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**BEYOND FACE TIME: THE EVOLUTION OF
MEDICARE FEE FOR SERVICE
IN A VALUE DRIVEN WORLD**

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Beyond Face Time: The Evolution of Medicare Fee For Service In A Value Driven World

In January of 2015, Secretary Burwell announced that by the end of 2016, thirty percent of Medicare's payments would be spent on alternative payment models like bundled payment and accountable care organizations and 50% would be spent that way by 2018¹. Yet both of those new models depend on fee for service to pay physicians in the ordinary course, with reconciliation at some predetermined time against pre-established budgets. Fee-for-service will remain in Medicare for years to come. But it is evolving; and, where throughout the history of Medicare, Part B has required physicians to interact face-to-face with patients to get paid, gradually new codes have been introduced that pay physicians for coordination of care, without requiring a patient visit. The point is to facilitate the delivery of value ó lowered cost with improved quality and better patient experience of care. This article looks at how we got where we are, to the changes that precede the most recent new codes. It then reports on the three new types of care coordination codes ó for transitional care, chronic care management, and oncology care management ó and considers pitfalls in undertaking to deliver them and get paid.

1. The History of Medicare Fee For Service

When Medicare was enacted in 1966, it was believed that the bulk of the funds to be expended would be under Part A for hospital services.² Against the fierce opposition of organized medicine, Congress enacted under Part B a program that was statutorily prohibited from interfering in the practice of medicine, and was intended to reflect and accommodate the way physicians practiced throughout the country. Carriers ó private insurance companies ó were given considerable discretion in administering the Part B benefits, in order to reflect local medical practice differences. There was no uniform system for claims submission, coding, or payment. It was also in 1966 that the American Medical Association first published the Common Procedure and Terminology (CPT) Manual which was primarily oriented around surgical procedures, and was intended mostly to facilitate medical record keeping by physicians.

In 1966, most physicians charged a fee for each of their services. They often charged differentially if they spent more time with the patient. If they did more procedures or tests, they charged more for each additional service. The Medicare payment amount was determined normatively, based on a physician's "usual, customary, and reasonable charge." The carrier made that determination based on the claims submitted to it by the respective physician compared with other physicians in the locale

¹ Press Release, "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value" (January 26, 2015) <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>

² For a historical look at the development of Medicare policies regarding physician reimbursement, see Gosfield, "Part B Physician Reimbursement: Developments, Limits and Pitfalls," (Gosfield ed) HEALTH LAW HANDBOOK, Clark Boardman, (1990 ed), pp. 275-310

of the same specialty. Because they were private insurers as well, Congress established a comparability factor limiting the carriers to paying no more than they paid in their private business. By 1970, merely four years after its enactment, spending on the Part B program had far exceeded actuarial estimates and the discussions of imposing a nationwide fee schedule had begun.³ That same year the AMA published the second edition of the CPT to include more services.

Through the 1970s until 1983, there was some tinkering with the Part B payment model including the establishment of a Medicare Economic Index to put a cap on how much Medicare would pay if physicians continued to raise their fees. The policy of waiver of liability was also introduced which essentially said the patient could not be held financially liable if a physician knew or should have known that the carrier would not pay the claim. Then in 1983, Congress enacted the inpatient prospective payment system (PPS) to create a diagnosis related group (DRG) payment model, in essence an early form of episode based payment, where the diagnostic coding on the claim would determine how much would be paid, regardless of how long the patient was in the hospital up to approved outlier amounts.⁴

In 1977 Congress had enacted a provision requiring the Health Care Financing Administration (HCFA) to establish a uniform code system for identifying physicians' services for use in Medicare⁵. Rather than create its own system, in 1983, HCFA entered into a non-exclusive, royalty free license agreement to use the AMA's copyrighted CPT system which would be combined with the HCFA Healthcare Common Procedure Coding System (HCPCS), that had some national codes that the CPT book did not, and allowed local codes as well. The AMA agreement was controversial since, while the license was non-exclusive, HCFA agreed to use the AMA's coding system exclusively. Litigation later ensued. A medical book publisher sought to publish the CPT book itself on the grounds that the license agreement effectively put the copyrighted book into the public domain. They also argued that the AMA misused its copyright by requiring exclusivity. On appeal from the District Court the ninth circuit held that the copyright was effective, but that the AMA had misused it.⁶ Nevertheless, the CPT book remains the primary descriptor for how services are reported on claims for Medicare, Medicaid and other federal programs.

³ "Medicare and Medicaid: Problems, Issues and Alternatives," Report of the Staff of the Senate Finance Committee (91st Cong., 1st Sess, Feb 9, 1970)

⁴ For a discussion of what this shift meant and how it was first received, see, Guterman, et al, "The first 3 years of Medicare prospective payment: An overview" Health Care Finance Rev. 1988 Spring; 9(3): 67677. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4192876/>

⁵ 42 USC §1395w-4(c)(5)

⁶ Practice Management Information Corporation v. The American Medical Association, 121 F 3d 516 (9th Cir. 1997)

Where the hospital reimbursement system had been completely revamped in 1983 moving from primarily a cost-report based program to the DRG system, nothing was done to significantly alter the physician reimbursement program until 1989, when Congress enacted the Resource-Based Relative Value Scale (RBRVS) national fee schedule, first implemented in 1992.⁷ The fee schedule, like the DRG program, was intended to take into account appropriate resource consumption in the delivery of services by segmenting each service into a work component ó reflecting the level of effort of the physician to deliver the service -- an overhead component which varied geographically, taking into account the equipment, supplies and other inputs to provide the service ó and a malpractice expense component ó recognizing that this expense was highly variable by both the type of service and geographically. Virtually all specialty differentiations were eliminated, so a neurosurgeon and a family physician would be paid the same amount for the same visit with a patient. In establishing the payment amounts in the fee schedule, the work components were compared with each other so that more complicated services were assigned more work relative value units.

One of the major changes was the standardization of visit codes; but that came from the CPT Manual and not the RBRVS system, which was a pricing methodology. Until RBRVS, while there were varying levels of visit codes, they were also variably interpreted and applied, since the intermediate level of visit was supposed to be that level of visit the physician performed most often, whether twenty minutes or five. The new codes created five levels of visit, with time benchmarks associated with each. If more than 50% of the service was counseling or coordination of care, then the physician would bill using the time benchmarks. Otherwise how much time the visit took was irrelevant.

Each visit required face time between the billing physician and the patient. The level of visit was to be determined based on the extent of the clinical history taken, the scope of the physical examination and the complexity of the clinical decision-making rendered. It was 1995 before CMS published guidance⁸ pertaining to how to document what was essentially an effort to quantify the intellectual firepower the physician would bring to bear in the patient encounter. The Guidelines were expanded in 1997 to recognize that certain specialists, like ophthalmologists for example, would not be doing foot or abdominal exams, but still might have the need to perform one system focused complex services.⁹ Both sets of Guidelines remain in effect; and a physician can choose either to drive his documentation. Both sets of Guidelines require the physician to create the documentation, except for the past family and social history and review of systems

⁷ For a historical view of the complexities this change posed for physicians, see Gosfield, "Unintentional Part B False Claims: Pitfalls for The Unwary," (Gosfield ed.) HEALTH LAW HANDBOOK, Clark Boardman (1993 ed). Pp. 205-229

⁸ "1995 Documentation Guidelines for Evaluation and Management Services" <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/95docguidelines.pdf>

⁹ "1997 Documentation Guidelines for Evaluation and Management Services" <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnedwebguide/downloads/97docguidelines.pdf>

which may be completed by the staff or by the patient himself. The Guidelines have not been changed at all over twenty years.

2. Early Forms of Non Face Time Services

From the beginning of Medicare, the definition of a physician service emphasized visualization of the patient. "A service may be considered to be a service where the physician either examines the patient or is able to visualize some aspect of the patient's condition without the interposition of a third party."¹⁰ The latter part of the definition is what permits a radiologist or a cardiologist to bill professional component only for the interpretation of a diagnostic test. Probably the first version of anything approaching a team based idea of care was the concept of "incident to" billing. It has always been my belief that if Congress had not included that concept in the original legislation¹¹, permitting the physician to include the services of support staff in the office in his own bills, no one would have agreed to participate in Medicare. Although to bill "incident to" the physician must be involved in the patient's ongoing care, each visit does not require the physician to see the patient. But in the office setting, where more than 50% of the visit is counseling or coordination of care, the only counseling time which can be billed is face time between the physician and patient. Even if ancillary personnel like a nurse practitioner or a physician's assistant performed the visit, they may not bill for counseling or coordination of care on an incident to basis¹².

In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.¹³

By contrast, in the same sub-section of the Manual, it is stated that in the inpatient setting, the time spent in coordinating care may be spent on the unit or the floor where the patient is. The same prohibition on time spent by non-physicians is not explicit.

The emphasis on face time can also be seen in the Medicare telehealth rules which require real-time interaction with the patient¹⁴ The CPT book offers other codes which

¹⁰ Medicare Benefit Policy Manual Ch 15 §30A

¹¹ 42 USC §1395u(b)(6)

¹² Clinicians whom Medicare recognizes for billing on their own numbers, like PAs and NPs are permitted to bill counseling or coordination of care time on their own numbers paid at 85% of the physician fee schedule.

¹³ Medicare Claims Processing Manual (MCPM) Ch 12 §30.6.1C

¹⁴ MCPM Ch 12 §190

do not require face-to-face encounters such as team conferences, case management, and prolonged services without direct patient contact. Medicare simply doesn't cover them.¹⁵ For primary care physicians, in particular, their role in performing services went beyond the time they spent in visits with patients. Confronting administrative burdens, long standing criticism of the procedural bias in the CPT codes, and payment policy generally, the government began to understand the need to pay physicians for managing care between visits. The first real movement in that direction was the advent of coverage for care plan oversight which was first introduced in 1994.

In 2002, turning a full 180 degrees from staunchly held positions that a hospital visit had to be completed entirely by the physician, Medicare suddenly recognized the concept of a "shared visit."¹⁶ Similar to "incident to" billing where the ancillary personnel may perform part of the service, this new concept was even more liberal since the physician and the non-physician didn't have to be in the hospital at the same time. While "incident to" required that a physician be in the office suite, the shared visit required only that the physician perform some aspect of the visit face-to-face with the patient and then he could include what the non-physician from his practice did with the patient as if he did it all himself.

3. Care Plan Oversight (CPO)

The first true care coordination code was introduced in the 1995 Medicare Physician Fee Schedule. Care Plan Oversight ("CPO") services, with their own codes, may be billed by a physician managing a patient receiving Medicare home health or hospice services.¹⁷ While commenters speaking to proposed regulations had requested that the code be available for patients receiving care at home from their families, the regulators rejected that approach. "[T]he purpose of allowing separate payment for care plan oversight services is to compensate physicians for the time they spend coordinating complex care among practitioners and integrating significant new information into the treatment plan."¹⁸ As with all Medicare services, medical necessity is the critical first issue in billing CPO.

Medicare has two HCPCS codes, G0181 for patients in home health and G0182 for patients receiving hospice care. The CPT book has two CPO codes, but what they describe is not consistent with Medicare's coverage policy or regulations.¹⁹ One physician per patient may bill for care coordination for a qualifying patient when he

¹⁵ See MCPM Ch 12 §§30.6.15 and 30.6.16

¹⁶ MCPM Ch 12 §30.6.1B

¹⁷ 59 Federal Register 63418 (December 8, 1994)

¹⁸ 59 Federal Register 63422 (December 8, 1994)

¹⁹ 42 CFR §414.39 and MCPM Chapter 12, §180

spends at least 30 minutes in a calendar month developing or revising care plans; reviewing subsequent reports of patient status; reviewing laboratory or other studies; communicating with other health care professionals not employed in the same practice who are involved in the patient's care; integrating new information into the medical treatment plan; and/or adjusting medical therapy. Telephone calls with family members may not be counted, nor may travel time, nor time telephoning prescriptions unless the telephone conversation involves discussions of pharmaceutical therapies.

A qualifying patient must require complex multidisciplinary care modalities requiring ongoing physician involvement in the plan of care. The physician who bills CPO must be the same physician who signed the home health or hospice plan of care. The physician must have provided a covered physician service that required a face-to-face encounter with the patient within the six months immediately preceding the provision of the first CPO service.²⁰ A surgeon rendering services within the global surgery period may not bill CPO, nor may a physician who is paid a capitation rate for end stage renal disease services. Because CPO is a time based code, the billing physician must keep records of the services that are added up to constitute the 30 minutes in the month. In addition, like almost all physician services, CPO is subject to the 20% copayment by the patient, who is not experiencing the services directly for which she must pay the co-pay. Depending on the geographic area, each CPO claim is paid at about \$100 or more.

Between 2000 and 2001, the popularity of CPO had increased as seen in Medicare's payment of \$15 million in 2000 rising to \$41 million one year later.²¹ When the codes were first introduced, many physicians did not utilize them effectively. In one report²² of a review by the government, one third of the reviewed claims did not match the dates submitted on claims that were submitted by the corresponding home health agency or hospice. In another third of the claims, physicians billed CPO for dates when patients were in the hospital. In some instances, emergency physicians, radiologists and pathologists billed when they clearly were not the physicians supervising the patient's ongoing care. By 2010, in its Semi-Annual Report to Congress, the OIG touted a \$9.5 million settlement with physicians in Michigan who did not perform the care plan oversight services for which the government had paid.²³ In 2013 a national home health company stated that 60% of physicians didn't know about the care plan oversight coverage and that 80% chose not to bill it because of the complexity in providing and

²⁰ Non-physician practitioners can also bill CPO services for home health patients subject to some relatively limited restrictions. A nurse practitioner can bill CPO for a hospice patient, but only if she has been designated the attending physician for hospice purposes. 42 CFR §414.39(c)

²¹ Nicoletti, "How to Document and Bill Care Plan Oversight" Family Practice Management (May 2005) pp. 23-25

²² Mikolanic, "Avoiding coding snafus in oversight services, diabetes," ACP Internist, <http://www.acpinternist.org/archives/1996/10/avoidcod.htm>

²³ OIG Semi-Annual Report to Congress, (Spring 2010) p. 38

documenting the service²⁴. Yet, the complexity of billing for CPO services pales by comparison with the new codes introduced in the current value-driven world.

4. Today's Coordination of Care Codes

Going back to 2012, MedPac in its annual report to Congress called out, in a whole chapter on care coordination in fee-for service Medicare, that failures to coordinate had led to repeat medical histories and tests, inconsistent medical instructions, and using higher intensity settings when they were unnecessary.²⁵ They reviewed a variety of care coordination programs including "the chronic care model" which they had first noted in 2008. They considered embedded care manager models, placing care managers in physician offices, which Aetna had tried, among others. They looked at "transitions" models which included a transition coach working with patients and their families as well as advanced practice nurses creating an evidence-based plan of care for patients in the hospital focusing around comprehensive discharge planning with follow-up visits. They also looked at external care manager models including health teams in the community that work with medical practices, as well as disease management models.

They reviewed a variety of demonstration projects in Medicare citing seven demonstrations over the prior ten years. The three most recent large scale demonstrations tested commercial disease management (Medicare Health Support), Medicare Care Management for High Cost Beneficiaries demonstration, and the Medicare Coordinated Care Demonstration. They considered all the results to be tepid and as not showing significant effects on spending and outcomes, with most of them unable to recoup their care management fee paid, through lower utilization.²⁶

They addressed one of the primary barriers to effectiveness to be that the payment system was inconsistent with the attempts to coordinate. They suggested that paying explicitly for care coordination could overcome this barrier. They proposed paying a provider's office per beneficiary on a monthly basis for care coordination. They considered paying an outside entity a per beneficiary payment for care coordination but concluded that such a policy would require additional resources. They proposed transitional care payment for a care manager to work with beneficiaries leaving the hospital, which could be coordinated with the hospital's incentives to reduce unnecessary hospitalizations. They considered using payment policy to pay for outcomes resulting

²⁴ Amedisys, "Getting To Know CPO", <http://www.amedisys.com/physicians-and-health-care-professionals/resources/download/care-plan-oversight-download/guide-to-care-plan-oversight-amedisys-2013> Ironically, the next year, the same company paid \$150 million in settlement of alleged false claims for home health services in response to six whistleblower cases. <http://www.justice.gov/opa/pr/amedisys-home-health-companies-agree-pay-150-million-resolve-false-claims-act-allegations> But their questionable claims submission had nothing to do with their information about using CPO.

²⁵ Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System, (June 2012) p. 33

²⁶ Id at 43.

from coordinated care (or a penalty for outcomes that result from fragmented care such as excess readmissions or unnecessary use of the emergency department). They addressed payment reforms such as ACOs and bundling payments as facilitating care coordination. In the last analysis, citing variability problems and operator dependent effects, they viewed a broader payment reform as better to encourage coordination, but said finally policies to encourage care coordination within the FFS system may be an interim step as Medicare begins to move toward more global approaches to payment.²⁷ And so, here we are!

A. Transitional Care Management (TCM)

Made available for use in the Calendar Year 2013 Medicare Physician Fee Schedule, two codes were made reimbursable by Medicare. Astonishingly, by October 2015, there was not a word of regulation, nor in the CMS Manuals, describing what is required to bill either of the codes, one for moderate complexity and the other for high complexity. There are discussions in the prefaces to the Fee Schedules for 2012, 2013 and 2014; but those aren't regulations themselves. There is a Medicare Learning Network article²⁸ and some FAQs²⁹ published on the CMS website. But otherwise, there is essentially no formal guidance with respect to the scope, documentation requirements or other issues associated with billing these codes.

Transitional care management (TCM) services are intended to prevent readmissions when patients are discharged from an inpatient setting to home. The codes (99495 for patients requiring moderate medical decision complexity; and 99496 for patients requiring high complexity medical decisionmaking) are to be used when a patient is discharged to home, a rest home or assisted living from an inpatient acute care hospital, inpatient psychiatric hospital, long term care hospital, skilled nursing facility, inpatient rehabilitation facility, hospital outpatient observation or partial hospitalization and partial hospitalization at a community mental health center. They are used once during the twenty-nine days after the patient's discharge which counts as the first day of TCM. The moderate complexity code pays about \$160 for the thirty day period; while the high complexity code is reimbursed at about \$228.³⁰

The physician or non-physician practitioner must have an interactive contact with the patient and/or caregiver, within two business days following the beneficiary's discharge, whether by telephone, email or face-to-face. Although the bulk of the care management takes place in the professional's office, there is a face-to-face visit required,

²⁷ Id at 54.

²⁸ Medicare Learning Network, "Transitional Care Management Services" (ICN 908628 (Jun 2013))

²⁹ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf> (August 21, 2013)

³⁰ Singh, "What Tools Help Ensure Successful Transitional Care Management (TCM)?" HIMSS Ambulatory Information System Committee (Dec 31, 2103)
<http://www.himss.org/ResourceLibrary/genResourceSteps.aspx?ItemNumber=26615>

for moderate complexity patients within 14 days of discharge and for high complexity patients within 7 days of discharge. CMS does not specify any level of visit so the typical evaluation and management code rules would pertain. Non face-to-face services included in the code are review of discharge information such as discharge summary or continuity of care documents, review of the need for or follow-up on diagnostic tests and treatments; interaction with other health care professionals who will assume or reassume care of the beneficiary's system-specific problems; provide education to the patient, family or caregiver; establish or re-establish referrals and arrange for needed community resources; and assist in scheduling required follow up with community providers and services. TCM may not be billed in conjunction with care plan oversight services.

Medication reconciliation must be completed by the time of the face-to-face visit. To bill either code, the required documentation includes the date of initial discharge, the date of post-discharge communication with the patient or caregiver, the date of the first face-to-face visit, medication reconciliation and complexity of medical decision-making. The physician's staff is permitted to conduct the initial "within two days" interaction. Originally the rules required direct supervision by the physician, but that was changed in 2015 to permit general supervision, although all the other indicia of "incident to" billing must be present. Only one clinician may be paid for TCM for a beneficiary, so there is a race to the gate if physicians are sharing the care of the patient after discharge. Some of the non-face-to-face services may be performed by licensed clinical personnel (such as a nurse), but not a medical assistant.

CMS offers no guidance regarding the content of the services included in the code. The Medicare Administrative Contractors are variable as to whether they even have guidance for TCM. Noridian has a page with TCM Questions and Answers³¹ that goes further than anything CMS has said. They list a host of questions that should be included in the initial interactive communication:

- How is the patient's transition going returning (sic) to the residence?
- Does the patient have and is the patient taking all of the prescription medications the discharging physician recommended?
- Does the patient have any questions or concerns about his/her medications?
- Does the patient need home medications assistance to obtain medications?
- If home care services were ordered at discharge, has the home care agency made contact with the patient?
- If home IV medications were to be delivered, have they been delivered? Does the patient or caregiver feel comfortable administering the home care medications?
- Does the patient need additional home care services?
- Is the patient able to get to bathrooms and move about the home safely?
- Does the patient have any questions or concerns?³²

³¹ <https://med.noridianmedicare.com/web/jeb/education/event-materials/transitional-care-management-qa> (Updated July 16, 2015)

³² Id at 1.

The questions and answers caution as to who may perform the communication, emphasizing variable scopes of licensure among nurses, social workers and medical assistants as an example, and further cautions that the physician who will perform the face-to-face visit and the person conducting the initial communication must work for the same practice, even if the services are conducted in an outpatient facility such as a hospital clinic.

The answers clarify what medication reconciliation means, “Medication reconciliation is not simply a confirmation of discharge medication or the medication the patient has. It is intended to be an assessment of medications needed to treat active or chronic medication problems and reduce the risk of duplicate medications for the same purpose. It includes reviewing medications with harmful interactions, unnecessary medications, identifying problems and providing assistance when patient for some reason has been unable to fill needed medication prescriptions. All of this information needs to be documented in the medical records.”³³ The tone and detail in the questions and answers stands in stark contrast to the vague directions offered by CMS:

“Q9. Will a practice management system "sign off" suffice for documentation if it lists the medication, dosages and time of administration (including PRN medications) during the visit? Is it required that each medication be reviewed as part of the assessment and plan with a problem attached to why that medication is being administered?”

A9. The intent from CMS is a medication reconciliation addressing all medications needs to treat all active and chronic medical problems.

- CMS' intent was for a practitioner to review a list of everything currently prescribed for that patient, review it for appropriateness and possible interaction or contraindications and compare this with what the patient is actually taking.
- It is not a review of the medicine cabinet contents, but rather a verbal review with the patient confirming what they are taking, when and why. The practitioner should assess the benefits and risk of each medication for the specific medical problem it is addressing.
- Narrative documentation must be clear that it results from a discussion with the patient. It may be preferable for the medication reconciliation as part of the assessment and plan.
- As noted by several national specialty associations to be "best practice", a brown bag brought in containing all of a patient's medication is encouraged for the face-to-face visit.³⁴

³³ Id at 2.

³⁴ Id.

A search of the Medicare Local Coverage Determination database produces no results for “transitional care management”. Only a Google search produced the 25 questions and answers sheet from Noridian. There is an absurdity to this approach. How are physicians elsewhere in the country to know what is required of them? Medicare is a national insurance program the benefits of which should be the same throughout the country. More importantly, other than the general documentation requirements noted in the MedLearn Matters article cited above, will any of the myriad auditors rooting out fraud and waste in the program seek to apply the Noridian standards or some other interpretation of what is required? How can the government regulate by prefatory publications? This does not rise to hornbook levels of what the Administrative Procedure Act requires. Yet, it appears to be the current style of driving change and can be seen in the most recent new codes as well.

B. Chronic Care Management (CCM)

Although the code became billable in January 2015, set forth in a Medicare Learning Network article³⁵ in March 2015, and further elucidated in FAQs posted on its website,³⁶ CMS has described a program to pay physicians for interaction with other providers, their patients, and managing a care plan through CPT code 99490³⁷. By October 2015, although CMS had estimated that 35 million Medicare patients would be eligible to receive the services, they had received reimbursement requests for only 100,000.³⁸ The code is billable once a month at about \$42, (decidedly less than TCM) so a physician could receive \$511 a year additional payment per patient for delivering these services. The requirements to bill, however, are demanding.

Chronic care management services require at least twenty minutes of clinical staff time, directed by a physician or other qualified health care professional per calendar month. It may be billed for patients with two or more chronic conditions expected to last at least 12 months or until the death of the patient. But the mere presence of two chronic conditions is not enough. The conditions must place the patient at “significant risk of death, acute/exacerbation/decompensation or functional decline.”³⁹ The core of the service involves the development of a comprehensive care plan, established, implemented, revised or monitored by the physician’s staff. Although CMS expected the code to be used predominately by primary care physicians, specialists are eligible to bill it as well.

³⁵ Fact Sheet, “Chronic Care Management Services” ICN 909188 (March 2015)

³⁶ MedLearn Matters SE1516 (May 11, 2015)

³⁷ The CPT book offers an additional code, 99491, for complex chronic care management but Medicare does not recognize that one.

³⁸ Robeznieks, “CMS care-management fees help medical home practices”, Modern Healthcare (Oct 19, 2015) pp 8-9

³⁹ See n. 35.

Given the types of conditions listed as relevant but not exclusive of Alzheimer's, atrial fibrillation, autism spectrum disorders, cancer, chronic obstructive pulmonary disease, depression, diabetes, heart failure and more one could imagine oncologists, pulmonologists, rheumatologists, and psychiatrists billing for it as well. The problem is only one physician may bill the code in a month; and the first claim in is the first claim paid.

i. Who May Render CCM?

The services may be provided directly by a physician, non-physician practitioner or by clinical staff, rendering services incident to the billing practitioner. Non-clinical staff time cannot be counted. This raises the issue of what constitutes "clinical staff". Rather than provide a definition, CMS instructs the reader to "consult the CPT definition of "clinical staff"⁴⁰ First, this seems a ridiculous approach on the part of CMS. They don't even provide a link. Second, as someone who has worked with the CPT book for more than thirty years, I spent time leafing through the book searching for the definition to no avail. There are no "definitions" in the CPT book. One might think the definition would appear in the discussion of the Care Management Services, but that would be wrong. I then Googled "CPT definition of clinical staff". The CPT book itself did not come up, but the Texas Medical Society in its guidance around chronic care management services published a quote from the CPT book, without a citation. I then took that quote and Googled it and still produced nothing. After 45 minutes I went back to the CPT book and to my utter astonishment found it in the third paragraph of the Introduction under the subheading "Instructions for Use of the CPT Codebook"! After a sentence addressing advanced practice nurses and physician assistants the following language appears:

*A physician or other qualified health care professional is an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff". A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.*⁴¹

This is a critical definition because clinical staff time may be counted in the twenty minutes of CCM services to be rendered each month, but non-clinical staff time cannot be counted. Because of the requirement that the clinical staff must be allowed by law or

⁴⁰ See n. 35.

⁴¹ Emphasis added AMA, Current Procedure and Terminology Manual (2015 ed.) p. xii

regulation, medical assistants could not be used unless they were licensed. Nurses, licensed practical nurses, and non-physician practitioners would qualify. And, while the services must meet incident to standards, general supervision is permitted, meaning no physician need be on premises while time is counted in rendering the management services.

ii. Scope of Services

To begin to count the time which qualifies to be billed under the code, CMS requires the billing practitioner to furnish a comprehensive evaluation and management visit, Annual Wellness Visit or Initial Preventive Physical Examination to the patient and to initiate the CCM services as part of this visit. Before the service can be billed, the patient must sign a consent which must have specific elements in it: It must inform the patient of the availability of the CCM service, include not only a written agreement to receive the services but authorization for electronic communication with other treating practitioners and providers. It must state how the patient may revoke the consent. It must inform the patient that only one provider may bill for the service in a month. The 20% co-payment requirement for all Medicare services applies to CCM services as well. Although not required to be documented in the consent, it is a good idea to record that as well since the patients will only experience some of the services directly, such as reporting and discussing test results with them. This is finally one service where physicians can charge for telephone calls, which are otherwise included in the visit codes. The American Academy of Family Physicians, the American College of Physicians and the Medical Group Management Association have all published toolkits for billing CCM which include consents, as well as templates for care plans.⁴²

CMS itself notes that "The CCM service is extensive, including structured recording of patient health information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing information with practitioners and providers outside the practice."⁴³ The purpose is stated, in part as a justification to patients for the value of the service and therefore the co-pay, as an effort to help avoid the need for more costly-face-to-face services in the future by proactively managing patient health, rather than only treating disease and illness. The service itself has four components: (1) structured data record; (2) the care plan; (3) access to care; and (4) managing care.

⁴² American College of Physicians, "Chronic Care Management Toolkit" https://www.acponline.org/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf; American Academy of Family Physicians, "Chronic Care Management Toolkit" <http://www.aafp.org/practice-management/payment/coding/ccm.html>; Medical Group Management Association, "Medicare Chronic Care Management Service Essentials," <http://www.mgma.com/government-affairs/issues-overview/medicare-payment-policies/medicare-physician-reimbursement/medicare-chronic-care-management-service-essentials>

⁴³ See n. 35

The documentation for the service includes recording the patient's demographics, problems, medications and medication allergies creating structured clinical summary records using certified EHR technology. Within the record must also be recorded a comprehensive patient centered care plan based on a physical, mental, cognitive, psychosocial, function and environmental assessment or reassessment and an inventory of resources. The patient must be given a copy of the plan either in hard copy or electronically; and the practitioner must document its provision in the medical record. The care plan must be available electronically "at all times" to anyone within the practice providing the CCM service. The electronic care plan must be shared outside the practice as appropriate. The plan itself typically includes but is not limited to the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions and identification of the individuals responsible for each, medication management, community/social services ordered, a description of how services of agencies and specialists outside the practice will be directed/coordinated and schedule for periodic review and, when applicable, revision.

With regard to access to care, to bill the code, the practitioner must ensure 24/7 access to care management services providing the patient with a means "to make timely contact with health care practitioners in the practice" who have access to the patient's electronic care plan to address his or her urgent chronic care needs."⁴⁴ Without specifying any measurement of how this would be assessed, CMS requires that the practitioner ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments. In addition, the practitioner must provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner through telephone, secure messaging, secure internet or other asynchronous non-face-to-face consultation methods.

The care management services include systematic assessment of the patient's medical, functional and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions and oversight of patient self-management of medications. The code includes managing care transitions between and among health care providers and settings including referrals to other providers, which is why you can't bill CCM with TCM services, since they are redundant.

All of that information comes solely from the Fact Sheet posted in March 2015. In May 2015, CMS posted the FAQs. Notably in the very first one, in response to the question "who qualifies as "clinical staff" again, rather than provide the definition or a link, the answer refers the reader to the CPT book. They clarified that practices can contract with outside vendors to provide CCM services as long as the "incident to" standards are met. As to when the service may be billed during a month, as soon as the 20 minute requirement is met the service is eligible to be billed, as long as all the other

⁴⁴ See n. 35

components have been provided. The place of service would typically be physician office or hospital outpatient setting. The code cannot be billed while a patient is in a facility which receives Medicare compensation, like a hospital or nursing home. In a regulatory response unlike any I have seen in the history of my career, several answers refer the reader to the final CY 2014 Medicare Fee Schedule (78 FR 74424) or the CY 2015 Fee Schedule (79 FR 67727). But neither are rules or regulations.⁴⁵ They are the preface to the regulations including discussions of the fee schedule construction.

At question 8 the analysis of patient-generated health data and other services described by CPT code 99091 (remote patient monitoring services) may be included in the 20 minutes, although that code is not billable to Medicare. When the practitioner provides the face-to-face visit that triggers CCM, that is separately payable. The face-to-face visit included in transitional care management services qualifies as a comprehensive visit for CCM initiation, but TCM and CCM cannot be billed in the same month, unless the month that concludes the TCM services comes before the twenty minutes of CCM in the same month. Other visits may not be included in the CCM time qualification. It is intentionally for non-face-to-face services.

There are no Local Coverage Determinations for CCM. A few Medicare Administrative Contractors⁴⁶ have posted the Fact Sheet. Noridian has posted FAQs for Jurisdictions E. (California, Hawaii Nevada Samoa, Guam and the Mariana Islands); and F. (Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming); and they aren't the same as those on the CMS website, although they do repeat the stupid direction to the CPT definition of "clinical staff". They say the care plan must be signed by the person billing for the service. In response to the practical issue of how to share the electronic care plan when outside providers are not on the same EHR they observe that CMS does not require that the certified EHR be shared electronically. They state that measurable goals for each chronic condition must be listed in the care plan. In response to how often a care plan needs to be written they state "Every CCM billing month, a care plan is needed."⁴⁷ To have one and revise as necessary seems to be what CMS requires, but the Noridian statement is misleading and essentially non-responsive to the practicalities of delivering CCM. At Q20 they say that community health workers can be counted toward the 20 minutes as long as they are employees of the practice. That is not correct, as CMS has stated.

iii. Challenges

⁴⁵ See n. 36 at questions 7-9

⁴⁶ https://www.noridianmedicare.com/shared/partb/bulletins/2015/301_july/chronic_care_management_services_faqs

⁴⁷ Noridian FAQs at #14.

One of the biggest challenges in delivering the services as described by CMS, lies in the clunkiness of most electronic health records. Practices that report success in implementing CCM have had to create technical work arounds in their software to be able to document team delivery of care, as well as to document discontinuous periods of time spent to qualify for the 20 required minutes.⁴⁸ The requirement to share the care plan with other providers, when it is mandatory that the care plan be documented in the EHR, is also problematic because other providers are often using non-interoperable programs themselves. However, CMS does not require that the other providers be given electronic access to the care plan.

Other physicians report patient resistance to paying the \$8 co-pay for services they don't experience themselves. Still others have reported that the development of the care plan alone, even if based on a template, can take between 8 to more than 30 minutes.⁴⁹ Even large integrated groups have chosen not to implement CCM and apply for payment because of the documentation requirements associated with it. Given all the elements required for a care plan, it is hard to imagine completing one in 8 minutes. Other practices report having to hire additional personnel to perform the functions. But in practices certified as patient-centered medical homes, for which Medicare does not pay for the additional engagement with patients, the CCM payments have reportedly helped them recoup some of the expense of the process changes in which they have had to engage to achieve PCMH status.⁵⁰

In a survey of 500 primary care physicians in July 2015, almost half were unaware that Medicare paid for non-face-to-face time to coordinate care.⁵¹ While Medicare anticipated a much higher volume of claims for CCM than they have received, the requirements to qualify for the payment are burdensome and go beyond what medical home certification requires. Reportedly commercial payors are beginning to pay for CCM with less burdensome documentation requirements and additional payment for more complex patients.⁵²

C. Oncology Care Management

⁴⁸ Terry, "Chronic Care Management Success: How to overcome tech limitations," Medical Economics (March 25, 2015,) pp.32-38

⁴⁹ Twiddy, "Chronic Care Management in the Real World," Family Practice Management Sept/Oct 2015, pp 35-41

⁵⁰ Robeznieks, "CMS care-management fees help medical home practices," Modern Healthcare (October 19, 2015) pp. 8-9

⁵¹ SmartCCM, "Challenges in Caring for Medicare Patients with Two or more Chronic Conditions," (July 2015) <http://smartccm.com/wp-content/uploads/2015/09/Challenges-in-Caring-for-Medicare-Patients-with-Two-or-More-Chronic-Conditions.pdf>

⁵² See n. 49

Unlike the other care coordination payments, the Oncology Care Model (OCM) as CMS refers to it, is only available to practices which apply for it and are accepted as having the capacity to deliver services in the way the payment is intended to incentivize. The government states the model encourages participating practices to improve care and lower costs through a model that incorporates a care coordination fee and episode based payments. In addition, unlike the other new payments, applicants to participate in the OCM will be measured on the extent to which other payors in their market will participate as well. The applications were due in June 2015 with an expected implementation in spring of 2016. The program is slated to operate over a five year period. Focused around Medicare patients receiving chemotherapy, the payment model has two components – one episode based, and the other performance based: (1) a per patient monthly payment of \$160 for six months; (2) a performance based incentive on top, which is in the nature of a bundled budget. Both are in addition to the regular fee for service payments that are available under the Medicare Physician Fee Schedule. As of October 2015, reportedly 450 practices had submitted letters of intent.⁵³

i. Who can participate?

Solo physicians, group practices and hospital owned practices that prescribe chemotherapy are eligible to participate. Practices owned by PPS-exempt cancer hospitals may not participate. The practices enter into separate participation agreements with CMS, that were not yet available at this writing. There are operational requirements they must meet and maintain⁵⁴:

(1) They must provide and attest to 24 hour 7 day a week patient access to an appropriate clinician who has real-time access to the practice's medical records. Remote access including telephone access can qualify. Nurses, non-physician practitioners and physicians are all permitted here. (2) They must attest to their intent to meaningfully use EHR technology certified by the Office of the National Coordinator They have to attest to Stage 1 by the end of the first performance year and to Stage 2 by the end of the third performance year. (3) They must utilize data for continuous quality improvement and must collect and report data regarding specified metrics. The CMS Innovation Center intends to provide them quarterly reports based on claims received, but the practices are also expected to generate their own data internally for improvement. (4) They are expected to provide the core functions of patient navigation as specified by the National Cancer Institute.⁵⁵ (5) They must document a care plan that contains the 13 components

⁵³ Reinke, "CMS Takes the Lead In Oncology Payment Reform," *Managed Care* (October 2015) pp. 22-25

⁵⁴ Oncology Care Model Request for Applications (February 2015, updated 6/3/15) <https://innovation.cms.gov/Files/x/ocmrfapdf>

⁵⁵ These include ten elements: 1. Coordinating appointments with providers to ensure timely delivery of diagnostic and treatment services; 2. Maintaining communication with patients, survivors, families and the healthcare providers to monitor patients' satisfaction with the cancer care experience; 3. Ensuring that appropriate medical records are available at scheduled appointments; 4. Arranging language translation or

in the Institute of Medicine Care Management Plan⁵⁶, engaging patients in the development of the plan. The agreements between the practice and CMS will include more detail regarding more specific reporting. (6) They must treat patients with therapies consistent with nationally recognized clinical practice guidelines. If they deviate from those guidelines, they must document why.

Because CMS wants this to be a multi-payer program, they have requirements for the other payers who would participate as well. The payors may be commercial, Medicare Advantage plans, Medicaid programs, self-insured businesses or TPAs, among others. They must commit to participate in the program for its 5 year term. They must sign a memorandum of understanding with the Innovation Center, They must enter into agreements with the practice participants that include requirements to provide high quality care, which sounds like nothing more than a boy-scout pledge. They have to share their model methodologies with the Innovation Center and provide payments to practices for enhanced services and performance as described in the application. They are expected to align their own practice and quality performance measures with the CMS model and must agree to provide participating practices regularly with aggregate and patient-level data about payment and utilization for their patients receiving care in the OCM program. Although the request for applications (RFA) indicated that the Center would publicly post the list of payers who submit LOIs along with the practices, by May 14, 2015, by November 15, 2015 no such list was posted, and the website reported Applications under review.

ii. *What is the performance-based component of payment?*

interpretation services; 5. Facilitating financial support and helping with paperwork; 6. Arranging transportation and/or child/eldercare; 7. Facilitating linkages to follow-up services; 8. Community outreach; 9. Providing access to clinical trials; and 10. Building partnerships with local agencies and groups (e.g. referrals to other services and/or cancer survivor support groups). National Cancer Institute Center to Reduce Cancer Health Disparities Patient Navigator Research Program. Available at <http://www.cancer.gov/aboutnci/organization/crchd/disparities-research/pnrrp>

⁵⁶ These are 1. Patient information (e.g. date of birth, medication list, and allergies); 2. Diagnosis, including specific tissue information, relevant bio markers, and stage; 3. Prognosis; 4. Treatment goals (curative, life-prolonging, symptom control, palliative care); 5. Initial plan for treatment and proposed duration, including specific chemotherapy drug names, doses, and schedule as well as surgery and radiation therapy (if applicable); 6. Expected response to treatment; 7. Treatment benefits and harms, including common and rare toxicities and how to manage these toxicities, as well as short term and late effects of treatment; 8. Information on quality of life and a patient's likely experience with treatment; 9. Who will take responsibility for specific aspects of a patient's care (e.g. the cancer care team, the primary care/geriatrics care team, or other care teams); 10. Advanced cancer plans, including advanced directives and other legal documents; 11. Estimated total and out-of-pocket costs of cancer treatment; 12. A plan for addressing patient's psychosocial health needs, including psychological, vocational, disability, legal or financial concerns and their management; and 13. Survivorship plan, including a summary of treatment and information on recommended follow-up activities and surveillance as well as risk reduction and health promotion activities. Institute of Medicine, Report Levitt, Balogh, Nass and Ganz ed, DELIVERING HIGH QUALITY CANCER CARE: CHARTING A NEW COURSE FOR A SYSTEM IN CRISIS. (2013)

The participating practices have the obligation of submitting claims for the monthly care management fee using a new HCPCS code. Practices are paid for six months of chemotherapy even if the patient stops after two months. This makes little sense. CMS will engage in attribution of beneficiaries after the completion of each episode, but as of June 15, 2015 when it published FAQs (which apparently were later removed from the website), they were not able to state the methodology they would use. Attribution is not an inconsequential issue when the chemotherapy itself may be administered at a hospital based provider while the clinical management of the patient is handled by a community based hematology oncology group.

The performance based component of the payment turns on several convoluted factors, beginning with cost benchmarking to establish a "target price" for each practice. In this calculation, benchmark expenditures for each participating practice will be calculated based on Medicare claims data from a historical baseline period that is static for the entirety of the model. They will adjust both for geographic variation as well as other risk adjustment factors that were unidentified at this writing. In the RFA, they indicated that risk adjustment factors might fall into the following categories: (1) beneficiary characteristics, such as age strata or comorbidities; (2) episode characteristics, such as whether or not an episode is the first for that beneficiary; (3) disease characteristics, such as cancer type; and (4) types of services provided, such as provision of radiation therapy or initiation of an endocrine therapy. The target price is calculated by analyzing the practice's Medicare beneficiaries' historical billings and applying a discount of 4% (for the one-sided risk model) that will be in effect for the first two years for all participants or 2.75% (for a two-sided risk model which practices can choose to join after the initial period).

The Innovation Center will measure the practice's performance on a predetermined set of quality measures to calculate a "performance multiplier". The quality measures span several domains of patient care including communication and care coordination, person and caregiver centered experience, and outcomes and clinical quality of care. In determining whether a practice qualifies for a performance bonus, they will calculate total Medicare expenditures, including the per beneficiary per month payment for all performance period episodes, including all Medicare services. Consequently, the physicians are at risk for emergency department visits, as well as hospital admissions, and other physician services. Patients with chronic conditions will have the expenditures for their other ongoing care reduced from any savings that the practices achieve over their target price. But the target prices will not be available to the practices until reconciliation. The amount of the performance bonus is the difference between their target price and their actual expenditures, factored by the application of the quality metrics.

The American Society for Clinical Oncology (ASCO) has criticized the model as too limited in scope and based on the flawed fee for service system.⁵⁷ ASCO has its own

⁵⁷ Anderson, "Critics Scold CMS Value-Based Oncology Model for Putting Providers at Rx Risk," Nelson, ASCO Business News (March 2015) <https://aishealth.com/archive/nabn0315-03>

new model for oncology payments.⁵⁸ Others have criticized inadequate risk adjustment, insufficient real time information on which to change behavior and more.⁵⁹ In addition, because the target price is based on historical performance of the specific practice, those already performing well at the advent of the program are penalized for their good behavior. The performance bonus calculation is complex; and at this writing details remained vague. But the entire approach does manifest how CMS is likely to move from volume to value incentives drawing on features present in the Bundled Payment for Care Initiative as well as the Medicare Shared Savings Program ó including the requirement to perform above benchmarks on quality and cost to obtain performance bonuses.

5. False Claims Issues

Given the new model of Medicare Learning Network Factsheet and FAQ publication of the new codes, with no regulatory support whatsoever except in prefaces to the Medicare Physician Fee Schedule, on what basis false claims liability will arise raises some interesting questions. In an increasing number of cases, courts are distinguishing between conditions of payment and conditions of coverage. In *US ex rel. Landers v. Baptist Memorial Health Care Corporation*⁶⁰, the court held that conditions of participation, provided in federal regulations, were not conditions of payment and therefore false claims could not be based on their violation. In *US ex rel. Swafford v. Borgess Medical Center*⁶¹, the court held that the Medicare Carrierø Manual provisions regarding physician supervision could not be the basis for false claim. In *US ex rel. Hobbs v. MedQuest Associates Inc.*⁶², physician supervision regulations published in the Code of Federal Regulations were not conditions of payment and could not support false claims liability. And in *US ex rel. Troxler v. Warren Clinic Inc.*⁶³, the evaluation and management services documentation guidelines did not rise to a sufficient level of mandate to yield false claim liability for not complying with them. How then could website FAQs and Medicare Learning Network articles form the basis for false claims? Nevertheless, given the rise of the plaintiffø whistleblower bar and the volume of filed claims, surely some will try to bring these cases. Still further, there have been multiple settlements on those bases by practices not willing to risk going to court. For that reason, it is worth considering how problems may arise in the new codes.

⁵⁸ öASCO Unveils New Model for Oncology Payments,ö Medscape (May 22, 2015) http://www.medscape.com/viewarticle/845222_print

⁵⁹ Clark, ö10 Reasons Why CMSøCancer Payment Model Could Failö Health Leaders Media (Mar. 3, 2015)

⁶⁰ 525 F. Supp. 2d 972 (WD Tenn 2007)

⁶¹ 98 F Supp. 2d 822 (WD Mich 2000) affød 24 Fed Appx 491 (6th Cir, 2001)

⁶² 711 F 3d 707 (6th 2013)

⁶³ 2015 BL 353837, 10th Cir., No 14-5144, 10/28/15

Care plan oversight has already been the basis for false claims settlements. Failing to document the amount of time in a calendar month or failing to document interactions with other health care professionals not employed in the same practice would make claims for the service improper. If the physician who bills CPO is not the same physician who signed the home health or hospice plan of care the services would be non-compliant.

Under transitional care management, missing the deadline of two (2) business days following the beneficiary's discharge for interactive contact with the patient and/or caregiver would be problematic. Failing to document sufficiently the required face-to-face visit in a timely manner would be problematic. Failing to conduct medication reconciliation before the face-to-face visit would disqualify the claim. However, in the absence of clear guidelines regarding what medication reconciliation consists of, it is difficult to understand how auditors would survey, let alone how false claims would be brought.

The chronic care management code offers even more opportunities to fail. Using the wrong type of practitioners to conduct the services (e.g. the notorious non-clinical medical staff) would be problematic. Utilizing a consent that does not conform with the requirements appears to be a condition of payment as well. An unqualified EHR, as well as an incomplete systematic assessment of the patient would conceivably provide grounds for false claims allegations. However, by regulating without regulations, the burgeoning distinction between a condition of payment and a condition of coverage will likely be a robust source of interaction between the enforcers, whistleblowers, and practices submitting claims. Without better guidance, however, it is hard to understand how the government's own auditors would proceed in evaluating the new claims.

The oncology care model requires a variety of "attestations". That word reeks of potential false claims liability if statements are inaccurate. Once the contracts between the practices and CMS are available, there likely will be other types of attestations that, if unfulfilled, will prove problematic.

Looking at CMS's current approach to information sharing and regulation with respect to the new coordination of care codes, it would seem difficult to demonstrate that physicians had real notice of the scope of their obligations in billing these codes. It will be interesting if someone raises an Administrative Procedure Act challenge for transitional care management and chronic care management. The oncology care model is different because it is a demonstration that was starting to be manualized by Nov. 5, 2015 in the Demonstration Manual (Pub. No. 100-19), although CMS distinguished this Manual by saying it is for programs that do not need to be manualized "at this point".

6. Conclusion

In this shift from a system which incentivized the volume of services rendered to one which is beginning to drive toward value — lower cost with improved quality — the role of fee for service codes remains more important than many have thought. The evolution of codes that pay for coordination of care has, paradoxically, added more

complexity to delivering what is required to bill the codes with less regulatory guidance. The administrative burdens associated with transitional care management and chronic care management are daunting even to sophisticated practices who are abstaining. The lack of true regulation or even Manual language, though, is bewildering. As lawyers, we now have to add MedLearn Matters articles and FAQs to our legal research.

The oncology care model was still unfinished in its design by the end of 2015. Still, the new codes will be deployed in the midst of a system that continues to reward volume over value for the most part. Within the ACO and bundled payment models, the new codes will provide some compensation for care coordination pending the results of those programs which reconcile savings at their conclusions.