

A Proposal Requesting CMS to Implement the CCCC Codes for CY 2014

from the Complex Chronic Care Coordination (CCCC) Workgroup

I. Introduction: The Importance of implementing the CCCC codes in CY 2014

The Workgroup believes that implementing the CCCC codes in 2014 would accomplish several important objectives: (1) it would increase access to CCCC services for the patients who are most likely to benefit; (2) it would reimburse practices who are capable of, and may already be, providing these services; and (3) it would allow those practices who would like to provide CCCC services with the policy guidance and the financial wherewithal to develop the infrastructure needed for CCCC.

The Workgroup believes that implementing these codes is an important opportunity for CMS and the medical community to work together to transform care for Medicare patients away from the fee-for-service system by allowing CMS and the medical community to gain experience with CCCC services with the long term objective of coming to a common understanding of the optimal place of CCCC services in the care continuum, with the short term benefit of immediately improving care to the sickest, most frail Medicare patients.

II. Policy Proposal: What Policy Requirements Should CMS Establish With Respect to Medical Practices Who Wish to Report CCCC Services?

a. Definition of a Practice

A practice may be office -based, mobile, hospital- based or part of a health system and it may be owned by physicians, qualified health care providers, a hospital or other entity, as allowed under applicable law. Therefore, the CCCC codes should be payable off the physician fee schedule, the hospital outpatient prospective payment system (HOPPS) and to hospitals that are not paid under HOPPS (e.g., critical access hospitals).

b. Practice Requirements and Capabilities

The practice reporting the code must have established, or be in the process of establishing, a care plan for the patient. The practice also must be responsible for executing the care plan. This care plan must be medically necessary (see patient attributes below), part of the medical record and available upon request (see documentation requirements below).

The Workgroup is aware of the definition of an APCP in the CMS Advanced Primary Care Practice Demonstration Program and that CMS has stated that it is considering ways of making enhanced payments to APCPs. The Workgroup believes that all practices who wish to be eligible to report CCCC services must have the following capabilities:

- Provide 24/7 access to care providers or clinical staff
- Use a standardized methodology to identify patients who meet the CMS requirements for CCCC services (i.e., risk-stratify patients)

- Have an internal care coordination process/function whereby a patient identified as meeting the requirements for CCCC services starts receiving those services immediately upon referral
- Include a care plan using a standardized form and format in the medical record
- Be able to engage and educate patients and caregivers as well as coordinate care across the medical neighborhood, as appropriate for each patient

c. Care Plan Requirements

A care plan is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, cognitive and functional assessment, symptom management, planned interventions, medication management, environmental evaluation, caregiver assessment, community/social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identify the individuals responsible for each intervention, requirements for periodic review and, when applicable, revision, of the care plan.

A care plan is part of the medical record and is typically required for patients living in a non-facility setting with multiple medical problems who (1) receive care from one or more Medicare providers/suppliers and (2) because of impairment in the ability to perform one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs)¹ are unable to adhere to the treatment plan without substantial assistance from a caregiver. Only a small minority of patients in most practices would be expected to require such care plans.

CCCC codes are reported on a calendar month basis - not on a “per 30 day” basis. Not all patients who have care plans are eligible for CCCC reporting. On months where a care plan is unchanged or requires minimal change (e.g., only a medication change or an order for, or adjustment in, a treatment modality such as physical therapy), the CCCC codes should not be reported. This is because such patients are typically clinically stable, there is little need to contact other providers or educate the patient and caregiver about the care plan and frequent monitoring is not required.

Note: The Workgroup would be happy to answer any questions from CMS regarding the care plan and would be happy to provide additional detail if CMS wishes to more specifically describe the activities that should be included in the care plan.

d. Definition of Substantial Revision to the Care Plan

Substantial revision to a care plan typically is required when the patient’s clinical condition changes sufficiently to require: significantly more intensive staff monitoring, significant changes in the treatment regimen, and significant time to educate the patient/caregiver about the patient’s condition/change in treatment plan and prognosis.

e. Reporting Requirements for CCCC Services

CCCC may be reported for a month when (1) the care plan is in the process of being developed by the practice or (2) if the care plan is already in place, when, due to the medical needs of the patient, it

¹ An ADL is a basic activity required to sustain life (e.g., feeding, toileting, bathing) and an IADL is a life function required to maintain independence (e.g., cooking, managing money, take medications correctly)

undergoes substantial revision or refinement. In either case, the practice reporting the code must be responsible for executing/coordinating the care plan and any revisions/refinements to the plan.

By reporting the code, the practice/signatory is attesting that the practice is capable of - and is - executing/coordinating the original care plan and the revised care plan. Further, the practice is attesting that a care plan is being implemented by appropriately licensed/credentialed clinical staff. Only time spent in activities performed by appropriately trained, licensed and, when applicable, credentialed clinical staff who are a cost to the practice reporting the code may be counted towards care coordination time. In the case of states where licensure or credentialing of appropriate clinical staff is not required, the training and education of those clinical staff members must be in compliance with any applicable state requirements. Proof of staff licensure/credentialing, education and training must be available upon request.

Time spent by entities other than the billing entity, such as home health agencies on CCCC activities may not be counted towards care coordination time. Time spent by practitioners who may independently bill Medicare, such as advanced practice nurses (APNs) and licensed clinical social workers (LCSWs) on care coordination activities, may only be counted towards CCCC time if those activities are a cost to the practice and the practitioner performing those activities does not bill for them (in addition to CCCC). The Workgroup notes that the CPT descriptor for the base CCCC codes includes 60 minutes of clinical staff time and that the actual clinical staff time requirement for reporting the base CCCC codes, according to CPT convention, is 31 minutes (i.e., more than 50% of the time in the descriptor). It is also the Workgroup's understanding that for many time -based codes, CMS policy is in agreement with this convention. As stated above, only time spent by clinical staff who are a cost to the practice may be counted towards the requirements for the CCCC code(s).

f. Clinical Attributes of Patients for Whom CCCC is Reported

The Workgroup considered many options and reviewed several methodologies for identifying patients who should be eligible for CCCC services, including, the criteria used for the Independence at Home Demonstration Project and Gunderson Health (Berry, et al. Care Coordination for Patients With Complex Health Profiles in Inpatient and Outpatient Settings. Mayo Clin Proc Feb 2013; Vol. 88(2); p. 186-196). Based on its review, the Workgroup determined that patients who are eligible for CCCC reporting should have a baseline level of medical complexity and usually, but not always, have a superimposed acute or sub-acute change in their health care needs that necessitate a significant change in the care plan. The Workgroup believes these criteria are similar to those it reviewed but are more appropriate and targeted to the general Medicare population.

Patient Baseline:

- The beneficiary must reside in a non-facility setting (e.g., home, assisted living facility, domiciliary) (**required element**),

And two of the following:

- Multiple chronic conditions,
- Taking multiple medications,
- Requires the substantial assistance of a caregiver to perform ADLs, and/or IADLs and to comply with the care plan, or

- Has, over the last six months been hospitalized , has had two or more visits to the emergency department, and/or been a resident in a Skilled Nursing Facility under Medicare Part A.

Note: It is possible for patients with one very severe condition or for patients on only a few medications to qualify - but this would be rare.

Additional Clinical Issues which Support Reporting CCCC:

- Deterioration in the patient such that there is an imminent risk of hospitalization or an ED/ Urgent Care visit without appropriate clinical intervention, managing the patient at home is appropriate and/or managing the patient in the hospital is inappropriate (e.g., the patient is terminally ill), or
- Significant medication management is required

And

- Due to the change in the patient’s condition and because the patient is unable to care for him/herself, close monitoring by the practice is required,

The Workgroup notes that some patients may meet the requirements for CCCC although they do not have any of the “additional clinical issues” described above. In such cases, the care plan must document the clinical basis for the significant change in the care plan and why the patient met the requirements for CCCC services.

The Workgroup considered using specific diagnoses or conditions (e.g., congestive heart failure, dementia), possibly in conjunction with a recent hospitalization, to define the universe of patients eligible for CCCC. Such an approach could be consistent with targeting patients at high risk of readmission and could make it possible to use claims data to understand how the CCCC codes are being used. However, after considerable discussion, the group felt that this approach was not restrictive enough, could result in over utilization, and would likely exclude many specialties from using the codes.

The Workgroup also considered the issue of children. This proposal is focused on the care of adults; however, the Workgroup would be pleased to provide additional information to CMS regarding what modifications might be needed to better define the use of the CCCC codes when reported for young children.

g. Beneficiary Protections

Because Medicare beneficiaries have a 20% coinsurance requirement for most Part B services, including CCCC services, it is important that beneficiaries be aware that they are receiving CCCC services, that they understand that those services will be billed to Medicare and that they are obligated to pay the 20% coinsurance. Practices who believe they meet the CMS requirements for reporting CCCC services, and who intend to report CCCC services to Medicare should take the following actions:

- At the time a care plan is created, notify the Medicare beneficiary (and caregiver, if applicable) for whom the plan is being created, that the practice provides non-face-to-face CCCC services and that these services may be billed to Medicare from time-to-time. This notification should include a description of the services and how the practice determines whether such services are

medically necessary. This information can be provided orally or via a fact sheet; however, the notification must be documented in the care plan. This notification should be updated periodically, but no less frequently than once a year.

- For any calendar month where the practice determines that it has met the requirements to report CCCC services, a notification to the Medicare beneficiary (and caregiver) that a bill will be submitted to Medicare for CCCC services must be sent stating: that he/she has been receiving CCCC services during that calendar month, the reason(s) why the services were provided and a description of the services provided. The notice should give the beneficiary the opportunity to ask questions about the CCCC services provided as well as to dispute whether those services were provided. The notice may be delivered in person (e.g., at the time of an office visit) or sent by mail, email or facsimile. The notice must be sent before the practice submits the claim for CCCC and must be given each month for which a CCCC service is billed. A copy of the notice should be part of the care plan.

h. Documentation Requirements

The care plan and any revision/refinement to that plan must be documented in the medical record and available upon request. Each practice should use a standard form and format for care plans which is separate and distinct from the office progress notes and which includes the specific items discussed in this section. However, there is no requirement that the practice perform duplicative documentation (e.g., document the same activities in the care plan and the progress notes). For example, on a date where the care plan is updated, the progress note can simply refer to the documentation in the care plan.

The activities performed by clinical staff members, and the time spent on those activities, must be documented in the medical record and available upon request if they are intended to count toward the required CCCC clinical staff time. The documentation should be made by the clinical staff who performed or supervised the activity. For example, if two or more clinical staff members meet for 15 minutes to coordinate the care of a patient. The total time recorded should be 15 minutes and only one of the clinical staff needs to document the meeting. However, when a physician meets with a clinical staff member as part of CCCC, the physician may count her time towards the physician work and the clinical staff member may count her time towards the required clinical staff time for the CCCC code.

i. Reporting Other Evaluation & Management Services

The Workgroup agrees that CMS should follow the CPT guidelines for which services may not be reported during the month in which a CCCC service(s) is reported.

The following organizations have signed-on in support of this proposal:

- | | |
|---|--|
| - AMDA – Dedicated to Long Term Care Medicine | - American College of Chest Physicians |
| - American Academy of Family Physicians | - American College of Physicians |
| - American Academy of Home Care Physicians | - American Geriatrics Society |
| - American Academy of Neurology | - American Nurses Association |
| - American Academy of Pediatrics | - American Osteopathic Association |
| - American Academy of Physician Assistants | - American Thoracic Society |