PUBLICATION

CMS Proposes Additional Payments for Care Coordination by Primary Care Physicians [Ober|Kaler]

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When CMS published its Proposed Physician Fee Schedule [PDF] rules in the July 30, 2012 Federal Register, it included the creation of new codes to allow payment to primary care physicians and non-physician practitioners for post-discharge care management services. CMS emphasizes in the preamble to the Proposed Rule that primary care and care coordination are crucial to the Medicare program goals. The proposal recognizes that, while non-face-to-face management services have in the past been bundled into evaluation and management codes (E/M codes) and not paid for separately, the E/M codes may not adequately reflect all of the resources and services necessary to provide coordinated care management upon discharge from facilities such as hospitals or skilled nursing facilities. Comments on the proposed rule are due by September 4, 2012.

Specifically, the Proposed Rule addresses this deficiency by creating a new G-code that can be billed by primary care physicians who coordinate services for a beneficiary after discharge from a hospital, in order to capture the activities involved in the patient's transition from the treating physician in the facility to a "community physician and NPP." CMS anticipates that most community physicians and NPPs will be primary care physicians. The code would be paid for all non-face-to-face services provided by the community physician or qualified non-physician practitioner (NPP), or by clinical staff or office-based case mangers under the supervision of the physician or NPP, provided within 30 days of discharge. The new code would be payable once during the transition period to a single community physician or NPP who assumes the responsibility for the patient's post-discharge transitional care management. In order to pay only once, CMS will accept the first claim it receives. In addition, the proposal would require that the physician or NPP must have billed an E/M visit for the patient within 30 days prior to the hospital discharge or within the first 14 days of the post-discharge period. Further, when physicians or NPPs bill certain current hospital discharge or SNF discharge management codes, the G-code could not be billed separately. Further, physicians and NPPs that bill for a procedure within a global period would not be entitled to payment. Consequently, physicians that provide services and then continue to follow the patient after discharge would not be eligible to bill for the G-code.

In order to bill for the new G-Code, CMS has proposed that the services provided would include the following:

- Assuming responsibility for the beneficiary's care without a gap
  - Obtaining and reviewing discharge summary
  - Reviewing diagnostic tests and treatment
  - Updating the medical record based on discharge summary
- Establishing or adjusting the beneficiary's plan of care to reflect certain required elements
  - Assessment of the beneficiary's health status, medical needs, functional status, pain control, and psychosocial needs following discharge
- Communication with the beneficiary or caregiver, including education of patient/caregiver within two days of discharge
  - Assessment of understanding of medication regimen

    - Assessment of other post-discharge care plan items
- Communication with other health care professionals
- Assessment of follow-up needs
- Establishment and re-establishment of community resources
- Assistance in scheduling follow-up visits

Ober|Kaler's Comments

The creation of a new post-discharge transitional care management code is intended to focus on the benefits of having primary care physicians managing beneficiary care, thereby reducing inpatient readmission rates. This proposal is in line with the administration's goals of benefitting primary care and providing greater reimbursement to primary care physicians. Both primary care physicians, NPPs and specialists will need to pay close attention to the details of the final rule to determine whether the detailed list of services provided by the new code will be adequately reimbursed and whether the exclusion of physicians who have billed for a service using a global surgery code should automatically be excluded from receiving such payments.