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Hiding the Ball in the Age of Transparency: The New Care Coordination Codes as a Case Study

By Alice G. Gosfield

As the shift from volume to value is expanding throughout the health-care system, a concomitant development is a wide ranging emphasis on transparency of information to consumers and others. Transparency of pricing also has become a major issue.[1] Transparency of performance is a bedrock principle of the Centers for Medicare and Medicaid Services programs reporting on comparative performance of providers across settings including hospitals, nursing homes, home health services, dialysis facilities, physicians and other health professionals and health and drug plans.[2]

Another part of the dramatic shift that is taking place is an emphasis on care coordination. In connection with that emphasis, new Current Procedural Terminology (CPT) codes have been introduced in Medicare for services that focus less on procedures and visits and more on the management and coordination of care. Most recently, these include transitional care management codes along with chronic care management codes. These codes and the payment for them offer the opportunity for physicians to be paid, even in the context of an accountable care organization or bundled payment arrangement, as alternative payment models that typically use gain-sharing arrangements allow distribution of funds to the physicians following reconciliation.

[1] Hostetter and Klein, ''Health Care Price Transparency: Can It Promote High Value Care?'' The Commonwealth Fund, *Quality Matters*. (April 2012), available at http://www.commonwealthfund.org/publications/newsletters/quality-matters/2012/april-may/in-focus.

[2] https://www.medicare.gov/forms-help-and-resources/find-doctors-hospitals-and-facilities/quality-care-finder.html.

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Historical Approaches to Medicare Reimbursement Research

For lawyers who have long worked on Medicare fee for service reimbursement, the typical sources of information have been the statute, the Code of Federal Regulations, and the Medicare Manuals which morphed from paper manuals to Internet-Only Manuals. The logic of their organization is opaque, and their search functions are beyond unwieldy. Then there are National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) which are in a searchable database on the CMS website—searchable by jurisdiction, topic and date.

LCDs have been a particularly thorny problem given the fact that Medicare is a national insurance program. The benefits made available to patients in California should mirror those of patients in Florida. However, from the inception of the program, because of the use of commercial carriers to administer the program, along with the fierce opposition from organized medicine, the fundamental concept was that payment models would mirror what went on outside of Medicare. In 1966, when Medicare was enacted, there was no national system for claims submission, coding or payment. Everything reflected local practice. Not only did the payment model of usual, customary and reasonable fees reflect local billing patterns, so did the notion that there were regional differences in the way medicine also was practiced clinically.

Today, in an era when we have moved to evidence-based medicine, which reflects science and not geographic eccentricities, the persistence of LCDs is anomalous and should be considered obsolete. The fact that in one locale only a registered nurse may perform a service, while no such requirement is stated in others, makes no sense. The language in LCDs addressing the

same topics is similar but not the same. What is the point of that? Still, lawyers know that in researching a problem that involves fee for service Medicare, they must look to the regulations, the interpreting manuals, and the relevant coverage determinations in order to advise clients appropriately.

Welcome to the New World Order

In the process of researching an article[3] on the transition of Medicare fee for service to encompass more payment for care coordination, the first code I chose to address was one that was introduced for first use in 1995. The Care Plan Oversight (CPO) codes are to be used for patients in home health care (G0181) or hospice care (G0182). The concept was presented in the Federal Register.[4] There are actual regulations addressing it,[5] and manual provisions further explicate its use.[6] There are no LCDs as of Jan. 30, 2016, addressing the service. Nevertheless, a lawyer seeking to advise a client regarding the requirements for care plan oversight could follow the traditional pathways and produce information that would be relevant and applicable.

In my research I moved on to far more recent care coordination codes, adopted after the enactment of the Affordable Care Act, presumably reflecting the new values it calls for in changing payment for care in the hopes of motivating changes in the care itself. The transitional care management codes, one for patients of moderate complexity and one for patients of higher complexity, and the chronic care management code manifest an entirely different challenge for lawyers. First, there is not a single regulation, manual provision, NCD, LCD or Medicare transmittal addressing either of them. Information about these new codes, presumably important to motivate better care delivery, is available in fact sheets, Medicare Learning Network Articles and frequently asked questions pages! Lawyers now must add these sources to their research in advising clients. Still further, I have been able to identify only one fact sheet and set of FAQs from one Medicare administrative contractor (MAC), Noridian, which addresses transitional care management. Although LCDs present certain problems, they are subject to comment and review by advisory committees and they have to state their sources. FAQs and Learning Network articles do not. But the story gets better.

There is some discussion of transitional care management in the prefaces to the publication of the Medicare Physician Fee Schedule (MPFS) in 2012, 2013 and 2014. There is a Medicare Learning Network article[7] and a page of FAQs.[8] There are multiple elements of service that must be provided. Intended to prevent readmissions, the code may be billed once during the 29 days post discharge from an inpatient setting (hospital, skilled nursing facility or other inpatient setting). The physician or nonphysician practitioner (NPP) must have an interactive contact with the patient and/or caregiver by telephone, e-mail or face to face. Within 7 or 14 days after discharge, depending on the patient's complexity there must be a face-to-face visit. There are at least six types of coordination activities which may be counted toward the service. CMS defines the documentation requirements and states that medication reconciliation (one of the required elements) must be completed by the time of the face-to-face visit. CMS does not define what medication reconciliation is. Noridian, a MAC with most of its jurisdictions in the West, has published in its FAQs a full paragraph describing medication reconciliation.[9] Where does that definition come from? Unlike an LCD there is no source cited. Will patients in Noridian's jurisdiction get that definition of medication reconciliation while beneficiaries elsewhere get something different?

The chronic care management code is a worse story yet. This code is so important in the effort to transform chronic care that by October 2015, CMS had estimated that 35 million Medicare patients would be eligible to receive the services it pays for, but by that time CMS had received reimbursement requests for a grand total of 100,000 beneficiaries![10] The CPT code 99490 is intended to pay physicians for interactions with other providers in managing a care plan for their patients. CMS describes the services as follows:

> *''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.''* [11]

The service is billed monthly and requires a minimum twenty minutes of staff time, although the type of staff who may render it are ''clinical staff'' as defined in the CPT book. I have worked with the CPT book for more than thirty years. There are no definitions in the CPT book. CMS offers no link, no citation and no further reference.

I spent half an hour trying to find where any such definition exists in the CPT book. Google can't produce the CPT book itself because of copyright issues. The definition does not appear in the descriptions of 99490 in the CPT book. I Googled the issue and found only a vague reference inside a document authored by the Texas Medical Society which quoted a phrase addressing the clinical staff requirement. I then Googled that phrase and found the sentence within which it appeared. I looked for that sentence in the physical CPT book and found that the critical definition of what type of personnel may render this service to 35 million Medicare beneficiaries is located under the subheading ''Instructions for Use of the CPT Codebook.''

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[3] Gosfield, ''Beyond Face Time: The Evolution of Medicare Fee For Service in A Value-Driven World.'' HEALTH LAW HANDBOOK (2016 ed.), available at http://www.gosfield.com/images/PDF/BeyondFaceTime.010516.pdf.

[4] 59 Fed Reg 63418, December 8, 1994.

[5] 42 CFR 414.39.

[6] Medicare Claims Processing Manual, Chptr. 12, § 180.

[7] ICN 908628 (June 2013).

[8] https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf (Aug. 21, 2013).

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

[10] ''Robeznieks, ''CMS care-management fees help medical home practices,'' Modern Healthcare (Oct. 19, 2015) pp 8-9.

[11] Fact Sheet, ''Chronic Care Management Services'' ICN 909188 (March 2015).

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The complexity of what is required to bill the code has stymied many practitioners, although practices that have become patient-centered medical homes find that the code can help defray some of their expenses in reorganizing processes of care and deploying new or different staff to deliver the services. Still, for both new codes the administrative burdens are not inconsequential; the patients must pay a co-pay for services they do not experience directly themselves and which they reportedly believe they will obtain anyway.[12]

False Claims Implications

There are many ways to fail at providing what the new codes require. But with those codes explained and their requirements set forth only in fact sheets and FAQs it is hard to imagine a prosecutor or a court basing false claims exposure on such wildly informal methods of guidance. Courts have found that provisions in Medicare manuals are insufficient.[13] The evaluation and management documentation guidelines have been rejected as a basis for a false claim case.[14] While there is disparity in the circuits regarding whether a failed condition of participation can be the basis for a false claim or only a condition of payment can qualify, this new realm of communication arguably doesn't even create any condition in a legal sense. Based on what is available to date, it is hard to postulate how these codes will ever be audited by the myriad squads of investigators that now abound in Medicare, let alone used by prosecutors or whistle-blowers!

Conclusion

The development of payment for coordination of care is an essential component of the move from volume to value. Because of the long-standing emphasis on procedures and visits in what Medicare would pay for, as the system changes in its organizational and clinical orientations, payment needs to be available, flexible, useful and productive. Making information about such payment easily found and also subject to the hornbook requirements of the Administrative Procedure Act would seem elementary. Unfortunately, left with inadequate guidance, lawyers now must expend inordinate time, and utilize nontraditional legal research methods, to help providers determine how reimbursement can be obtained in the new care-coordination world.

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[12] Robeznieks, ''CMS care-management fees help medical home practices,'' Modern Healthcare (Oct. 19, 2015) pp. 8-9.

[13] *U.S. ex rel. Swafford v. Borgess Medical Center*, 98 F. Supp. 2d 822 (W.D. Mich. 2000), *aff'd*, 24 Fed. Appx. 491 (6th Cir., 2001).

[14] *U.S. ex rel. Troxler v. Warren Clinic Inc.*, 2015 BL 353837, 10th Cir., No 14-5144, 10/28/15.