access to a qualified healthcare professional who can address urgent needs outside of regular office hours.
 - Enhanced communication methods, such as secure email portals, allow patients to contact the practice at any time.
- **Time tracking:** A mechanism and workflow for tracking time spent providing these services.

What is required of patients?

Patients must provide advance consent to ensure they are actively involved in their treatment plan and fully aware of any applicable cost sharing. They must understand that only one healthcare practitioner and/or one hospital can provide these services in a given month, meaning they cannot receive CCM from multiple providers. Patients should not give consent for these services to anyone else. Additionally, they should be informed that they can request to discontinue CCM at any time. Informed consent may be given verbally, but you may also choose to use electronic or paper forms.

Note: Standard cost-sharing rules apply to CCM services, meaning many patients will be responsible for the usual Medicare Part B cost-sharing (deductible and coinsurance) if they do not have supplemental (“wraparound”) insurance. However, most dually eligible individuals (those with both Medicare and Medicaid) are not responsible for cost-sharing. Medigap plans cover cost-sharing for CCM, and many individuals have Medigap or other supplemental insurance to assist with this.

Technology Barriers and Alternative Communication Methods

Home-based primary care (HBPC) providers often face significant challenges when it comes to technology barriers, which can impact the delivery of care to patients. Many HBPC patients, particularly those in rural or underserved areas, may have limited access to reliable internet, which hinders the use of telehealth and other digital communication tools. Additionally, some patients may struggle with using technology due to age, cognitive impairment, or lack of digital literacy. To overcome these barriers, HBPC providers can explore alternative communication methods such as phone calls, text messages, or even in-person visits when feasible. These alternatives help ensure that patients receive the necessary care and maintain consistent communication with their providers, while minimizing the digital divide. Adapting communication strategies to meet patients’ needs is essential for improving care delivery and fostering better patient-provider relationships in home-based settings.

Emergency And Safety Protocols in Home-Based CCM

Emergency and safety protocols in home-based Chronic Care Management (CCM) are crucial for ensuring patient safety and timely intervention in case of health crises. Home-based care providers must have clear, well-defined procedures for handling medical emergencies, such as sudden health deterioration, falls, or complications related to chronic conditions. This includes ensuring that patients and caregivers are aware of the steps to take during an emergency, such as how to contact emergency services, when to seek immediate medical attention, and how to manage chronic conditions that may lead to acute events. Providers should also maintain up-to-date medical records and have emergency contact information readily available, including nearby hospitals or urgent care centers. Additionally, safety protocols should include regular check-ins with patients, especially those with cognitive or mobility impairments, to identify risks before they lead to emergencies. Using technology, such as remote monitoring tools or emergency alert systems, can enhance real-time tracking of patient health and facilitate quick response in critical situations. By establishing and reinforcing emergency and safety protocols, HBPC providers can minimize risks and ensure a rapid, coordinated response when urgent care is needed.

Remote Monitoring and Telehealth Integration

Remote monitoring and telehealth integration in Chronic Care Management (CCM) are essential components for delivering continuous, high-quality care to patients with chronic conditions. These technologies allow healthcare providers to track patient health metrics, such as blood pressure, glucose levels, or weight, in real-time, without requiring patients to visit the clinic. This ongoing monitoring helps detect early signs of deterioration or complications, enabling timely interventions and reducing the need for emergency visits or hospitalizations. Telehealth integration facilitates virtual consultations, offering patients greater access to care from the comfort of their homes, particularly for those with mobility issues or living in remote areas. For HBPC providers, incorporating remote monitoring and telehealth tools enhances communication with patients and allows for more frequent check-ins, improving the management of chronic conditions. However, successful integration requires ensuring that patients are comfortable with the technology and have access to the necessary devices and internet connectivity. Additionally, providers must ensure compliance with privacy and security regulations, such as HIPAA, to protect sensitive health information. Overall, remote monitoring and telehealth integration improve care efficiency, increase patient engagement, and support better health outcomes for patients managing chronic conditions at home.

Benefits

The benefits of offering CCM services in your practice:

- Improved patient care and enhanced patient satisfaction.
- Increased reimbursement for the practice by providing coordinated CCM services.

Benefits of offering CCM services to your patients:

By offering CCM services and billing through Medicare, eligible patients benefit from having a dedicated team member who manages their care and regularly interacts with them. This team member helps patients plan for better health, stay on track with treatments, medications, referrals, and appointments, and provides regular check-ins and reminders.

For regular (non-complex) care, patients can receive at least 20 minutes per month dedicated to care coordination.

For complex CCM, patients may receive additional time (60 minutes or more) and services.

Encouraging patients to use CCM services provides valuable support between visits, ensuring they stay on top of their care.

Explaining CCM to Patients

The following information is intended to help healthcare professionals explain CCM services to patients and caregivers, outlining the benefits to the patient and their caregiver, and their role in coordinating these services.

What is CCM?

If you have Medicare or both Medicare and Medicaid and are managing two or more chronic conditions, Medicare offers Chronic Care Management (CCM) services to help you better manage your health and spend more time enjoying life in good health.

If you have chronic conditions such as Alzheimer's disease and related dementia, arthritis, asthma, atrial fibrillation, autism spectrum disorders, cancer, cardiovascular disease, chronic obstructive pulmonary disease (COPD), depression, diabetes, hypertension, substance use disorder, or infectious diseases like HIV/AIDS, CCM is an essential part of the care we can provide to support your health and well-being.

What Are the Benefits of CCM?

Regular participation in CCM allows you to better manage your care and focus on your health. It helps you work toward your health and quality of life goals, while reducing the risk of health setbacks like emergency department visits, falls, or worsening conditions.

Coordinated care means you will receive personalized attention and support from a healthcare provider who knows you and your health conditions, helping you stay healthy.

Informed Consent Notification

Patients must provide consent to receive CCM services. This consent can be given verbally or in writing and must be documented in the medical record. Informed consent is required only once unless the patient switches to a different CCM practitioner.

The following language is a guide for having conversations seeking verbal consent for CCM services. Please ensure you cover the key points below:

- Your care team will review your medical records and may contact you if needed. They will also check in with you to keep you informed about how they are working to support your health.

Questions to ask:

- Do you have any questions about the CCM services?
- Do you agree to receive the CCM services?
- Do you understand that a monthly fee could apply to the CCM services?
- How would you prefer to be contacted?
- What is the best time for us to contact you?

Additionally, the care team in your practice will share relevant health information to make sure we can discuss everything when we meet again.

Please note: Standard cost-sharing rules apply to CCM services, meaning many patients will be responsible for the usual Medicare Part B cost-sharing (deductible and coinsurance) if they do not have supplemental (“wrap-around”) insurance. However, most dually eligible individuals (those with both Medicare and Medicaid) are not responsible for cost-sharing. Medigap plans also provide wrap-around coverage for CCM cost-sharing, and many individuals have Medigap or other supplemental insurance to assist with this.

How Will We Be Paid for Providing CCM Services to Individuals with Medicare Fee-for-Service?

Payment Information

CPT Code	Descriptor
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).
99487	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of comprehensive care plan, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.
99489	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or significant revision of comprehensive care plan, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month (List separately in addition to code for primary procedure).
99491	Chronic care management services, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of a physician or other qualified healthcare professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored.
99437 (add-on to 99491)	Additional 30 minutes of a physician or qualified professional time each month for patients with two or more chronic conditions.

Master List- Diagnosis (CCM) *

- Congestive Heart Failure (I50.9)
- Cancer- Lung, Breast, Liver, Colorectal, Prostate (C34.90)
- Leukemias and Lymphomas (C95.92)
- Chronic Obstructive Pulmonary Disease (COPD) (J44.9)
- Asthma (J45.909)
- Coronary Artery Disease (CAD) (D59.12)
- Hypertension (I10)
- Diabetes Insipidus (E23.2)
- Type 2 Diabetes with diabetic neuropathy (E11.40)
- Chronic Kidney Disease (N18.9)
- Ischemic Heart Disease (I25.9)
- Stroke / Transient Ischemic Attack (I63.9)
- Atrial Fibrillation (I48.91)
- Obesity (E66.9)
- Osteoarthritis (M19.90)
- Alzheimer's Disease (G30.9)
- Depression (F32.A)
- Dementia (F03.90)
- Anemia (D64.9)
- Multiple Sclerosis (G35)
- Hypothyroidism (E03.9)
- Hyperlipidemia (E78.5)
- Post-Traumatic Stress Disorder (PTSD) (F43.10)
- Anxiety Disorders (F41.3)
- Schizophrenia (F20.9)
- Bipolar Disorder (F31.9)
- Cystic Fibrosis (E84.9)
- Sickle Cell Disease (D57.1)
- Spinal Cord Injury (S34.139S)
- Glaucoma (H40.9)
- Benign Prostatic Hyperplasia (N40.1)
- Fibromyalgia (M79.7)
- Chronic Pain (G89.29)
- Human Immunodeficiency Virus and/or Acquired Immunodeficiency Syndrome (HIV/AIDS) Traumatic Brain Injury (B20)
- Hepatitis A (B15.9), Hepatitis B (acute or unspecified) (B19.10), Hepatitis B (chronic), (B19.10) Hepatitis C (acute) (B19.20), Hepatitis C (chronic) (B19.20), Hepatitis C (unspecified), Hepatitis D (B18.0) , Hepatitis E (B17.2)
- Cirrhosis (K74.60)
- Muscular Dystrophy (G71.00)
- Rheumatoid Arthritis (M06.9)
- Opioid Use Disorder (F11.94)
- Peripheral Vascular Disease (PVD) (I73.9)

Chronic Care Management (CCM) Script for Talking to Patients

Good morning/afternoon, [PATIENT'S NAME],

My name is [YOUR NAME], and I'm a clinical coordinator with [ORGANIZATION NAME], working alongside your provider, [PROVIDER NAME, if known]. I'm reaching out to share information about a valuable program available to you called Chronic Care Management, or CCM.

CCM is like having a dedicated health coach. It connects you with a trained healthcare professional who will regularly check in with you to support your health needs. This can include help with medication refills, arranging specialist referrals, coordinating transportation, or ordering medical equipment.

As part of this program, we also offer Remote Patient Monitoring, or RPM. With RPM, we can provide devices like a blood pressure cuff to track your health in real time. If any readings are abnormal, a healthcare professional will be notified and will reach out to check on you. If needed, we can arrange a same-day telemedicine visit to address concerns and help avoid unnecessary ER visits.

You'll also have access to a 24/7 phone line to speak with a healthcare provider or nurse whenever you need assistance. We'll schedule regular check-ins to ensure the program continues to meet your needs.

Please let me know if you have any questions or would like to learn more about enrolling in CCM.

Best regards,

[YOUR NAME]

[ORGANIZATION NAME]

[CONTACT INFORMATION, if applicable]

Frequently Asked Questions (By Patients):

1. What is Chronic Care Management?

Chronic Care Management (CCM) is a Medicare program designed to provide coordinated care for patients with two or more chronic conditions expected to last at least 12 months or until the end of life. It offers support outside of regular office visits, including personalized care plans, 24/7 access to a care team, and assistance with managing medications, appointments, and health goals. CCM aims to improve your quality of life and help you manage your conditions more effectively.

2. Who is eligible for CCM?

You are eligible for CCM if you are a Medicare beneficiary with two or more chronic conditions, such as diabetes, hypertension, arthritis, heart disease, or others, that are expected to last at least 12 months or until the end of life. These conditions should place you at risk of worsening health or functional decline. Your healthcare provider can confirm if your conditions qualify.

3. What kind of services will I receive through CCM?

CCM services include:

- A dedicated care coordinator who contacts you at least monthly to check on your health and goals.
- A personalized care plan outlining your health conditions, medications, and care needs.
- 24/7 access to a care team for urgent needs.
- Help with scheduling appointments, refilling prescriptions, and coordinating care between your doctors, specialists, and pharmacies.
- Support for social needs, such as finding community resources for food, housing, or emotional support.
- These services are mostly provided remotely via phone or online, though in-person visits may occur if needed.

4. Will CCM cost me anything?

Yes, CCM typically involves a monthly copay. Medicare Part B covers 80% of the cost after you meet your deductible, leaving you responsible for about a 20% copay, which averages around \$12 per month. If you have secondary insurance (like Medigap), it may cover the remaining cost. Dual-eligible Medicare and Medicaid patients may be exempt from copays. Always check with your provider for specific costs.

5. Do I need to consent to participate in CCM?

Yes, you must give informed consent to enroll in CCM, which can be verbal or written. Your provider will explain the program, including services, costs, that only one provider can bill for CCM per month, and your right to stop the program at any time. Consent ensures you understand and agree to participate.

6. Can I stop participating in CCM if I change my mind?

Yes, you can opt out of CCM at any time by notifying your provider or care coordinator via phone or in writing. There is no long-term commitment, and you can re-enroll later if needed.

7. How is CCM different from my regular doctor visits?

CCM provides ongoing support between office visits. While regular doctor visits focus on in-person exams and treatment, CCM offers non-face-to-face care, such as monthly check-ins, care coordination, and help with managing your chronic conditions. It ensures continuous support to prevent health issues and keep your care on track.

8. Will I still need to see my doctor in person?

Yes, CCM complements but does not replace in-person visits. You'll still need regular check-ups, such as annual wellness visits, to monitor your health. CCM helps ensure you follow your care plan and prepares you for those visits by coordinating care and addressing issues early.

9. Can I enroll in CCM with more than one doctor?

No, only one healthcare provider can bill Medicare for CCM services per month. If you're enrolled with one provider, another cannot bill for CCM unless you switch providers. Your care coordinator will confirm you're not enrolled elsewhere before starting.

10. How will CCM benefit me?

CCM improves your health by:

- Helping you stick to your treatment plan, reducing the risk of complications.
- Providing regular support to manage symptoms and prevent hospital visits.
- Coordinating care between your doctors to avoid gaps or errors.
- Offering access to resources for better self-management and quality of life.
- Patients in CCM often have better health outcomes and fewer emergency room visits or hospitalizations.

11. What chronic conditions qualify for CCM?

Common conditions that may qualify include, but are not limited to:

- Diabetes
- Hypertension (high blood pressure)
- Heart disease
- Arthritis
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Cancer
- Alzheimer's disease or dementia
- Asthma

Your provider will determine if your specific conditions meet Medicare's criteria (expected to last at least 12 months and pose a risk of worsening health).

12. How do I enroll in CCM?

To enroll, talk to your healthcare provider. They will confirm your eligibility, explain the program, and obtain your consent. Enrollment can often be done over the phone or during an office visit, sometimes in less than five minutes. An initiating visit (like an annual wellness visit or evaluation) may be required if you're a new patient or haven't seen the provider in over a year.

13. What is a comprehensive care plan, and will I get a copy?

A comprehensive care plan is a personalized document listing your health conditions, medications, goals, other providers, and community resources. It's created by your care team to guide your care. You or your caregiver can access or receive a copy of this plan to stay informed about your treatment.

14. How often will I hear from my care coordinator?

Your care coordinator will contact you at least once a month for a minimum of 20 minutes to review your health, care plan, and needs. These check-ins are usually by phone or online, but you can also reach out to them anytime, including 24/7 for urgent issues.

15. Can CCM be provided by specialists, or is it only for primary care?

CCM can be provided by primary care providers or specialists (e.g., cardiologists, nephrologists) as long as they oversee your care and you meet eligibility criteria. However, only one provider can bill for CCM each month.



The HCCIntelligence™ Community provides exclusive access to a wealth of resources tailored for home-based medical care professionals. Benefit from free access to our entire library of online courses and HCCIntelligence™ Premier Resources. Engage in 1-on-1 Office Hour sessions with a subject matter expert in home-based medical care, including a nationally Certified Professional Coder (CPC®). Participate in a Discussion Forum to connect with peers, including our House Call Advisor Network, and stay on the leading edge of home-based medical care. Utilize our propriety AI-driven chatbot, built on the expertise of seasoned house call professionals, to access expert-curated home-based medical care insights, best practices, and real-time solutions.

Join the HCCIntelligence™ Community at bit.ly/hccintelligence-community.



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