Common Classification of Medical Procedures

Country: France
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Health Policy Issues: Others, Remuneration / Payment

Current Process Stages

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1. Abstract

The French government and the Sickness Fund are introducing a new nomenclature of medical and technical procedures and services with the following general aims: to describe more precisely medical and technical procedures and services on a common basis both for hospital and ambulatory care; to recast the fee structure between specialists in private practice based on a nomenclature that is consistent and without financially adverse incentives.

2. Purpose of health policy or idea

The Common Classification of Medical Procedures (Classification Commune des Actes Médicaux, CCAM) aims to describe more precisely medical and technical procedures and services on a common basis both for hospital and ambulatory care and to recast the fee structure between specialists in private practice based on a nomenclature that consistent and without any financially adverse incentives.

There are two main stages in the development process of the CCAM:

1. The technical stage with:
   1. the construction of the nomenclature itself;
   2. the estimation of neutral fee parameters, first for technical procedures and services and in the future for clinical procedures and services (i.e. visits);

2. The political stage, which defines the fees (see point: adoption and implementation).

The process of development of the CCAM is quite long and currently under implementation which has been postponed several times due to interest conflicts between health professionals, especially physicians’ unions and sickness funds - at this stage:

- CCAM coding of medical procedures and services in hospital involved in the PMSIs mandatory since January 2004;
- CCAM is only defined for medical (with the exception of anatomopathology) and dental technical procedures
and services, such as diagnosis, surgery, radiology…;

- The legislative text of the fee-schedule of the 'technical CCAM' has just been published at the end of March 2005;

- Finally, physicians' clinical and technical procedures and services provided by other health professionals are not yet covered by the CCAM and still regulated by the former schedule for ambulatory care called *Nomenclature Générale des Actes Professionnels* (NGAP).

1. The construction of the nomenclature

The conception of the CCAM followed five steps:

- Drawing-up of labels (most of them come from the *Catalogue des Actes Médicaux*, CDAM, the former nomenclature for hospital care);

- Test/evaluation in practice;

- Rereading by scientific societies;

- Checking conformity with the European Norm Generalised Architecture for Languages, Encyclopedias and Nomenclatures in Medicine (GALEN) and with the French terminology;

- Assessment of benefit/risk by the National Agency for Accreditation and Evaluation in Health Care (ANAES which is now replaced by the The High Authority on Health, *Haute Autorité de Santé*, HAS) for 300 problematic procedures and services.

The CCAM is fully comprehensive in content, as it contains details of all technical procedures and services, even those that are not reimbursable. Each of the 7200 procedures and services (as opposed to 1500 in the NGAP) corresponds to only one label and one code, so there is no ambiguity, and it is easy to use.

The classification is according to ‘anatomic classification’ and not by specialties.

There are seventeen chapters from 'Nervous system' (1), Eye and annex of the eye (2)… to 'Procedures without localization ' (17).

Each label includes the mention of two mandatory axes - action and topography - and two optional - way and technique used - and no mention of the pathology following the European norm GALEN.

**Example : Biopsy/renal/transcutaneous/ without assistance**

The CCAM is based on the rule of comprehensiveness. Each code and label implicitly contains all the operations necessary for the performance of the medical procedure or service. It is called ‘global’ or ‘principal’ code and has 7 characters (e.g. HAMA007 for *Reconstruction du philtrum par lambeau hétérolabial, pour séquelle d'une fente profaciale*). In order to better qualify the procedure or service the physician can optionally add to the principal code a 'complementary gesture’ (see the chapter 18 of the CCAM).

Physicians must add to this principal code some mandatory code :

- **Activity**: when several physicians or health professionals participate in the intervention there is one code for the principal procedure or service (e.g.: HAMA007 1 code by the surgeon who first intervene) and another code for every added procedure and service run by different physicians or health professionals who intervenes (e.g. HAMA007 4 code by the anaesthetist, the fourth to intervene);

- **Stage of the procedure or service**: when the procedure requires more than one stage there is one code for each stage (e.g. HAMA007 1 1 code by the surgeon to show he was the first practitioner for the first stage of the intervention involved).
Physicians can add to this principal code some optional code:

- 'modifier(s)' (see chapter 19 of the CCAM): add a piece of information to the general label such as 'procedure realized in emergency by specialists, between 8 pm and 8 am' and gives issue to extra-fee. A physician cannot add more than 4 'modifiers' for one procedure or service.

- 'complementary procedure(s)': optional and always added to the principal procedure and service on the same line.

2. The estimation of neutral fee parameters

The second aim of the CCAM is to recast on a new basis the fees between specialist in private practice by the construction of a common scale resource-based relative value for services and procedures, without any financially adverse incentives.

In order to achieve this aim the methodology (following a model develop by the Public Health Department of Harvard University for Medicare) is based on the following principle: the value of each procedure or service (VP) equals the sum of two types of work input:

- a. The medical work value of a procedure or service (which depend on its difficulty), WV
- b. The cost of the practice of a procedure or service, CP

\[ VP = WV + CP \]

a. Organization into a hierarchy within and between specialties.

The medical work is measured by organizing into a hierarchy procedures and services and attributing relative work value for each procedure and service (W) in two steps: first within specialties and second between specialties.

Within specialties the medical work for a procedure is divided into 5 categories:

- 4 subjective variables: the medical work as a global variable, the stress, the technical skill required and the mental effort. Twenty experts (randomly selected from a list of 60 to 100 experts proposed by scientific societies of each specialty) rate relative work value (and other subjective variable) by using as reference standard (fixed at the level of 100) a procedure or service commonly performed within the specialty; 1 objective variable: time devoted (in minutes).

- Consequently we obtain for each specialty a common scale of relative work for each procedure and service. However, since the reference standard use in rating relative work within specialty differed from one specialty to another, separate specialty-specific resource-based relative value for services and procedures cannot be related directly to each other.

- Then, the relative work of all procedures and services of each specialty is ranked on a common scale between specialties by linking the scales.

- After identifying pairs of services (which are called 'link-procedures') from different specialties that require approximately equivalent amounts of intra-service work, there is a selection of sufficient links (at least 3-4 links) to connect each specialty to others.

- Finally, a procedure of maximization under constraints allocates possible values: the closest to the link-procedures to the same pair, without changing anything to the intra-specialty hierarchy, and then it locates all the optimal links on a single and common scale. This common scale of relative work constitutes the tool for assessment of the fees.

Each relative work value (W) is then monetary valued by the mean of a conversion factor (CF) identical for each
specialty and equal to:

- the total amounts of euros allocate of work for all procedures and services minus total amount of professional costs
- divided by the total amount of work estimate by adding for all the procedures and services the relative work value multiplied by its frequency.

$$VW = W \times CF$$

With: $$CF = \frac{\text{SumW} - \text{SumCP}}{\text{SumW} \times \text{frequency}}$$

b. Allocation of professional cost for each procedures or services

The cost of the practice for each procedure or service (CP) is determined by allocating two types of professional cost:

- the general cost (salary, rent...), GC, estimated by the means of total cost by specialty minus additional cost;
- the additional cost, S, specific to each procedure or service estimated by expert.

$$CP = (W \times GC) + S$$

Main objectives

The CCAM aims to describe more precisely medical and technical procedures and services on a common basis both for hospital and ambulatory care and to recast the fee structure between specialists in private practice based on a nomenclature that consistent and without any financially adverse incentives.

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1. The technical stage with:
   1. the construction of the nomenclature itself;
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2. The political stage, which defines the fees (see point: adoption and implementation).

Groups affected

Physicians, Sickness Fund, Government

3. Characteristics of this policy

<table>
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<th>Degree of Innovation</th>
<th>traditional</th>
<th>innovative</th>
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<tr>
<td>Degree of Controversy</td>
<td>consensual</td>
<td>highly controversial</td>
</tr>
<tr>
<td>Structural or Systemic Impact</td>
<td>marginal</td>
<td>fundamental</td>
</tr>
<tr>
<td>Public Visibility</td>
<td>very low</td>
<td>very high</td>
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4. Political and economic background

See point adoption and implementation.

5. Purpose and process analysis

Origins of health policy idea

The coexistence of two nomenclatures (one for ambulatory care, one for hospital care) as their respective default - The General Fee nomenclature, Nomenclature Générale des Actes Professionnels (NGAP) is obsolete, uncomplete, and without fee consistency ; the Catalogue of Medical Procedures, Catalogue des Actes Médicaux (CDAM) is uncomplete and heterogeneous - generates a need to move from classification tools to a management and cost containment instrument which facilitate consensus : the CCAM.

The CDAM was created in 1985 to give a rating to medical procedures and services in hospitals for the information computer system based on the creation of a Diagnosis Related Groups (DRGs) classification (Programme médicalisé des systèmes d'information, PMSI). Until now, this schedule has been used to classify hospital stays in French DRGs and to calculate "reference" costs for each DRG. Until 2005, public and most not-profit hospitals were paid on a global budget basis and procedures and services in private not-for-profit hospitals were paid on a per diem basis for "general services" and on a fee-for-service basis for specialists' services. CDAM was thus not used to price hospital services.

The NGAP specifies the list of medical procedures and services which are reimbursable by the statutory health insurance funds when delivered by licensed health professionals in private practice, whether in their own consulting rooms or in private for-profit hospitals, and the rate of reimbursement. For each medical procedure or service, the NGAP allocates an item, a coefficient and a key letter (varying according to the specialty of the professional involved) which give the rate of the service when multiplied by the current value of the key letter. This determines the professional fees of general practitioners, specialists, dentists, midwives, laboratory directors, physiotherapists, speech therapists, orthoptists, and chiropodists working in private practice. In private for-profit hospitals the NGAP is used to determine certain fixed charges (operating room...). In public hospital and private not for profit hospital the NGAP is used to classify and charge outpatient care.

Then in 1996 the Pole of Expertise and National Reference of Health Nomenclatures (Pôle d'Expertise et de Référence National des Nomenclatures de Santé, PERNNS), the Directorate of Hospitalization and Health Care Organization from the Ministry of Health (Direction de l'Hospitalisation et de l'Organisation des Soins, DHOS), the 'Nomenclature Section' of the General Scheme (Caisse Nationale d'Assurance Maladie des Travailleurs Salariés, CNAMTS), and some scientific societies and about 1,500 experts launched a project for the establishment of one new sole nomenclature which will replace the two existing medical activity classification systems : the CCAM.

Initiators of idea/main actors

- Government
Approach of idea
The approach of the idea is described as: new:

Stakeholder positions
See adoption and implementation.

Actors and positions
Description of actors and their positions

Government
- Government: very supportive strongly opposed
- Payers: very supportive strongly opposed
- Physicians: very supportive strongly opposed

Influences in policy making and legislation
The implementation of the technical CCAM is notably support by:
- the decree of 21 March 2005, J.O. of 30/03/05:  
  www.legifrance.gouv.fr/WAspad/UnTexteDeJorf?numjo=SANS0521104A
- the decision of 11 March 2005 of UNCAM, J.O. of 30/03/05:  
  www.legifrance.gouv.fr/WAspad/UnTexteDeJorf?numjo=SANU0521001S

See adoption and implementation too.

Legislative outcome

Actors and influence
Description of actors and their influence

Government
- Government: very strong none
- Payers: very strong none
- Physicians: very strong none

Positions and Influences at a glance

Adoption and implementation
As explain before there are two main stages in the development process of the CCAM:

- The technical stage with the construction of the nomenclature itself and the estimation of neutral fee parameters;
- The political stage, which define the fee.

The technical stage began in 1996, and straightened until September 2004. It bring together state department,
sickness fund and medical scientific societies. As a consequence, at this stage there is no institutional representation of physicians’ union (even if at an individual level some physicians could be member both of scientific societies and union).

In any way there was a broad consensus among government, sickness fund and physicians’ union representatives in order to consider that the development of the CCAM enable to go through incompatible nomenclatures with many defaults (obsoleteness, incompleteness…) and 10 years relationship deterioration between payers-providers regarding key-letter negotiation. There is one notable exception : the non involvement of physicians’ union was source of criticism by them regarding the evaluation of practice cost of the technical CCAM.

The technical stage closing with a steering comity involved physician's union in September 2004 during which the first financial consequences of the transition from NGAP to CCAM, under the general principle of constant budget, was communicated.

At the same time the political stage began (in July 2004) in order to define, or negotiate (between state, sickness fund and physicians’ union) the fees.

At this time some cracks appeared and the implementation of the CCAM was postponed to 2005

On one hand as all the physicians are waiting for this reform of the CCAM the government asks to the sickness to delay its implementation in order to ensure the support of physicians’ union during the implementation process of the 2004 Health Reform Act. On a second hand the physicians’ union realize that the transition from NGAP to CCAM plan with constant budget generate a new financial hierarchy between specialties with some winner and loser (radiology, cardiology, radiotherapy and nuclear medicine).

As the negotiation of The National Agreement between physicians unions and the recently created Union of sickness funds was concluded last January, and the support of physicians to the reform was assured, a general agreement for the transition from NGAP to CCAM could be concluded in February 2005. This agreement specifies the following points:
• There is one year of observation and consultation and there is no loser for the time being (loosed specialties still be paid based on the NGAP);

• There is a gradual convergence to CCAM fees of 5-8 years

• The transition to CCAM for winner specialties is supported by a new special budget of 180 million euros. Indeed the CCAM fee (based on a monetary conversion factor of 0,44 euros) was equal to :

\[
\text{CCAM fee } 2005 = \text{NGAP reference fee} + (\text{CCAM fee} - \text{NGAP reference}) \times 33\%
\]

6. References

Sources of Information
All the relevant papers, references and links are available on this two website:

www.ameli.fr/77/DOC/83/enquete.html

www.ccam.sante.fr/

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