

# Documentation for CCC Reimbursement

| **General Documentation Practices for TCM, CCM, and CCC** | | |
| --- | --- | --- |
| Documentation Component | Potentially Performed By | Potential Changes Needed |
| Date of hospital discharge | Front office staff |  |
| Receives discharge documents | Front office staff |  |
| Date and time nurse initiates call with patient to conduct medication reconciliation | Nurse calls patient prior to visit to check medications being taken, prescriptions filled, and health record updated |  |
| Review of pending lab results (report) | Nurse ensures lab results are present in health record |  |
| Documentation of patient concerns/questions during call | Nurse responds to any patient concerns/questions and documents in health record |  |
| Order for new labs | Nurse determines if new labs need to be ordered (nurse or provider documents order) |  |
| Date and time nurse completes call with patient | Nurse documents in health record |  |
| Date and time provider communication with patient initiated (e.g., within two days of discharge) | Provider documents in health record |  |
| Place of service (facility/non-facility) | Provider documents direct contact, telephone or email contact in health record |  |
| Medical decision making | Provider documents medical decision making in health record |  |
| Date and time provider communication with patient ends | Provider signs off on documentation in health record |  |
| Arrangement for face-to-face visit (7 or 14 days per provider recommendation in health record) | Front office staff |  |
| Office receives lab results and other documents | Front office staff ensures information is placed in patient’s health record |  |
| Pre-visit planning conducted (e.g., new lab results, medication issues as advised by pharmacist, prescription fill issues as notified by pharmacy) | Nurse conducts and documents in health record including date, time, and findings |  |
| Date and time face-to-face visit with physician initiated | Physician documents in health record |  |
| Medication reconciliation at time of face-to-face visit | Physician conducts and documents in health record |  |
| Medical decision making | Physician documents level of complexity in health record |  |
| Date and time physician communication with patient ends | Physician documents in health record |  |
| Other medically necessary billable services provided (including during 30 day period after discharge) | Provider documents in health record |  |
| Regularly updated comprehensive patient-centered plan of care | Care coordinator, nurse, provider documents in health record (with copy to patient) |  |
| Continuity of care through access to established care team for successive routine appointments | Primary care provider documents in health record |  |
| 24x7 patient access to care team to address acute chronic care needs | Care team 24x7 access to patient’s full EHR |  |
| Opportunity for patient to communicate with care team by telephone, secure messaging, and other asynchronous communication modalities | Patient communications are documented in health record |  |
| Management of care transitions facilitated by electronic exchange of health information | Health information accessed via HIE documents in health record |  |
| Coordination with home- and community-based providers required to support patients psychosocial needs and functional deficits | Care coordinator, nurse or provider documents in health record |  |
| <Other requirement (specifiy)> |  |  |
| <Other requirement (specifiy)> |  |  |
| <Other requirement (specifiy)> |  |  |
| <Other requirement (specifiy)> |  |  |
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