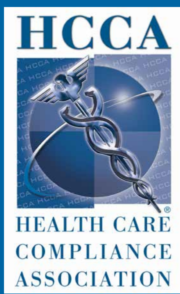

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by Alice G. Gosfield

Regulating by FAQ

» The Medicare Physician Fee Schedule has begun to include codes for care coordination that do not require physician-patient visits to be paid.
» There is no regulation or provision in the CMS Online Manual System addressing these codes.
» Their complicated requirements are described in Medicare Learning Network articles and Fact sheets.
» These codes will be important to pay physicians for their care of patients pending reconciliation in alternative payment models, which will be increased in volume according to CMS.
» There are real questions about how auditors will confront these codes, not to mention whistleblowers.

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As the physician reimbursement system moves from the volume driven, fee-for-service approach of the last 50 years, new codes have been added within the Medicare Fee Schedule to pay physicians for care coordination.

Gosfield

The transitional care management (TCM) code, first made available for use in calendar year 2013, is a code that pays physicians for managing patients when they are discharged to home, a rest home, or assisted living from an inpatient setting, as well as hospital outpatient observation or partial hospitalization.

The two CPT codes (99495 for patients requiring moderate complexity medical decision making, and 99496 for patients requiring high complexity medical decision making) are relatively complicated. The physician or non-physician practitioner billing for transitional care management must have an interactive contact with the patient and/or caregiver within two business days following the beneficiary's discharge. Although the bulk of the care management takes place in the professional's office, a face-to-face visit is required within 14 days of discharge for moderate complexity patients and within seven days of discharge for high complexity patients. Non–face-to-face services included are the discharge information, such as discharge summary or continuity of care documents; review of the need for follow-up on diagnostic treatments; the interaction with other healthcare professionals who will assume care of the beneficiary's system-specific problems; education for the patient, family, or caregiver; establishment or reestablishment of referrals and arrangements for needed community resources; and assistance scheduling required follow-up with community providers and services. Medication reconciliation must be completed by the time of the face-to-face visit. These services may be provided under general supervision, although the other indicia of "incident-to" billing must be provided.

Similarly, a chronic care management (CCM) code has been established for use beginning in calendar year 2015. This service, CPT code 99490, requires at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare 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. The conditions must place the

patient at "significant risk of death, acute/exacerbation/decompensation or functional decline." The core of the service involves a development of a comprehensive care plan established, implemented, revised, or monitored by the physician's staff. To bill the code, the patient must sign a consent form that must have specific elements in it. It must also state how the patient may revoke the consent. CMS notes that:

> …the CCM service is extensive, including structure recording, patient health information, electronic care plan addressing all healthcare issues, access to care management services, managing care transitions, and coordinating sharing information with practitioners and providers outside the practice.[1]

These new codes represent a significant change in the way Medicare pays for care. In addition, because DHHS Secretary Sylvia Mathews Burwell has said that 30% of Medicare payments will be attached to alternative payment models such as accountable care organizations or bundled payments, these codes provide for payment during the months before a reconciliation for gain sharing can occur under the alternate payment models. And yet there is not a word of regulation, nor a national coverage database article covering any of this.

All of the information alluded to above can be found in Medicare Learning Network articles, Fact sheets, and FAQs posted on the CMS website. Medicare administrative contractors are quite variable with regard to whether they offer any additional information. The Noridian Medicare website, for example, does provide additional data, but you will not find it if you search in the Local Coverage Determination database, because it is not an LCD.[2]

In replying to some of the FAQs, CMS directs the reader to look at the preface to the regulations for the calendar years 2012, 2013, and 2014 Medicare Physician Fee Schedule. However, those are not regulations, and courts have held that they do not have the force of law.

The Administrative Procedure Act has long required that regulations be published in proposed form, offer a comment period, account for the comments received, and be published in final form in the Federal Register. Although there is a discussion of transitional care management and chronic care management in the applicable prefaces, there is not a word of regulation published about these codes.

Given the complexity of what is required to qualify to be paid for these codes, one would think that, at a minimum, they would be manualized. In fact, they are not. There is nothing in any of the CMS online manuals that addresses either of these two new sets of codes.

Given this unusual approach, it is interesting to contemplate on what basis false claims liability could arise. In an increasing number of cases, courts are distinguishing between conditions of payment and conditions of coverage, asserting that a false claim can be based on only a condition of payment. Even in the face of Conditions of Participation published in federal regulations, a district court in Tennessee held that false claims could not be prosecuted against Baptist Memorial Healthcare Corporation.[3] Failure to comply with carriers/Medicare Administrative Contractors manuals regarding physician supervision could not form the basis for a false claim in Michigan.[4] Finally, failure to comply with the evaluation and management services documentation guidelines could not rise to a sufficient level of mandate as to form the basis for a false claim.[5]

1. Fact sheet, "Chronic Care Management Services" ICN 909188 (May 2015). Available at http://go.cms.gov/1Wy3FRN
2. See http://bit.ly/1Nn35zd
3. U.S. ex rel. Landers v. Baptist Memorial Health Care Corp., 523 F. Supp. 2d 972, 978 (W. D. Tenn. 2007)
4. *U.S. ex rel. Swafford v. Borgess Medical Center*, 98 F. Supp. 2nd 822 (WD Mich. 2000) Aff'd 24 Fed. Appx. 491(6 Cir. 2001)
5. *U.S. ex rel. Troxler v. Warren Clinic Inc.*, 2015 BL 353 837, 10th CRI #14-5144 (D.C. No. 4:11-CV-00808-TCK-FHM) (N.D. Okla.) 10/28/15