United States Government Accountability Office

Report to Congressional Committees

July 2019

MEDICARE PHYSICIAN SERVICES

Spending On and Use of Billing Codes for Comprehensive Care Planning Services

GAO-19-557

July 2019

MEDICARE PHYSICIAN SERVICES

Spending On and Use of Billing Codes for Comprehensive Care Planning Services

GAO Highlights

Highlights of GAO-19-557, a report to congressional committees

Why GAO Did This Study

Medicare's physician fee schedule contains over 8,000 billing codes for office visits, surgical procedures, or other services provided to beneficiaries. Some provider groups have concerns that these codes do not sufficiently account for the LCCP-type services they provide to Medicare beneficiaries with complex medical needs.

The BBA included a provision that GAO examine billing codes that may be used for LCCP-type services for beneficiaries with a serious or life-threatening illness.

GAO identified, among other things, (1) existing Medicare physician fee schedule billing codes that can be used to bill LCCP-type services; and (2) trends in Medicare spending on these services from 2013 through 2017.

GAO reviewed Centers for Medicare & Medicaid Services (CMS) billing code manuals and American Medical Association (AMA) code descriptors to identify existing codes containing key components of LCCP-type services; analyzed Medicare Part B claims data from 2013 to 2017 (the most recent available at the time of GAO's review); and interviewed officials from CMS and 19 stakeholders, including the AMA, national physician groups, and other provider groups that had previously given input on the topic to Congress.

GAO provided a draft of this report to the Department of Health and Human Services (HHS). In response, HHS provided technical comments, which GAO incorporated as appropriate.

View GAO-19-557. For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov.

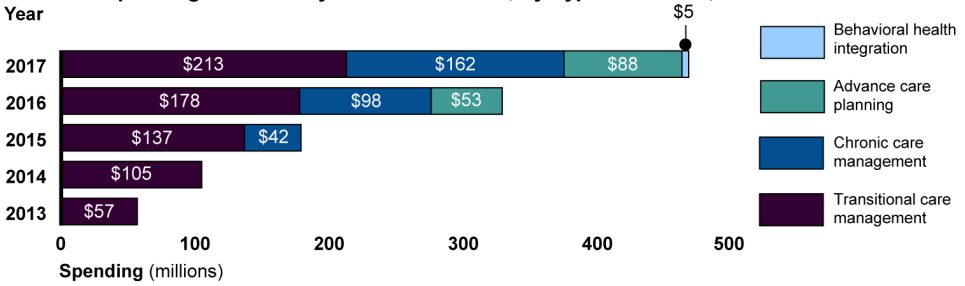
What GAO Found

The 2018 Bipartisan Budget Act (BBA) defined longitudinal comprehensive care planning (LCCP) as services involving an interdisciplinary team of providers who develop and communicate a care plan to Medicare beneficiaries diagnosed with a serious or life-threatening illness. GAO identified at least 58 billing codes in Medicare's physician fee schedule that could be used by providers to bill for services that cover some or all of the LCCP service components as defined in the 2018 BBA —referred to by GAO as LCCP-type services. The 58 billing codes may be used individually or in combination, depending on a beneficiary's medical needs. Stakeholders representing providers told GAO their members generally use one or a combination of these codes to bill for LCCP-type services.

- Forty-five of the 58 codes are broadly-defined longstanding codes that can be used for LCCP-type services as well as other services such as the treatment of a specific medical complaint.
- The remaining 13 codes are more recent narrowly-defined codes introduced starting in 2013 that only cover LCCP-type services. They include transitional care management services introduced in 2013, chronic care management starting in 2015, advance care planning in 2016, and behavioral health integration in 2017.

GAO found that overall Medicare spending on LCCP-type services that were billed to the 58 codes increased from $26 billion in 2013 to almost $29 billion in 2017. While narrowly-defined services accounted for a small share of this total spending ($467 million in 2017), spending on these narrowly-defined services such as chronic care management increased rapidly. Moreover, spending growth on narrowly-defined services was driven by increased use of these services rather than increases in reimbursement rates. From 2013 through 2017, more beneficiaries received and more providers billed for narrowly-defined services. The number of Medicare beneficiaries receiving these services grew from about 267,000 to about 2.5 million. The number of providers billing these services grew from about 31,000 to about 100,000.

Medicare Spending on Narrowly-Defined Services, by Type of Service, 2013-2017



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-19-557

Contents

Letter		1
	Background	5
	Medicare's Physician Fee Schedule Contains at Least 58 Billing Codes That Providers May Use to Bill for LCCP-Type Services	8
	Medicare Spending Increased for All LCCP-Type Services and Increased More Rapidly for New Narrowly-Defined Services That Were Furnished to More Beneficiaries by More Providers	13
	Stakeholders Had Mixed Views on Whether a New Billing Code for an LCCP Service Is Needed	23
	Agency Comments	29
Appendix I	Example of an American Medical Association Vignette	31
Appendix II	Longitudinal Comprehensive Care Planning Service Components in the Balanced Budget Act of 2018	32
Appendix III	Stakeholder Groups Interviewed by GAO	34
Appendix IV	Medicare Physician Fee Schedule Billing Codes for Longitudinal Comprehensive Care Planning (LCCP)-Type Services	35
Appendix V	Specialty Billing of Complex Evaluation and Management Codes in 2017	42
Appendix VI	Longitudinal Comprehensive Care Planning (LCCP) Services: Stakeholder Perspectives on Potential New Billing Code	44

Appendix VII GAO Contact and Staff Acknowledgments 47

Tables

Table 1: Types of Narrowly-Defined Longitudinal Comprehensive Care Planning-Type Codes under the Medicare Physician Fee Schedule 10
Table 2: Examples of LCCP-Type Billing Codes in Medicare's Physician Fee Schedule, 2019 11
Table 3: Alignment of Key Components of the Longitudinal Comprehensive Care Planning (LCCP) Service as Defined in the Balanced Budget Act of 2018 with Equivalent Components in Existing Medicare Billing Codes 32
Table 4: Percentage of Complex Evaluation and Management (E/M) Visits by Specialty, 2017 42

Figures

Figure 1: Medicare Spending on Narrowly-Defined LCCP-Type Services, by Type of Service, 2013 - 2017 15
Figure 2: Number of Medicare Beneficiaries Receiving Narrowly-Defined LCCP-Type Services, 2013 – 2017 17
Figure 3: Percentages of Medicare Beneficiaries Who Received Narrowly-Defined LCCP-Type Services Compared to the Percentage of Services Received, 2017 18
Figure 4: Share of Medicare Beneficiaries Receiving Only One Type of Narrowly-Defined LCCP-Type Service, 2017 19
Figure 5: Number of Providers Billing Narrowly-Defined LCCP-Type Services, 2013 – 2017 20
Figure 6: Percentages of Providers Who Billed for Narrowly-Defined LCCP-Type Services Compared to the Percentage of Services Billed, 2017 21
Figure 7: Share of Total Spending on Narrowly-Defined LCCP-Type Services by Provider Specialty, 2017 22
Figure 8: Vignette for Current Procedural Terminology (CPT) Code 99213, Office/outpatient Visit, Level 3, Established Patient 31
Figure 9: Medicare Physician Fee Schedule Billing Codes That May Be Used to Bill for Longitudinal Comprehensive Care Planning (LCCP)-Type Services 36

Abbreviations

ACP	advance care planning
AMA	American Medical Association
BHI	behavioral health integration
BBA	Bipartisan Budget Act
CCM	chronic care management
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
E/M	evaluation and management
HHS	Department of Health and Human Services
HCPCS	Healthcare Common Procedure Coding System
LCCP	longitudinal comprehensive care planning
TCM	transitional care management

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

July 31, 2019

Congressional Committees

Over two-thirds of the 39 million beneficiaries enrolled in Medicare's traditional fee-for-service program in 2017 had two or more serious health conditions, such as diabetes and heart disease. The often complex nature of these types of conditions and the treatments for them generally necessitate care planning and coordination among providers in different medical specialties.[1] For example, a beneficiary with diabetes and heart disease may be simultaneously under the care of a primary care physician, an endocrinologist, a cardiologist, and a podiatrist, highlighting the need for planning and coordination of care to ensure that services are not being duplicated and that all providers involved in the patient's care share important clinical information and have clear expectations about their roles in the patient's care.

Providers have historically billed Medicare for care planning and coordination services using one or more of the over 8,000 billing codes in the program's physician fee schedule. The specific code or codes a provider uses depends on the time, skill, and complexity of the medical decision-making required for each patient's unique needs. In particular, evaluation and management (E/M) billing codes—codes used to bill for face-to-face patient visits that are provided in various settings such as physicians' offices or hospitals—are widely used by all physicians regardless of their specialty, accounting for over half of the $69.1 billion spent on all physician fee schedule services in 2017. However, certain physician specialties (largely those specializing in primary care) have raised longstanding concerns that E/M codes do not adequately account for the amount of time they spend in planning and coordinating care for beneficiaries with complex medical needs.

The Bipartisan Budget Act of 2018 (2018 BBA) defines longitudinal comprehensive care planning (LCCP) as a service that includes the following five components:

[1]For purposes of this report, we generally use the term "provider" to refer to physicians and other practitioners—such as physician assistants and nurse practitioners—who may also bill for services under the Medicare Physician Fee Schedule. Where appropriate, we refer to "physicians" directly.

- a conversation with a beneficiary diagnosed with a serious or life-threatening illness;
- shared decision-making through an interdisciplinary team that includes a physician, registered nurse, and social worker;
- development of a longitudinal comprehensive care plan (care plan) that is discussed with the beneficiary that addresses the progression of the disease and treatment options;
- a care plan that addresses the beneficiary's goals, values, and preferences; and
- a care plan that discusses the availability of other resources or social supports that may help mitigate the beneficiary's health risks.[2]

The 2018 BBA included a provision that we examine Medicare Physician Fee Schedule billing codes established by the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers the Medicare program—that may be used for care planning services provided to beneficiaries diagnosed with a serious or life-threatening illness or illnesses.[3] We refer to these services as LCCP-type services because they cover some or all of the LCCP service components as defined in the 2018 BBA.

This report describes

1. existing Medicare Physician Fee Schedule billing codes that providers may use to bill for LCCP-type services;
2. trends in Medicare spending on LCCP-type services from 2013 through 2017; and
3. stakeholders' views on the need for a new billing code representing the LCCP service as defined in the 2018 BBA.

To examine existing Medicare Physician Fee Schedule billing codes that providers may use to bill for LCCP-type services, we reviewed relevant information from CMS and the American Medical Association (AMA) and interviewed key stakeholders.[4] Specifically, we identified billing codes

[2]Pub. L. No. 115-123, § 50342(c)(4), 132 Stat. 211.

[3]Pub. L. No. 115-123, div. E, tit. III, § 50342, 132 Stat. 64, 209.

[4]The AMA develops and updates a list of billing codes used to report services by physicians and other providers.

included in one of the six main categories of codes under Medicare's 2018 physician fee schedule that would most likely cover some or all of the LCCP service components as defined in the 2018 BBA.[5] To identify these codes, we reviewed the code descriptors, claims processing manuals, and other documents from the Medicare Learning Network on CMS's website. We also reviewed CMS's proposed and final Medicare Physician Fee Schedule rules from 2012 to 2019 to understand the agency's rationale for establishing these codes.[6] Based on our review of these materials, we developed a preliminary list of billing codes that could be used to bill for LCCP-type services. As part of our analysis, we identified the extent to which these codes include the five key components of the LCCP service as defined in the 2018 BBA. To do this, we reviewed information from the AMA's *RBRVS DataManager,* a database that includes detailed 'vignettes' describing the components of services provided to a typical patient under each billing code.[7] We also reviewed estimates of physician and non-physician time used to provide these services to a typical patient, using publically available time files from the CMS website.[8] (See app. I for a sample vignette and app. II for our alignment of the five key LCCP components with equivalent components in our list of selected billing codes.) We finalized our preliminary list of billing codes based on our review of this information as well as input from CMS and 19 stakeholders, including the AMA, physician specialty societies, and other provider groups. To identify these stakeholders, we reviewed a list of over 300 organizations that had

[5]The six categories are: Evaluation and Management (E/M), Anesthesia, Surgery, Radiology, Pathology & Laboratory, and Medicine. E/M codes generally include services such as consultations with patients, examinations, coordination of care among various providers involved in a patient's care, counseling, and care planning. The five other categories of codes cover specific procedures, tests, or other types of services that would not include LCCP-type services. We examined existing billing codes included in the 2018 fee schedule since CMS had not yet finalized billing codes for 2019 at the time of our study.

[6]We selected 2012 as our starting point because that was the first year CMS began to develop proposals for new billing codes to address stakeholders' longstanding concerns about limitations of E/M codes for care planning services.

[7]For example, a vignette describes the services to be delivered to a typical patient and the estimated time spent by physicians and non-physicians to perform these services. It might specify that the provider should review the patient's medical history, coordinate with other physicians, and develop a detailed care plan.

[8]Throughout this report, we use the term "non-physician" to refer to clinical staff, such as nurses or medical technicians that may be employed by, or under contract with, physicians. CMS also refers to time spent by non-physicians as 'clinical staff time'.

participated in a Chronic Care Working Group organized by the Senate Committee on Finance in 2015.[9] We narrowed the list to national umbrella organizations representing a mix of physician and non-physician groups (such as the American College of Physicians and the National Association of Social Workers) that had specifically commented on the need for a new billing code.[10] (See app. III for a list of stakeholders.)

To determine trends in Medicare spending on LCCP-type services, we analyzed Medicare Part B claims data from 2013 through 2017 for the specific billing codes we identified as covering LCCP-type services.[11] We examined trends in spending and utilization on these services, including the number of beneficiaries receiving these services and the number of providers billing for these services. We report spending and utilization trends in the aggregate as well as by provider specialty (for example, internal medicine or family practice), and by setting (for example, facility settings such as hospitals and hospices, and nonfacility settings such as physicians' offices). We assessed the reliability of the Medicare claims data in several ways, including reviewing relevant CMS data documentation, performing manual and electronic tests of the data to identify any outliers or anomalies, and comparing it with data from published sources. We determined that the claims data were sufficiently reliable for the purposes of our reporting objectives.

To obtain stakeholder perspectives on the need for a new billing code for the LCCP service as defined in the 2018 BBA, we interviewed CMS and the 19 stakeholder groups we had selected for our study and reviewed written materials they provided to us. We obtained their perspectives on the extent to which the billing codes we had identified covered the LCCP service as defined in the 2018 BBA. Where stakeholders expressed support for a new billing code, we obtained their perspectives on how the new code should be structured, including beneficiary and provider

[9]The Senate Committee on Finance formed the Working Group in 2015 to explore options for improving the care of millions of Americans managing chronic illness. The Working Group solicited comments on the need for an additional Medicare billing code for care planning for beneficiaries with serious or chronic conditions from interested stakeholders.

[10]Where multiple national groups representing the same type of medical specialty provided comments to the Senate Finance Chronic Care Working Group, we selected the group that we determined best represented the physicians' viewpoints.

[11]We picked 2013 as our starting point because that was the first year CMS established a specific code for care planning, and 2017 was the most recent full year of data available at the time of this study.

eligibility, and the frequency with which the service could be billed (e.g. one-time, monthly, or as needed). Where available, we analyzed relevant information or data, including CMS final rules, code descriptors from AMA's *RBRVS DataManager,* and Medicare Part B utilization data found on the CMS website, to corroborate or provide additional context for stakeholders' testimonial evidence.

We conducted this performance audit from July 2018 to July 2019 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicare's Physician Fee Schedule

CMS uses the Medicare Physician Fee Schedule to pay physicians and other providers for services delivered to beneficiaries. Physicians and other providers bill Medicare for their services using various five-digit billing codes based in part on codes developed by an AMA panel.[12] Each year, the panel receives proposals from provider groups and others to revise existing billing codes or create new codes. The panel requires those who submit proposals to develop a clinical vignette that describes the typical patient who would receive the service, the diagnosis and relevant conditions, and estimates of time that physicians might spend in providing the service for the typical patient. The panel applies several criteria in reviewing these proposals. For example, a new code

- should represent a unique, well-defined procedure or service clearly identified and distinguished from existing procedures and services;
- should not fragment an existing procedure or service represented by one or more existing codes;

[12]Specifically, the AMA's Current Procedural Terminology (CPT) panel maintains and updates a list of billing codes that CMS adopts for use. CMS refers to these codes as Level I Healthcare Common Procedure Coding System (HCPCS) codes. CMS also develops codes for other services or items for which Medicare reimburses providers, such as ambulance services, medical equipment, and supplies; CMS refers to these codes as Level II HCPCS codes.

- should reflect the typical (not extraordinary) circumstances related to the delivery of the service;
- should be performed by many physicians or other qualified health care professionals across the United States; and
- should be consistent with current medical practice.

CMS pays providers a fixed amount known as the Medicare fee for each code. The fees are based on relative values—estimates of resources for the physician's work (time, skill, and level of training), and practice expenses (the costs of running a practice such as salaries of non-physician employees, rent, and overhead) required to provide a service relative to all other services.[13] In setting fees, CMS also does not allow certain codes to be billed together if it deems that payment for one code is already included in another.[14] CMS establishes and updates relative values annually. By law, the effect of any changes to its payment rates generally must be budget neutral. That is, if total spending increases by more than $20 million each year, including due to the creation of new billing codes, fees for all services would have to be reduced accordingly.[15]

Services billed under the physician fee schedule may be provided in a variety of settings, including physicians' offices and institutional settings such as hospitals, skilled nursing facilities and hospices. Non-physicians may also bill or be reimbursed by Medicare for services under certain circumstances. For example, some types of non-physicians practicing independently—such as physician assistants and nurse practitioners—

[13]For example, if one service requires twice as many resources as another, its fee should be twice as high. (Fees also include reimbursement for physicians' costs of obtaining malpractice insurance.) The AMA/Specialty Society Relative Value Scale Update Committee develops and updates these resource estimates based in part on the physician and non-physician work described in the clinical vignette as well as the estimates of physician and non-physician time that might be spent providing the service to a typical patient. The actual time that providers spend furnishing these services may vary depending upon the needs of individual patients, and providers are generally not required to document the amount of time they actually spent in order to bill and receive reimbursement for these services.

[14]For example, CMS considers code 99366—described by the AMA CPT manual as a "medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional"—to be bundled into the more comprehensive code 99483—described as assessment and care planning for patients with cognitive impairment. Therefore, codes 99366 and 99483 may not be billed together.

[15]See 42 U.S.C. § 1395w-4(c)(2)(B)(ii)(II).

may bill Medicare for certain services that they are legally authorized to perform under their respective state laws.[16] In other instances, physicians may bill as if they had furnished services that were provided by non-physician staff that they employ or with whom they have a contractual relationship as long as the physician has an established relationship with the beneficiary, and is on the premises to provide supervision if necessary.[17]

Care Planning Services in Medicare

Providers and other stakeholders have noted that they care for an elderly population with increasingly complex medical conditions who receive care from multiple providers across different sites of care including physicians' offices, hospitals, nursing homes, and hospices. As such, the focus of primary care has shifted from treating specific medical conditions to increased care coordination and planning. CMS also noted that a new trend in care planning is the use of shared care plans between the beneficiary and the provider rather than those created solely by the provider. These jointly developed care plans can be particularly important to improving overall beneficiary outcomes for beneficiaries with serious illnesses and also allow other providers involved in the beneficiary's care access to timely information that supports planned care.[18]

However, stakeholders have suggested that Medicare's payment system does not fully reimburse providers for such care planning services. For example, some note that the E/M billing codes that primary care physicians generally use to bill for their services were developed at a time when care coordination and planning was not part of the standard practice of medicine; as such, these codes do not reflect time spent on activities that do not require a face-to-face encounter with the beneficiary, including medical conferences with other physicians, or telephone calls to coordinate care with other providers. Some primary care physicians have requested that CMS conduct a comprehensive review of existing E/M codes to ensure they account for time spent on these services, or develop new codes that primary care physicians may exclusively use to bill for these services. However, others have noted that E/M codes have been

[16]Each state has its own scope of practice laws, which typically define a physician or non-physician's practice, qualifications, board representation, and fee/renewal schedule.

[17]These services are known as 'incident-to' services.

[18]See Medicare, Payment Policies Under the Physician Fee Schedule for CY 2012, 76 Fed. Reg. 42772, 42917 (proposed Jul. 19, 2011) (preamble, IV.K.).

reviewed and valued by the AMA, and the codes account for the time spent on these services. Moreover, they have stated that care coordination and planning services are delivered by multiple specialties, not just primary care physicians.[19]

Medicare's Physician Fee Schedule Contains at Least 58 Billing Codes That Providers May Use to Bill for LCCP-Type Services

Our analysis identified at least 58 Medicare Physician Fee Schedule billing codes that providers may use to bill for LCCP-type services.[20] These 58 billing codes generally contain components we determined to be equivalent to the five key components of the LCCP service as defined in the 2018 BBA.[21] For example, all 58 codes included a provision for the development of a care plan that addresses the beneficiary's goals, values, and preferences, and a provision for coordination with other providers, which is equivalent to the LCCP component related to interdisciplinary care.[22] Providers may choose a single code or a combination of these codes to account for the time, skill, and resources needed to deliver the service based on the unique health needs of each patient. (See app. IV for more information on the 58 codes and the LCCP components they contain as defined in the 2018 BBA.)

[19]See e.g., Medicare, Payment Policies Under the Physician Fee Schedule for CY 2012, 76 Fed. Reg. 73026, 73059 (Nov. 28, 2011) (preamble, II.B.5.a) and Medicare, Revisions to Payment Policies Under the Physician Fee Schedule for CY 2017, 81 Fed. Reg. 80170, 80225 (Nov. 15, 2016) (preamble, II.E.1.).

[20]We identified, and CMS also indicated that there may be, additional codes that contained one of more of the five key LCCP components. However, the estimates of physician time for these codes were more limited (between 5 and 10 minutes for some codes). Based on our interviews with several stakeholders, we determined this amount of time was not likely to be sufficient for providers to furnish all components of the LCCP service. We therefore excluded these codes from our list.

[21]The components included in the LCCP service are 1) a conversation with a beneficiary diagnosed with a serious or life-threatening illness; 2) shared decision-making through an interdisciplinary team that includes a physician, registered nurse, and social worker; 3) development of a longitudinal care plan that addresses the progression of the disease and treatment options; 4) a care plan that addresses the beneficiary's goals, values, and preferences; and 5) a care plan that discusses the availability of other resources or social supports that may help mitigate patient health risks. Although providers may use these codes to bill for LCCP-type services, providers do not need to furnish all of these components in order to use the codes to bill Medicare.

[22]All but two of the 58 billing codes included a provision for a conversation with the beneficiary about their diagnosis and care plan. However, while the description for these two codes did not specify a conversation, since these codes may only be billed along with a code that does involve a face-to-face visit (which would involve a conversation), by extension, they would include such a conversation.

The 58 billing codes for LCCP-type services include 45 longstanding, broadly-defined codes and 13 narrowly-defined codes that were more recently introduced starting in 2013.

Broadly-defined codes. Of the 45 broadly-defined codes, 39 are E/M codes that have existed for decades.[23] E/M codes are broadly defined to include services provided to treat a variety of illnesses (for example, treatment of a particular medical complaint), but they may also be used to bill for LCCP-type services. In general, the E/M codes range in complexity from low to high depending on the amount of time the provider spends with a patient as well as the complexity of the medical condition(s) being treated. E/M codes may also be billed if more than 50 percent of the time allotted for the service is spent on counseling and care coordination—for example, explaining treatment options and ways to mitigate the patient's health risks—which are key components of the LCCP service as defined in the 2018 BBA.

The E/M codes we identified as representing LCCP-type services were the more complex codes that had estimates of time that may be spent providing the service to a typical patient ranging from 30 to 120 minutes of physician time and 3 to 71 minutes of non-physician time.[24] While the majority of E/M codes have existed for decades, CMS added six new E/M codes starting in 2008—referred to as "prolonged" E/M codes—allowing payment for additional time for care planning and care management services for complex conditions.[25]

Narrowly-defined codes. Starting in 2013, CMS added 13 narrowly-defined LCCP-type codes to better account for the time spent

[23]The remaining six codes include four codes related to the monthly management of patients with end-stage renal disease.

[24]The actual time that providers spend furnishing these services may vary depending upon the needs of individual patients, and providers are generally not required to document the amount of time they actually spent in order to bill and receive reimbursement for these services.

[25]In its final Physician Fee Schedule rule for 2019, CMS stated that it is implementing another prolonged E/M code to reflect at least 30 minutes of physician time spent on patient visits that require more time than is typical for the visit. See Medicare, Revisions to Payment Policies Under the Physician Fee Schedule for CY 2019, 83 Fed. Reg. 59452, 59577 (Nov. 23, 2018) (preamble, II.H.4.(60)).

coordinating care for patients with complex treatment needs.[26] CMS implemented these more narrowly-defined care planning codes largely in response to provider complaints that E/M codes did not sufficiently account for extensive care management/coordination of care that was required across multiple providers and settings. Unlike broadly-defined codes, these narrowly-defined codes can only be used for LCCP-type services.

The 13 narrowly-defined LCCP-type codes fall into four types: transitional care management (TCM), chronic care management (CCM), advance care planning (ACP), and behavioral health integration (BHI).[27] (See table 1.) While some pertain to patients with specific types of health conditions or in certain settings, others are more general and may be used for a range of health conditions.

Table 1: Types of Narrowly-Defined Longitudinal Comprehensive Care Planning-Type Codes under the Medicare Physician Fee Schedule

Type of code	Type of patient	Year established	CMS purpose for adding the billing code(s)
Transitional Care Management (TCM)	Recently discharged from a hospital stay	2013	CMS added two TCM codes to account for care management in a patient's transition after a hospital stay. Activities include the establishment or revision of a care plan. TCM codes may be billed within 30 days of discharge.
Chronic Care Management (CCM)	Multiple chronic conditions	2015 2017	CMS added a new CCM code in 2015 to account for non-face-to-face time spent by clinical staff in coordinating care for patients with two or more chronic health conditions. (To bill the CCM code, the provider must have first provided an E/M or other visit as an initiating visit prior to providing the CCM service.) CMS added three additional CCM codes in 2017. Two of them were created because CMS determined that the 20 minutes of clinical staff time in the original CCM code was insufficient for complex patients. CMS added the third code as an add-on to the initiating visit because the time for the initiating visit was insufficient for complex patients.[a] CCM codes may only be billed once monthly.
Advance Care Planning (ACP)	All patients	2016	CMS added two new ACP codes because it determined that additional face-to-face time was needed for care planning beyond the E/M visit.[b] ACP codes may be used for care planning for any type of patient. There are no restrictions on frequency of billing.

[26]These codes include both face-to-face time when the patient is present as well as other time spent consulting with other treating physicians or in coordinating community-based resources such as social supports when the patient is not present.

[27]For purposes of this report, we have included one new billing code for assessment of cognitive impairment in the BHI category.

Type of code	Type of patient	Year established	CMS purpose for adding the billing code(s)
Behavioral Health Integration (BHI)[c]	Mental/ behavioral health conditions	2017	CMS added four new BHI codes to promote collaborative care between primary care physicians and psychiatrists for patients with behavioral health or cognitive conditions. BHI codes may generally only be billed once monthly. CMS also implemented a new code for assessment and care planning for patients with cognitive impairment. This code may be billed once every 6 months.

Source: GAO analysis of data from Centers for Medicare & Medicaid Services. | GAO-19-557

[a]See 81 Fed. Reg. 80243 (Nov. 15, 2016) (preamble, II.E.4.) In its final Physician Fee Schedule rule for 2019, CMS stated that it is implementing another code for CCM services that are personally provided by a physician or other qualified health care professional since the existing CCM codes largely include time spent by non-physician staff in care coordination. See 83 Fed. Reg. 59577 (Nov. 23, 2018) (preamble, II.H.4.(60)).

[b]See Medicare, Revisions to Payment Policies Under the Physician Fee Schedule, 80 Fed. Reg. 70886, 70955 (Nov. 16, 2015) (preamble, II.H.6.c.).

[c]For purposes of this report, we have included one new billing code for assessment of cognitive impairment in the BHI category.

The estimates of physician and non-physician time that may be spent on the broadly-defined and narrowly-defined codes vary, as does Medicare's 2019 fees for these billing codes—see examples of commonly used LCCP-type billing codes in table 2 and see appendix IV for related information on all 58 LCCP-type billing codes. For example, some stakeholders told us they might bill a complex E/M code (99214) along with a CCM code (99487). As our analysis shows, this combination could result in the provider spending 66 minutes of physician time and 113 minutes of non-physician time for a typical beneficiary, and receiving total Medicare fees of about $203 in 2019.

Table 2: Examples of LCCP-Type Billing Codes in Medicare's Physician Fee Schedule, 2019

Billing code	Short description[a]	Physician time[b] (minutes)	Non-physician time[b] (minutes)	2019 Medicare fee (office/outpatient) (in dollars)
Broadly-defined codes				
99214	Office/outpatient visit for the evaluation and management of an established patient	40	53	110.28
99222	Initial hospital care, per day, for the evaluation and management of a patient	75	N/A	139.11
99236	Observation or inpatient hospital care; same date	94	N/A	220.92
99305	Initial nursing facility care, per day, for the evaluation and management of a patient	57	14	132.26
99344	Home visit for the evaluation and management of a new patient	100	12	185.24

Billing code	Short description[a]	Physician time[b] (minutes)	Non-physician time[b] (minutes)	2019 Medicare fee (office/outpatient) (in dollars)
Narrowly-defined codes				
99496	Transitional care management	50	125	234.97
99487	Complex chronic care management	26	60	92.98
99497	Advance care planning	45	7	86.49
99483	Assessment of and care planning for a patient with cognitive impairment	85	92	263.81
99492	Initial psychiatric collaborative care management	40	85	162.18

Legend:
LCCP: longitudinal comprehensive care planning
N/A: not applicable

Source: GAO analysis of data from Centers for Medicare & Medicaid Services | GAO-19-557

[a]The short description is our interpretation of the short descriptor in the Medicare Physician Fee Schedule and long descriptors in American Medical Association and Centers for Medicare & Medicaid Services' Medicare Learning Network documents.

[b]The physician and non-physician times for each billing code are estimates of time that may be spent delivering these services to a typical patient. The actual time that providers spend furnishing these services may vary depending upon the needs of individual patients, and providers are not required to document the amount of time they actually spent in order to bill and receive reimbursement for these services. The time estimates included here are generally applicable to services provided in a nonfacility setting, such as a physician's office. Some services by definition are always provided in a facility setting (for example, an initial hospital care visit). In such cases, the non-physician services are generally provided by hospital staff.

Medicare Spending Increased for All LCCP-Type Services and Increased More Rapidly for New Narrowly-Defined Services That Were Furnished to More Beneficiaries by More Providers

Medicare Spending on All LCCP-Type Services Increased by 11 Percent from 2013 through 2017, While Spending on Narrowly-Defined Services Grew More Rapidly

Overall Medicare spending on LCCP-type services represented by the 58 billing codes we identified increased from $26 billion in 2013 to $29 billion in 2017, an 11 percent increase. The vast majority of this spending—about $28.3 billion in 2017—was on services represented by the 45 broadly-defined codes we identified earlier (henceforth we refer to these services as "broadly-defined services.")[28] By comparison, Medicare spending on LCCP-type services represented by the 13 narrowly-defined codes (henceforth referred to as "narrowly-defined services") was about $467 million in 2017.

Though smaller in terms of total dollars, spending on narrowly-defined services grew at a higher rate than spending on broadly-defined services, from about $2 per beneficiary in 2013 to $14 per beneficiary in 2017. This higher rate in growth can mostly be attributed to these four new types of services being introduced during this 4 year period. For example, as Table 1 shows, two TCM codes were introduced in 2013 and four CCM codes were introduced from 2015 to 2017. In contrast, spending growth

[28]We cannot determine the exact share of spending on broadly-defined services that was specifically related to LCCP. However, four of the stakeholders we interviewed, representing physician specialty groups, said they billed E/M services almost exclusively based on time. E/M services that are billed on the basis of time spent on planning and coordination are more likely to be related to LCCP. The four physician specialties accounted for about $10.6 billion (37 percent) of total spending on broadly-defined LCCP-type services in 2017.

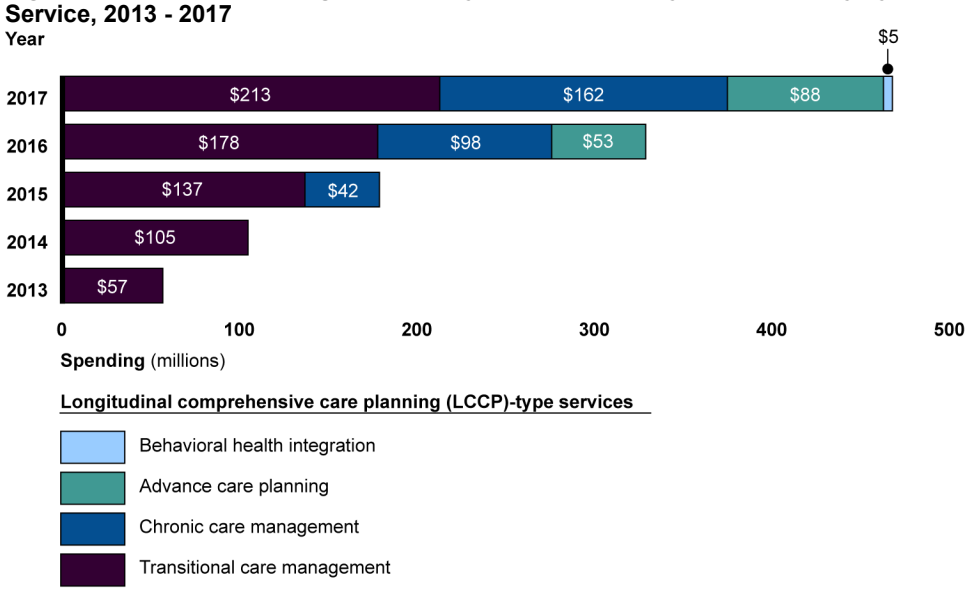
for broadly-defined services was much smaller, increasing from about $785 per beneficiary in 2013 to $844 per beneficiary in 2017. For all other Medicare Physician Fee Schedule services combined, per-beneficiary spending decreased from about $1,488 in 2013 to $1,426 in 2017.[29]

Spending on CCM and TCM services accounted for most of the total spending on narrowly-defined LCCP-type services from 2013 to 2017. (See fig. 1.) For example, in 2017, TCM services accounted for almost half ($213 million of the total spending of $467 million), while spending on CCM services accounted for over a third ($162 million of the $467 million).[30]

[29]We calculated spending on all other Medicare Physician Fee Schedule services by subtracting total spending on LCCP-type services from spending on all physician fee schedule services as reported in the 2018 *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: June 5, 2018).

[30]The frequency with which different types of narrowly-defined services may be billed and the beneficiaries eligible for each type of service also factor into the relative spending growth for each type of service. For example, CCM services may be billed monthly for beneficiaries with multiple chronic conditions, and many beneficiaries have these conditions.

Figure 1: Medicare Spending on Narrowly-Defined LCCP-Type Services, by Type of Service, 2013 - 2017



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-19-557

Note: Narrowly-defined services are represented by 13 codes identified by GAO that may only be billed for LCCP-type care planning services. These include transitional care management (established in 2013), chronic care management (established starting in 2015), advance care planning (established in 2016), and behavioral health integration services (established in 2017).

The growth in spending on narrowly-defined services was driven by increased utilization—that can be attributed in part to the development of new codes for these services—rather than increases in Medicare fees for these services.[31] Specifically, utilization of narrowly-defined services increased from about 9 services per 1,000 beneficiaries in 2013 to about

[31]Specifically, the new codes that were established starting in 2015 (CCM, ACP, and BHI) contributed to almost 80 percent of the growth in total utilization of narrowly-defined services.

177 services per 1,000 beneficiaries in 2017.[32] Average Medicare fees for these services remained flat during this period.

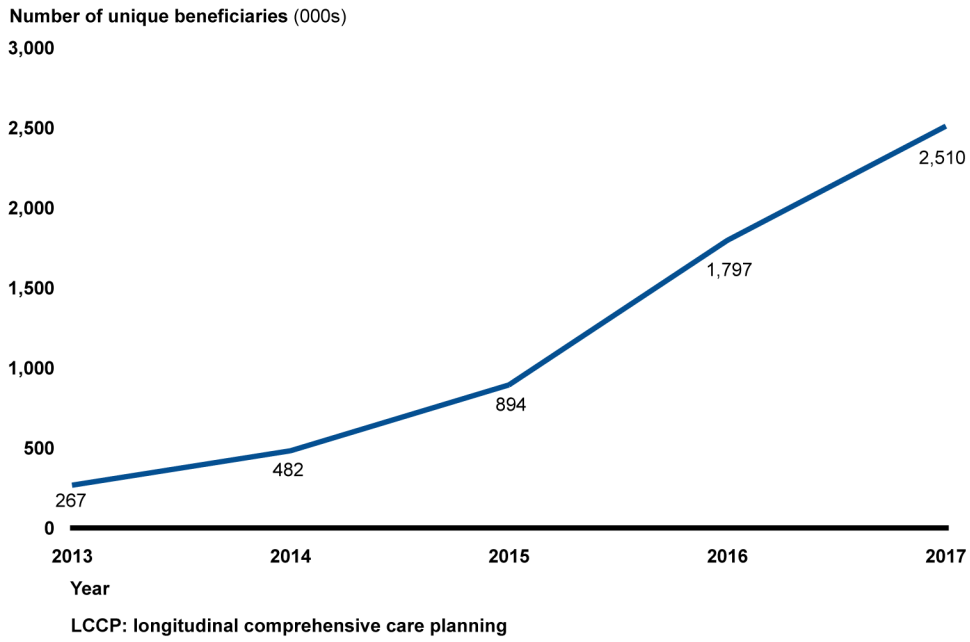
More Beneficiaries Received and More Providers Billed for Narrowly-Defined LCCP-Type Services, with a Small Share of Beneficiaries and Providers Accounting for Most of the Services

The number of beneficiaries receiving narrowly-defined LCCP-type services increased substantially from 2013 to 2017, as more of these Medicare billing codes were added and began to be utilized during this time. Specifically, in 2017, about 2.5 million beneficiaries received narrowly-defined LCCP-type services, representing an 839 percent increase from about 267,000 beneficiaries in 2013. (See fig. 2.)[33]

[32]Although growth of narrowly-defined services has been rapid, actual utilization of these services when they were first introduced has been lower than CMS projections. For example, actual utilization of TCM services in 2013 was about 9 per 1,000 beneficiaries compared to CMS's projection of about 172 per 1,000 beneficiaries. Similarly, actual utilization of CCM services in 2015 was about 31 per 1,000 beneficiaries compared to CMS's projection of about 122 per 1,000 beneficiaries. Billing of new services may initially be slow because it takes time for practices to learn the billing requirements for the new services, or because they perceive that the time spent in meeting Medicare's guidelines for billing outweighs the reimbursement for these services. Beneficiaries may also not be willing to avail themselves of the new service if there is a required copayment (which is generally 20 percent of Medicare's fee for the service).

[33]Where beneficiaries received more than one type of narrowly-defined service, we counted them only once.

Figure 2: Number of Medicare Beneficiaries Receiving Narrowly-Defined LCCP-Type Services, 2013 – 2017



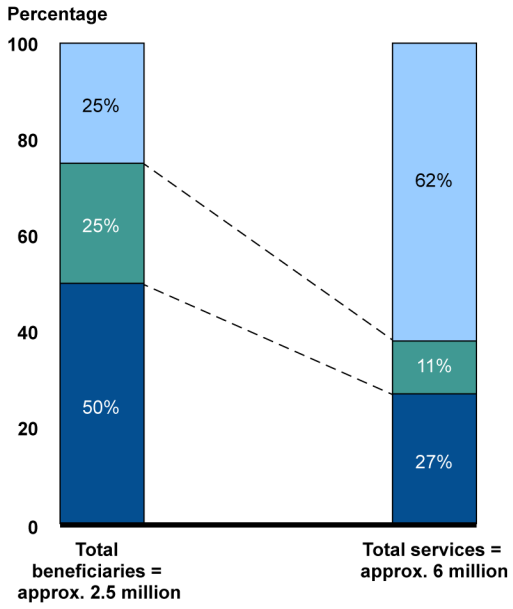
Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-19-557

Note: Narrowly-defined services are represented by 13 codes identified by GAO that may only be billed for LCCP-type care planning services. These include transitional care management (established in 2013), chronic care management (established starting in 2015), advance care planning (established in 2016), and behavioral health integration services (established in 2017).

While the overall number of beneficiaries receiving narrowly-defined services increased, these services were concentrated among a relatively small share of Medicare beneficiaries. Specifically, one-quarter of beneficiaries who received any of the narrowly-defined services in 2017 received 62 percent of the approximately 6 million services that were provided that year. (See fig. 3.)[34]

[34] Moreover, this concentration has increased over the years. Specifically, in 2013, one-quarter of beneficiaries accounted for only 20 percent of narrowly-defined services

Figure 3: Percentages of Medicare Beneficiaries Who Received Narrowly-Defined LCCP-Type Services Compared to the Percentage of Services Received, 2017

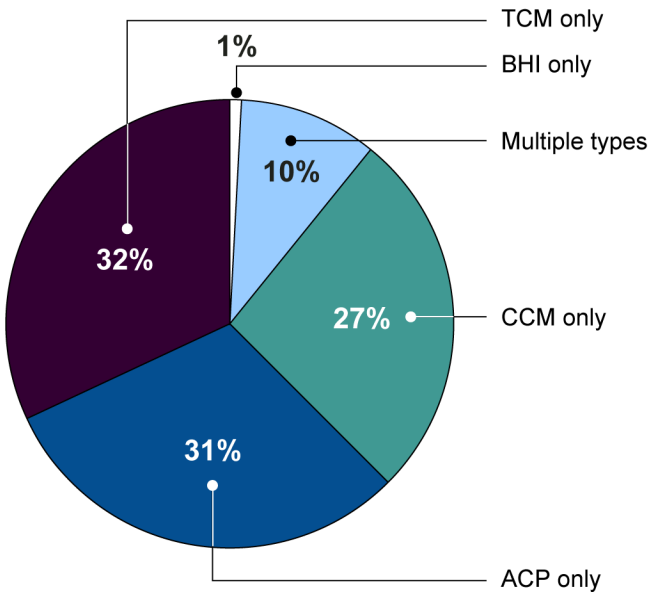


Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-19-557

Note: Narrowly-defined services are represented by 13 codes identified by GAO that may only be billed for LCCP-type care planning services. These include transitional care management (established in 2013), chronic care management (established starting in 2015), advance care planning (established in 2016), and behavioral health integration services (established in 2017).

In 2017, of the total 2.5 million beneficiaries that received narrowly-defined services, 90 percent received only one type of narrowly-defined LCCP-type service. (See fig. 4.) In contrast, only 10 percent of beneficiaries received multiple types of narrowly-defined LCCP-type services, the most common combination being CCM and ACP.

Figure 4: Share of Medicare Beneficiaries Receiving Only One Type of Narrowly-Defined LCCP-Type Service, 2017



Total longitudinal comprehensive care planning (LCCP)-type services = approx. 6 million

ACP: advance care planning
BHI: behavioral health integration
CCM: chronic care management
TCM: transitional care management

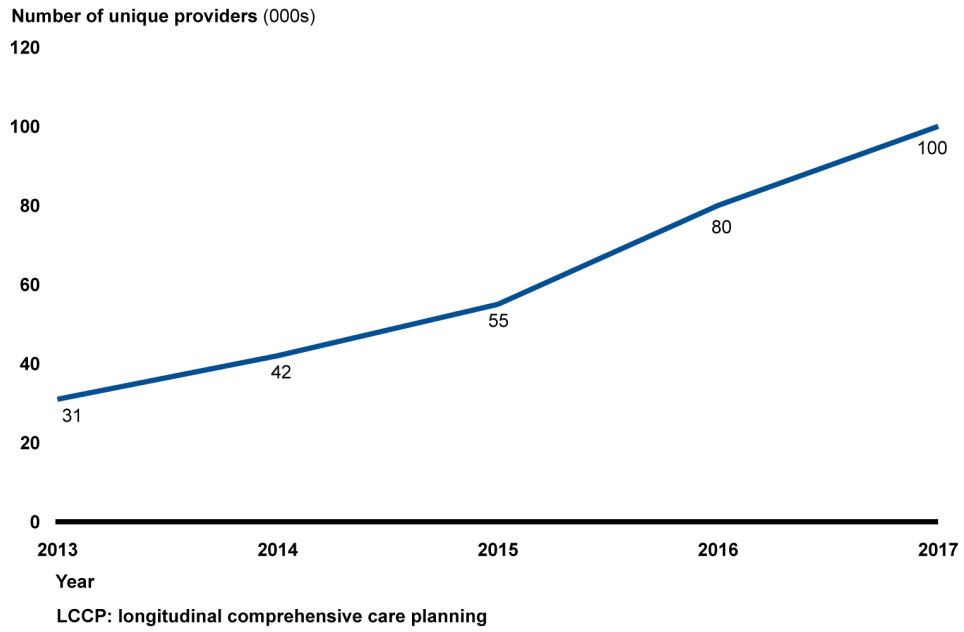
Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-19-557

Note: Narrowly-defined services are represented by 13 codes identified by GAO that may only be billed for LCCP-type care planning services. These include transitional care management (established in 2013), chronic care management (established starting in 2015), advance care planning (established in 2016), and behavioral health integration services (established in 2017).

Mirroring beneficiary trends, the number of Medicare providers billing for narrowly-defined LCCP-type services also increased significantly from 2013 through 2017, as these Medicare billing codes were established and began to be utilized during this time. In 2017, a total of about 100,000 providers billed for narrowly-defined services, representing a 227 percent increase from about 31,000 providers in 2013. (See fig. 5.)[35]

[35]Where providers billed more than one type of narrowly-defined service, we counted them only once.

Figure 5: Number of Providers Billing Narrowly-Defined LCCP-Type Services, 2013 – 2017



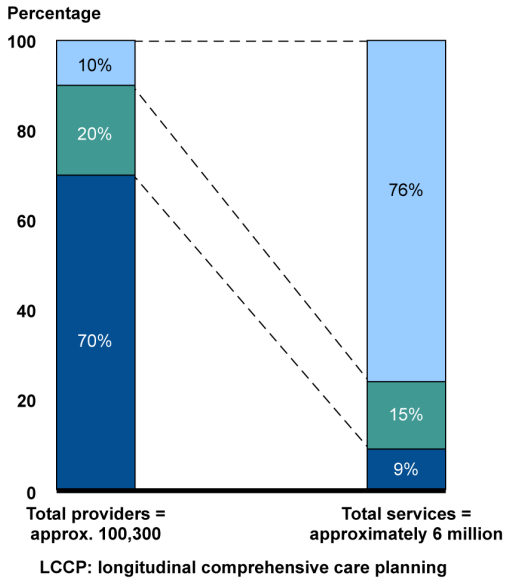
Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-19-557

Note: Narrowly-defined services are represented by 13 codes identified by GAO that may only be billed for LCCP-type care planning services. These include transitional care management (established in 2013), chronic care management (established starting in 2015), advance care planning (established in 2016), and behavioral health integration services (established in 2017).

As with beneficiary trends, while the overall number of providers billing narrowly-defined services grew from 2013 to 2017, billing for these services was also increasingly concentrated among a small share of providers. Specifically, in 2017, 10 percent of providers who billed for any narrowly-defined services billed about 76 percent of the approximately 6 million services that were provided in that year. (See fig. 6.)[36]

[36]This concentration has also increased over the years—in 2013, 10 percent of providers billed for just under half (45 percent) of narrowly-defined services.

Figure 6: Percentages of Providers Who Billed for Narrowly-Defined LCCP-Type Services Compared to the Percentage of Services Billed, 2017

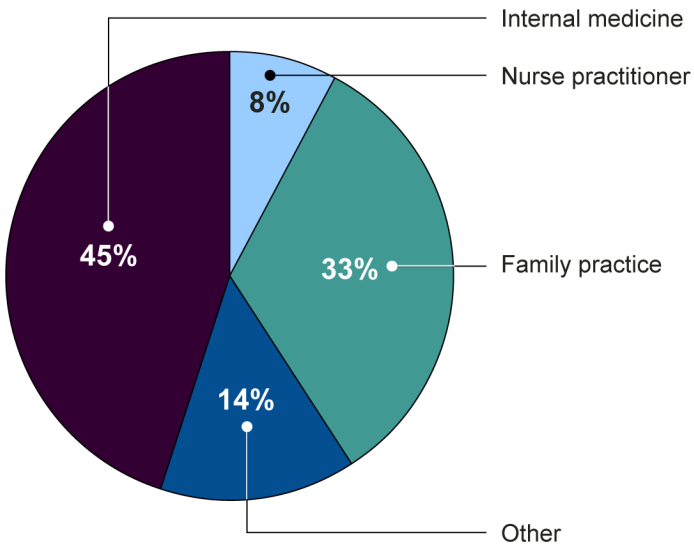


Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-19-557

Note: Narrowly-defined services are represented by 13 codes identified by GAO that may only be billed for LCCP-type care planning services. These include transitional care management (established in 2013), chronic care management (established starting in 2015), advance care planning (established in 2016), and behavioral health integration services (established in 2017).

Each year from 2013 through 2017, physicians specializing in internal medicine accounted for the largest share of spending on narrowly-defined LCCP-type services. In 2017, internal medicine accounted for 45 percent of the $467 million in total Medicare spending on narrowly-defined services. (See fig. 7.) Family practice and nurse practitioners were the other specialties accounting for the greatest shares of spending.

Figure 7: Share of Total Spending on Narrowly-Defined LCCP-Type Services by Provider Specialty, 2017



Total longitudinal comprehensive care planning (LCCP)-type providers = approx. 100,300

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services . | GAO-19-557

Note: Narrowly-defined services are represented by 13 codes identified by GAO that may only be billed for LCCP-type care planning services. These include transitional care management (established in 2013), chronic care management (established starting in 2015), advance care planning (established in 2016), and behavioral health integration services (established in 2017).

In terms of the setting in which narrowly-defined LCCP-type services were provided, the majority were provided in nonfacility settings such as physicians' offices. Specifically, in 2017, 94 percent of narrowly-defined services were provided in nonfacility settings. This trend was consistent over each of the 5 years from 2013 to 2017.

Stakeholders Had Mixed Views on Whether a New Billing Code for an LCCP Service Is Needed

Six Stakeholders Did Not Support Creating a New Billing Code for an LCCP Service

Six of the 19 stakeholders we interviewed did not support the creation of a new billing code for an LCCP service as defined in the 2018 BBA. Two of these—representing physician specialties that together accounted for almost one-fifth of total spending on LCCP-type services in 2017—stated that the existing billing codes were sufficient for them to provide and bill for the full range of the LCCP service. They stated that billing either a single code or a combination of an E/M code and one or more of the 13 narrowly-defined LCCP-type codes we identified allowed them to account for the full range of the LCCP service as defined in the BBA. As such, the two stakeholders said, there was no need for a new billing code.

The remaining four stakeholders expressed concerns about creating a new billing code for an LCCP service. These concerns included the following:

- *Overlap with existing codes that require the development of care plans:* While not explicitly stating that existing codes were sufficient, some stakeholders said that if a new billing code were created for the LCCP service as defined in the 2018 BBA, it would overlap with or duplicate existing billing codes. For example, three stakeholders noted potential overlap with existing billing codes, such as the ACP

and CCM.[37] Three stakeholders said that the care plan that would be required under the new LCCP code would duplicate existing care plans that are required by law for beneficiaries in hospices or skilled nursing facilities.[38] In addition, two stakeholders noted that providers in their specialty already prepare detailed care plans as a standard practice of care when evaluating their patients and billing for these services using existing E/M billing codes. They stated that these care plans exceed the components of the care plan specified in the 2018 BBA.[39] Stakeholders noted that the existence of multiple overlapping codes that include the development of a care plan could create confusion for providers in choosing the most appropriate billing code.

- *Concerns about code proliferation or code fragmentation:* Several stakeholders were concerned that adding another code to Medicare's billing system could result in increased Medicare spending and less, rather than more, care coordination. Specifically, two stakeholders stated that having multiple billing codes for care planning and care

[37]For example, the vignette for CCM code 99490 in the AMA's *RBRVS DataManager* states that "A plan of care must be documented and shared with the patient and/or caregiver. A care plan ...typically includes, but is not limited to, problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community and social services ordered, ... coordinating the care of other professionals and agencies; and educating the patient or caregiver about the patient's condition, care plan, and prognosis." While the provider is not required to furnish all components in order to bill the code, the inclusion of these components in the code descriptor indicates that they may be used for the LCCP service as described in the 2018 BBA.

[38]For example, CMS sets requirements for the care of hospice patients suffering from a terminal illness who have 6 months or less of life expectancy. Specifically, a written plan of care must be established and maintained by an interdisciplinary group (which must include a hospice physician, registered nurse, social worker, and pastoral or other counselor) in consultation with the patient's attending physician, if there is one. The plan of care must identify the frequency and scope of services to be provided that meet the patient's and family's needs. (These requirements are consistent with the requirements of the care plan specified in the LCCP service.)

[39]For example, one stakeholder stated that written care plans are required by the hospital's Tumor Board—a multidisciplinary team typically composed of cancer experts and other providers involved in the patient's care that meets regularly to discuss the details of patients recently diagnosed with cancer. These care plans contain detailed information including the specific type of cancer; treatment options (surgery, radiation, chemotherapy); planned course(s) of treatment; a list of providers coordinating the patient's care; predisposing genetic and other factors; a follow-up care plan that details additional treatments and their planned duration; possible immediate and late or long-term side effects of each treatment including emotional and psychosocial effects; possible lifestyle changes that might help mitigate the disease; and other available resources. The written care plan is shared with the patient.

management, respectively, would have the potential to increase spending because multiple providers could start billing the new codes even though one provider may have primary responsibility for the beneficiary.[40] (In contrast, under the existing billing codes a single code that encompassed both types of services could be billed.) For example, one of these stakeholders said that primary care physicians generally referred beneficiaries with complex treatment needs to a surgeon or specialist who then both planned and managed the beneficiary's care, yet the primary care physician might also bill the care planning billing code. In addition to the potential for increased Medicare spending, three stakeholders said that code fragmentation—splitting existing billing codes into multiple codes for services that were previously bundled together—was contrary to the comprehensive patient-centered model of care that Medicare was moving towards. Specifically, one provider stated that under such a model, rather than billing multiple different codes for care planning and coordination, a primary care practice is paid a monthly management fee to (among other things) improve care coordination for patients who receive most of their primary care services from that practice.[41]

Thirteen Stakeholders Stated That a New LCCP Code Could Address Concerns Regarding Interdisciplinary Care Reimbursement and Other Limitations They Identified in Existing Billing Codes

While six of the stakeholders we interviewed did not support creating a new LCCP code, the remaining 13 stakeholders told us that such a billing code is needed. According to the stakeholders, a new LCCP code as defined in the 2018 BBA could address several concerns they identified in Medicare's existing billing codes related to the provision of the LCCP service. However, some of these concerns could be addressed under the current Medicare billing framework, as shown by our analysis of available data. For example, stakeholders identified the following limitations that could be addressed by a new LCCP code:

[40]Increases in total spending due to multiple providers billing the new care planning code would be somewhat contained by Medicare's budget neutrality provision, which requires that increased spending on physician fee schedule services beyond a certain threshold—including due to increased spending on a particular set of services—would have to be offset by decreases in fees for all services.

[41]The stakeholder was referring to the Home-Based Primary Care track within the existing Comprehensive Primary Care Plus initiative to support the provision of a core set of five comprehensive primary care functions. These include improved care planning for high-risk patients through the development of care plans and team-based approaches like the integration of behavioral health services into primary care practices.

- *Inadequate reimbursement for time spent on interdisciplinary care:* The 13 stakeholders stated that Medicare's existing billing codes either did not require or did not sufficiently reimburse them for the time spent on interdisciplinary care. They stated there should be a separate code to reimburse this type of care. However, stakeholders representing two specialties told us they had proposed such a code to the AMA but the AMA had rejected their proposals because interdisciplinary care is already accounted for in the existing billing codes.[42] Moreover, as our analysis of the 58 billing codes shows, the majority of these codes include a provision for consultation and coordination among providers that is equivalent to input from an interdisciplinary team.[43] With regard to inadequate reimbursement, as another stakeholder noted, providers may bill a complex E/M service along with a narrowly-defined LCCP-type service such as CCM. The total reimbursement for such a combination of codes would be about $203 as of 2019. (See table 2.)
- *Insufficient physician time for care planning:* Six stakeholders representing a mix of primary care and medical specialties stated the existing billing codes (including the more complex E/M codes) had insufficient physician time to provide both care planning and care management, which they maintained are separate and distinct activities.[44] They stated a new code could include the appropriate time

[42]Moreover, in the final Physician Fee Schedule rule for 2019, CMS stated that it was implementing separate payment for six codes that were previously considered bundled into other codes and were therefore not separately payable. These six codes are for interprofessional consultations for assessment and management services conducted via telephone or electronically at the request of the patient's treating provider. The consulting provider may bill for the codes without a face-to-face visit with the patient. See 83 Fed. Reg. 59576 (Nov. 23, 2018) (preamble, II.H.4.(59)). Medicare's 2019 fees for these billing codes range from about $18 to about $73.

[43]For example, the description of Code 99214- *office/outpatient visit, established patient* in the AMA's *RBRVS DataManager* states that the physician or other practitioner may "provide necessary care coordination, telephonic or electronic assistance, and other necessary management related to this office visit". In addition, it states that "counseling and/or coordination of care with other physicians, other qualified health professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family/s needs". This code alone accounted for over a third of total LCCP-type spending in 2017.

[44]For example, one stakeholder stated that care planning was a more comprehensive service that considered the beneficiary's overall medical, social, and ancillary needs; as such, it was more "future-oriented" and generally preceded care management. Care management, on the other hand, referred to the implementation of the care plan and may be focused on the beneficiary's specific medical complaint. However, others stated that there is no such distinction and good patient care involves both types of activities.

needed. One stakeholder said that care planning requires at least 30 minutes of time, and the complex E/M codes do not allow providers to bill for the time it takes to provide both the care management of a complex patient as well as care planning for the patient. According to the stakeholder, for example, if a provider bills a complex E/M code that allows for 40 minutes of physician time, that is insufficient to provide both types of services. While CMS has recently established new prolonged E/M codes (which allow for an additional 60 minutes of time), the stakeholder noted that they do not address the problem of insufficient time because a prolonged E/M code may only be billed with a companion E/M code, and the threshold of time needed to bill the two codes together is now too high—specifically 40 minutes for the complex E/M code plus 60 minutes for the prolonged E/M code. However, our review of CMS guidance on billing of prolonged E/M codes shows that providers do not have to meet the full 60 minutes of time in order to bill a prolonged E/M code; they may bill it as long as the total time spent on the visit exceeds the typical time for the E/M visit plus 30 minutes.

- *Documentation requirements:* Three stakeholders, largely representing primary care and medical specialties, stated that burdensome documentation requirements for the more complex E/M codes hampered their ability to bill these codes.[45] They suggested that a new billing code could be structured similar to the new ACP or CCM codes which do not have the same documentation requirements. While these stakeholders expressed concern regarding documentation as a discouraging factor, our analysis of 2017 Medicare claims data showed that certain specialties, including some that had expressed this concern, billed the more complex codes at a significantly higher rate than the average across all specialties. This may indicate that these documentation requirements do not

[45]For example, one stakeholder said that to bill a complex E/M code, the physician has to document that two of three components of the service were performed: a detailed history that may involve multiple medical complaints, physical examination involving multiple body systems, and complex medical decision-making illustrated by the number of diagnoses or management options, amount and complexity of data to be reviewed, and risk of significant complications. The stakeholder told us that the documentation requirements are redundant and duplicative. For example, much of the detailed patient and family history may already be noted in the patient's electronic medical record yet the physician has to document them at each visit. In its final Physician Fee Schedule rule for 2019, CMS stated that it was simplifying documentation requirements for E/M codes to reduce some of this redundancy. For example, CMS stated that the provider would not be required to re-enter in the patient's medical record information about the patient's chief medical complaint and history that had already been entered by ancillary staff. See 83 Fed. Reg. 59634 (Nov. 23, 2018) (preamble, II.I.2.b.(2)(b)).

necessarily preclude providers from billing these codes. For example, 83 percent of all the E/M new patient visits billed by geriatricians in 2017 were billed using the more complex E/M codes, compared to 48 percent on average. Similarly, 80 percent of all the E/M established patient visits billed by clinical psychologists in 2017 were billed using the more complex E/M codes compared to 50 percent on average.[46] See appendix V for details on billing patterns for all medical specialties.

- *Inability of non-physician staff to independently bill for care planning:* Seven stakeholders expressed concerns that non-physician staff such as nurses and social workers cannot independently bill the existing Medicare billing codes that we identified as being LCCP-type services. As one stakeholder explained, non-physician staff may spend time providing coordination and care planning services separately rather than concurrently with the physician, but they cannot bill for this time independently because the physician was not present. These stakeholders stated that a new LCCP code that could be billed by physicians and non-physicians that participated in the care planning process could address this issue. However, other stakeholders expressed concerns about the effect on Medicare spending if multiple providers billed for an LCCP service. Moreover, reimbursement for non-physicians is built into Medicare fees. Specifically, Medicare's fee for each billing code includes reimbursement for physician's time as well as their practice expenses (which cover the costs of non-physician staff), and when the AMA panel develops resources estimates for each billing code (upon which Medicare fees are based), it considers the amount of non-physician time spent on that code. Certain non-physician practitioners, such as nurse practitioners and physician assistants, may also independently bill services under the Medicare Physician Fee Schedule subject to certain requirements, and as specified in their scope of practice under state law.

Stakeholders generally concurred that if a new LCCP code were implemented, the definition of interdisciplinary care should be flexible and not require a social worker. Currently, the LCCP billing code as defined in the 2018 BBA requires that the interdisciplinary team providing care planning services include a social worker. However, 13 stakeholders stated that a typical practice did not include a social worker, but rather included a nurse who might perform the functions of a social worker. They

[46]These trends were consistent in prior years as well from 2015 through 2017.

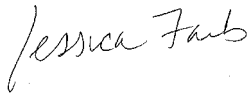
stated that smaller office-based medical practices could not afford to hire a social worker. The stakeholders concurred that social workers were generally available in larger integrated practices (such as a single or multiple groups aligning with each other or with a larger hospital system) and in facility settings such as hospitals or skilled nursing facilities. (Stakeholders also provided other comments on the structure of a potential new billing code for the LCCP service should such a code be established by CMS, which we summarize in app. VI.)

Agency Comments

We provided a draft of this report to HHS for review and comment. HHS provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or farbj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VII.



Jessica Farb
Director, Health Care

List of Committees

The Honorable Charles E. Grassley
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

The Honorable Frank Pallone, Jr.
Chairman
The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Richard Neal
Chairman
The Honorable Kevin Brady
Ranking Member
Committee on Ways and Means
House of Representatives

Appendix I: Example of an American Medical Association Vignette

Figure 8: Vignette for Current Procedural Terminology (CPT) Code 99213, Office/outpatient Visit, Level 3, Established Patient

Vignette:

Office visit, established patient, a 55-year old male with a history of hypertension and hyperlipidemia who presents for follow up.

Pre-service

- Review the medical history form completed by the patient and vital signs obtained by clinical staff.
- Communicate with other health professionals

Intra-service

- Obtain an extended problem-focused history (including response to treatment at last visit and reviewing interval correspondences or medical records received)
- Perform an extended problem-focused examination
- Consider relevant data, options, and risks and formulate a diagnosis and develop a treatment plan (low complexity medical decision-making)
- Discuss diagnosis and treatment options with the patient
- Address the preventive health care needs of the patient
- Reconcile medication(s)
- Write prescriptions
- Order and arrange diagnostic testing or referral as necessary

Post-service

- Complete the medical record documentation.
- Handle (with the help of clinical staff) any treatment failures or adverse reactions to medications that may occur after the visit.
- Provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit.
- Receive and respond to any interval testing results or correspondence.
- Revise treatment plan(s) and communicate with patient, as necessary.
- Two of these three components required**.**

Appendix II: Longitudinal Comprehensive Care Planning Service Components in the Balanced Budget Act of 2018

Table 3: Alignment of Key Components of the Longitudinal Comprehensive Care Planning (LCCP) Service as Defined in the Balanced Budget Act of 2018 with Equivalent Components in Existing Medicare Billing Codes

LCCP components in 2018 BBA[a]	Equivalent components in existing billing codes under Medicare's Physician Fee Schedule[b]	GAO analysis
"a conversation with Medicare beneficiaries who have received a diagnosis of a serious or life-threatening illness"	• "face-to-face" encounter; • "discuss the diagnosis and treatment options with the patient and/or family"; • "comprehensive history"; and • "comprehensive examination"	All of the components described in the existing billing codes could involve a conversation with the beneficiary.[c] Moreover, since there are generally no restrictions in the 58 codes on the type of patient who can receive these services, they may be used for patients diagnosed with a serious or life-threatening illness
"shared decision-making process furnished by an applicable provider through an interdisciplinary team"	• "a meeting with the clinical care team is held to review findings and develop a care plan"; • "counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and/or family's needs"; and • "provide necessary care coordination, telephonic or electronic communication assistance, and other necessary management related to this office visit".	Coordination of care with other providers involved in the patient's care is equivalent to the shared decision-making process by an interdisciplinary team described in the 2018 BBA.
"discuss a longitudinal care plan that addresses the progression of the disease, treatment options, goals, values and preferences of the beneficiary"	• "consider relevant data, options, and risks, and formulate a diagnosis and develop a treatment plan"; • "discuss diagnosis and treatment options with the patient and/or family"; • "revise treatment plan(s) and communicate with the patient as necessary"; • "a plan of care must be documented and shared with the patient and/or caregiver"; and • "the physician explains and discusses advance care directives with the patient and family member/surrogate…[including] a discussion of the patient's values and overall goals for treatment"	Since the activities described in the vignettes for the existing billing codes are likely taking place during a face-to-face encounter, there is an opportunity for the beneficiary's preferences to be discussed.[c]

LCCP components in 2018 BBA[a]	Equivalent components in existing billing codes under Medicare's Physician Fee Schedule[b]	GAO analysis
discuss "availability of other resources and social supports that may reduce the beneficiary's health risks and promote self-management and shared decision-making"	• "referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver" • "consider discharge needs of patient … write/review orders including ordering/arranging for necessary diagnostic testing, consultation and therapeutic interventions"; • "they *(i.e., physician and patient/family)* talk about palliative care options, ways to avoid hospital readmission, and the patient's desire for care if he suffers a health event that adversely affects his decision-making capacity"	The activities described in the vignettes for the existing billing codes clearly require discussion of available resources beyond the medical care provided by the treating physician.

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services and the American Medical Association's *RBRVS DataManager* | GAO-19-557

[a]Pub. L. No. 115-123, § 50342(c)(4), 132 Stat. 211.

[b]Providers are generally not required to furnish all components of services listed in the vignettes described in the AMA's *RBRVS DataManager* for these existing billing codes in order to bill and receive reimbursement for them.

[c]In a few instances, the vignette did not directly include a face-to-face encounter during which such a conversation might take place. However, Medicare Learning Network documents and other guidance from CMS indicated that the lack of this component did not preclude providers from billing the code if the conversation occurred through other means such as electronically or by telephone.

Appendix III: Stakeholder Groups Interviewed by GAO

This appendix lists the 19 national umbrella organizations, representing a mix of physician and non-physician groups that provided their perspectives on the need for a new billing code for the longitudinal comprehensive care planning service defined in the Balanced Budget Act of 2018.

- AARP
- American Academy of Home Care Medicine
- American Academy of Hospice and Palliative Medicine
- American Association of Family Physicians
- American College of Cardiology
- American College of Physicians
- American College of Surgeons
- American Geriatrics Society
- American Health Care Association
- American Medical Association
- American Medical Group Association
- American Society of Clinical Oncology
- American Society of Nephrology
- Endocrine Society[1]
- Medicare Payment Advisory Commission
- National Association for the Support of Long Term Care
- National Association of Social Workers
- Representative from the American Medical Association/Specialty Society Relative Value Scale Update Committee
- Society of General Internal Medicine

[1]The Endocrine Society provided written comments.

Appendix IV: Medicare Physician Fee Schedule Billing Codes for Longitudinal Comprehensive Care Planning (LCCP)-Type Services

We identified 58 billing codes in Medicare's physician fee schedule that may be used to bill for LCCP-type services as defined in the Balanced Budget Act of 2018 (2018 BBA). Figure 9 shows relevant information on these billing codes including the short descriptor, beneficiary eligibility criteria, our analysis of whether the billing code's components are equivalent to the components of an LCCP service as defined in the 2018 BBA, and Medicare's 2019 fee.[1]

[1]Providers are generally not required to furnish all components of services listed in the vignettes described in the AMA's *RBRVS DataManager* for these existing billing codes in order to bill and receive reimbursement for them.

Figure 9: Medicare Physician Fee Schedule Billing Codes That May Be Used to Bill for Longitudinal Comprehensive Care Planning (LCCP)-Type Services

Billing code	Short descriptor	Effective year or date	Type of patient	LCCP component					Billing frequency	Who can provide/bill	Physician time (minutes)	Non-physician time (minutes)	Medicare 2019 fee (non-facility)
				Conversation with beneficiary[a]	Inter-disciplinary team[b]	Care plan[c]	Beneficiary goals[d]	Other resources[e]					
90960	End-stage renal disease (4+ visits monthly)	1/1/2009	Patients with end stage renal disease	Y	Y	Y	Y	Y	Four times a month	Any provider	128	60	$289.03
90961	End-stage renal disease (2-3 visits monthly)	1/1/2009	Patients with end stage renal disease	Y	Y	Y	Y	Y	2-3 times a month	Any provider	113	60	$242.90
90962	End-stage renal disease (1 visit monthly)	1/1/2009	Patients with end stage renal disease	Y	Y	Y	Y	Y	Once a month	Any provider	63	60	$187.76
90966	End-stage renal disease for home dialysis, per month	1/1/2009	Patients with end stage renal disease	Y	Y	Y	Y	Y	As needed during a month	Nephrologist	75	60	$242.18
99204	Office/outpatient visit, new patient	1995	New patients but no other medical/ other condition	Y	Y	Y	Y	Y	Not specified	Any provider	45	62	$166.86
99205	Office/outpatient visit, new patient	1995	New patients but no other medical/ other condition	Y	Y	Y	Y	Y	Not specified	Any provider	67	71	$209.75
99214	Office/outpatient visit, new patient	1995	Established patients	Y	Y	Y	Y	Y	Not specified	Any provider	40	53	$110.28
99215	Office/outpatient visit, established patient	1995	Established patients	Y	Y	Y	Y	Y	Not specified	Any provider	55	63	$147.76
99219	Initial observation care	1995	Any patient	Y	Y	Y	Y	Y	Per day	Any provider	65	N/A	$138.03
99220	Initial observation care	1995	Any patient	Y	Y	Y	Y	Y	Per day	Any provider	75	N/A	$188.48
99222	Initial hospital care	1995	Any patient	Y	Y	Y	Y	Y	Per day	Any provider	75	N/A	$139.11
99223	Initial hospital care	1995	Any patient	Y	Y	Y	Y	Y	Per day	Any provider	90	N/A	$205.42
99225	Subsequent observation care	1995	Any patient	Y	Y	Y	Y	Y	Per day	Any provider	40	N/A	$74.24
99226	Subsequent observation care	1995	Any patient	Y	Y	Y	Y	Y	Per day	Any provider	55	N/A	$106.32
99232	Subsequent hospital care	1995	Any patient	Y	Y	Y	Y	Y	Per day	Any provider	40	N/A	$73.88
99233	Subsequent hospital care	1995	Any patient	Y	Y	Y	Y	Y	Per day	Any provider	55	N/A	$105.59
99234	Observation or inpatient hospital care, same date	1995	Any patient	Y	Y	Y	Y	Y	Not specified	Any provider	69	N/A	$135.15

Billing code	Short descriptor	Effective year or date	Type of patient	LCCP component					Billing frequency	Who can provide/bill	Physician time (minutes)	Non-physician time (minutes)	Medicare 2019 fee (non-facility)
				Conversation with beneficiary[a]	Inter-disciplinary team[b]	Care plan[c]	Beneficiary goals[d]	Other resources[e]					
99235	Observation or inpatient hospital care, same date	1995	Any patient	Y	Y	Y	Y	Y	Not specified	Any provider	84	N/A	$171.91
99236	Observation or inpatient hospital care, same date	1995	Any patient	Y	Y	Y	Y	Y	Not specified	Any provider	94	N/A	$220.92
99239	Hospital discharge day	1995	Any patient	Y	Y	Y	Y	Y	Not specified	Any provider	55	0	$108.84
99291	Critical care, first hour	1995	Critically ill patients	Y	Y	Y	Y	Y	Not specified	Any provider	70	63	$281.83
99292	Critical care, each additional 30 minutes	1995	Critically ill patients	Y	Y	Y	Y	Y	Not specified	Any provider	30	15	$124.70
99305	Initial nursing facility care, per day	1995	Nursing home patients	Y	Y	Y	Y	Y	Per day	Any provider	57	14	$132.26
99306	Initial nursing facility care, per day	1995	Nursing home patients	Y	Y	Y	Y	Y	Per day	Any provider	80	14	$169.38
99309	Subsequent nursing facility care, per day	1995	Nursing home patients	Y	Y	Y	Y	Y	Per day	Any provider	45	21	$92.98
99310	Subsequent nursing facility care, per day	1995	Nursing home patients	Y	Y	Y	Y	Y	Per day	Any provider	70	27	$137.67
99316	Nursing facility discharge day management, more than 30 minutes	1995	Nursing home patients	Y	Y	Y	Y	Y	Not specified	Any provider	54	12	$107.40
99326	Domiciliary or rest home visit, new patient	1995	Patients in nonfacility residence such as assisted living	Y	Y	Y	Y	Y	Not specified	Any provider	77	12	$141.27
99327	Domiciliary or rest home visit, new patient	1995	Patients in nonfacility residence such as assisted living	Y	Y	Y	Y	Y	Not specified	Any provider	100	12	$189.57
99328	Domiciliary or rest home visit, new patient	1995	Patients in nonfacility residence such as assisted living	Y	Y	Y	Y	Y	Not specified	Any provider	120	12	$223.08
99336	Domiciliary or rest home visit, established patient	1995	Patients in nonfacility residence such as assisted living	Y	Y	Y	Y	Y	Not specified	Any provider	65	12	$137.67

Appendix IV: Medicare Physician Fee Schedule Billing Codes for Longitudinal Comprehensive Care Planning (LCCP)-Type Services

Billing code	Short descriptor	Effective year or date	Type of patient	LCCP component					Billing frequency	Who can provide/bill	Physician time (minutes)	Non-physician time (minutes)	Medicare 2019 fee (non-facility)
				Conversation with beneficiary[a]	Inter-disciplinary team[b]	Care plan[c]	Beneficiary goals[d]	Other resources[e]					
99337	Domiciliary or rest home visit, established patient	1995	Patients in nonfacility residence such as assisted living	Y	Y	Y	Y	Y	Not specified	Any provider	95	12	$197.13
99343	Home visit, new patient	1995	Patients living at home	Y	Y	Y	Y	Y	Not specified	Any provider	77	12	$132.26
99344	Home visit, new patient	1995	Patients living at home	Y	Y	Y	Y	Y	Not specified	Any provider	100	12	$185.24
99345	Home visit, new patient	1995	Patients living at home	Y	Y	Y	Y	Y	Not specified	Any provider	120	12	$225.24
99349	Home visit, established patient	1995	Patients living at home	Y	Y	Y	Y	Y	Not specified	Any provider	65	12	$131.18
99350	Home visit, established patient	1995	Patients living at home	Y	Y	Y	Y	Y	Not specified	Any provider	110	12	$182.00
99354	Prolonged evaluation and management or psychotherapy service, office/ outpatient	7/1/2008	Any patient	Y	Y	Y	Y	Y	Not specified	Any provider	60	15	$132.26
99355	Prolonged evaluation and management or psychotherapy service, office/ outpatient, each additional 30 minutes	7/1/2008	Any patient	Y	Y	Y	Y	Y	Not specified	Any provider	30	13	$100.91
99356	Prolonged service, inpatient/observation setting	7/1/2008	Any patient	Y	Y	Y	Y	Y	Not specified	Any provider	60	N/A	$93.70
99357	Prolonged service, inpatient/observation setting	7/1/2008	Any patient	Y	Y	Y	Y	Y	Not specified	Any provider	30	N/A	$94.06
99358	Prolonged evaluation and management service, before and/ or after direct patient contact, first hour	1/1/2017	Any patient	N	Y	Y	Y	Y	Not specified	Any provider	60	3	$113.52
99359	Prolonged evaluation and management service, before and/ or after direct patient contact, additional 30 minutes	1/1/2017	Any patient	N	Y	Y	Y	Y	Not specified	Any provider	30	3	$54.78

Appendix IV: Medicare Physician Fee Schedule Billing Codes for Longitudinal Comprehensive Care Planning (LCCP)-Type Services

Billing code	Short descriptor	Effective year or date	Type of patient	LCCP component					Billing frequency	Who can provide/bill	Physician time (minutes)	Non-physician time (minutes)	Medicare 2019 fee (non-facility)
				Conversation with beneficiary[a]	Inter-disciplinary team[b]	Care plan[c]	Beneficiary goals[d]	Other resources[e]					
99483	Assessment of and care planning for a patient with cognitive impairment	1/1/2017[f]	Patients with cognitive impairment	Y	Y	Y	Y	Y	Not specified	Not specified	85	92	$263.81
99484	Care management services for behavioral health conditions	1/1/2017[g]	Patients with any mental, behavioral health, or psychiatric condition, who may warrant behavioral health integration services	Y	Y	Y	Y	Y	Per month	Any physician or other qualified health care professional	15	20	$48.65
99487	Complex chronic care management services	1/1/2017	Patients with 2 or more chronic conditions expected to last at least 12 months, or until the death of the patient	Y	Y	Y	Y	Y	Per month	Any physician or other qualified health care professional	26	60	$92.98
99489	Complex chronic care management, each additional 30 minutes	1/1/2017	Patients with 2 or more chronic conditions expected to last at least 12 months, or until the death of the patient	Y	Y	Y	Y	Y	Per month	Any physician or other qualified health care professional	13	30	$46.49
99490	Chronic care management services, at least 20 minutes	1/1/2015	Patients with 2 or more chronic conditions expected to last at least 12 months, or until the death of the patient	Y	Y	Y	Y	Y	Per month	Any physician or other qualified health care professional	15	20	$42.17
99492	Initial psychiatric collaborative care management	1/1/2017[h]	Patients with any mental, behavioral health, or psychiatric condition including substance use disorders	Y	Y	Y	Y	Y	Per month	Any physician or other qualified health care professional	40	85	$162.18
99493	Subsequent psychiatric collaborative care management	1/1/2017[i]	Patients with any mental, behavioral health, or psychiatric condition including substance use disorders	Y	Y	Y	Y	Y	Per month	Any physician or other qualified health care professional	36	60	$129.38
99494	Initial or subsequent psychiatric collaborative care management	1/1/2017[j]	Patients with any mental, behavioral health, or psychiatric condition including substance use disorders	Y	Y	Y	Y	Y	Per month	Any physician or other qualified health care professional	18	30	$67.03

Appendix IV: Medicare Physician Fee Schedule Billing Codes for Longitudinal Comprehensive Care Planning (LCCP)-Type Services

Billing code	Short descriptor	Effective year or date	Type of patient	LCCP component					Billing frequency	Who can provide/bill	Physician time (minutes)	Non-physician time (minutes)	Medicare 2019 fee (non-facility)
				Conversation with beneficiary[a]	Inter-disciplinary team[b]	Care plan[c]	Beneficiary goals[d]	Other resources[e]					
99495	Transitional care management services	1/1/2013	Patients with medical and/or psychosocial problems that require moderate or high complexity medical decision-making during patient's transition to community setting following discharge from certain inpatient hospital settings	Y	Y	Y	Y	Y	30-day period	Any physician or other qualified health care professional	40	92	$166.50
99496	Transitional care management services	1/1/2013	Same as code 99495	Y	Y	Y	Y	Y	30-day period	Any physician or other qualified health care professional	50	125	$234.97
99497	Advance care planning	1/1/2016	No restrictions on type of beneficiary	Y	Y	Y	Y	Y	No limits	Any physician or other qualified health care professional	45	7	$86.49
99498	Advance care planning, additional 30 minutes	1/1/2016	No restrictions on type of beneficiary	Y	Y	Y	Y	Y	No limits	Any physician or other qualified health care professional	30	0	$76.04
G0181	Home health care supervision	1/1/2001	Beneficiaries receiving Medicare-covered services provided by a participating home health agency	Y	Y	Y	Y	Y	Calendar month	Any physician or other qualified health care professional	57	36	$109.56
G0182	Hospice care supervision	1/1/2001	Beneficiaries receiving Medicare-approved hospice services	Y	Y	Y	Y	Y	Calendar month	Any physician or other qualified health care professional	58	36	$109.56
G0506	Comprehensive assessment and care planning	1/1/2017	Beneficiaries who require extensive face-to-face assessment and care planning by the billing practitioner	Y	Y	Y	Y	Y	One time visit for new patients or for patients not seen within a 1-year timeframe	Same as providers billing evaluation and management visits	29	36	$63.43

Legend: N= no; N/A= not applicable; Y= yes.

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services and the American Medical Association's *RBRVS DataManager*. | GAO-19-557

[a]Conversation with a patient who has received a diagnosis of a serious or life-threatening illness.

[b]Shared decision-making process that is furnished by an applicable provider through an interdisciplinary team.

[c]Discuss a longitudinal care plan that addresses the progression of the disease and treatment options

[d]Plan addresses goals, values, and preferences of the patient.

[e]Discuss availability of other resources and social supports that may reduce patient's health risk and promote self-management and shared decision-making.

[f]Since Code 99483 replaced Code G0505 which was implemented in 1/1/2017, we say Code 99483 was implemented 1/1/2017.

[g]Since Code 99484 replaced Code G0507 which was implemented in 1/1/2017, we say Code 99484 was implemented 1/1/2017.

[h]Since Code 99492 replaced Code G0502 which was implemented in 1/1/2017; we say Code 99492 was implemented 1/1/2017.

[i]Since Code 99493 replaced Code G0503 which was implemented 1/1/2017, we say Code 99493 was implemented 1/1/2017.

[j]Since Code 99494 replaced Code G0504 which was implemented 1/1/2017, we say Code 99494 was implemented 1/1/2017.

Appendix V: Specialty Billing of Complex Evaluation and Management Codes in 2017

Medicare's physician fee schedule contains evaluation and management (E/M) codes that providers may use to bill for face-to-face visits in their offices or other settings such as hospitals. These codes range in complexity from low to high depending on the amount of time the provider spends with a patient as well as the complexity of the medical decision-making and the medical condition(s) being treated. Table 4 shows the percentage of each specialty's E/M visits that were billed as complex visits (moderate or high complexity). In general, primary care and medical sub-specialties tended to bill complex visits at a higher rate than the all-specialty average, while surgical specialties tended to bill complex visits at a lower rate than the all-specialty average.

Table 4: Percentage of Complex Evaluation and Management (E/M) Visits by Specialty, 2017

Specialty	Complex E/M new patient visit (percentage)	Complex E/M established patient visit (percentage)	Complex initial observation care (percentage)	Complex initial hospital care (percentage)
All-specialty average	48	50	93	90
Primary care specialties				
Family practice	37	55	91	93
General practice	45	43	80	90
Geriatric medicine	83	72	93	93
Internal medicine	66	57	95	95
Medical sub-specialties				
Cardiology	81	68	90	92
Endocrinology	86	77	91	89
Gastroenterology	55	49	74	87
Hospice/palliative care	81	75	92	87
Nephrology	84	73	90	94
Neurology	89	71	91	91
Pulmonary disease	84	65	90	95
Rheumatology	86	67	95	87
Urology	60	40	66	74
Cancer-related specialties				
Gynecological/oncology	86	61	71	79
Hematology	91	73	93	90
Hematology/oncology	90	66	86	92

Specialty	Complex E/M new patient visit (percentage)	Complex E/M established patient visit (percentage)	Complex initial observation care (percentage)	Complex initial hospital care (percentage)
Medical oncology	90	69	82	90
Radiation oncology	86	36	100	78
Surgical oncology	73	39	73	76
Behavioral/mental health specialties				
Clinical psychology	93	80	N/A	85
Geriatric psychiatry	94	49	100	85
Neuropsychiatry	83	65	87	87
Psychiatry	86	40	71	86
Surgical specialties				
Cardiac surgery	70	50	88	83
General surgery	44	30	75	79
Neurosurgery	52	37	61	71
Thoracic surgery	73	42	81	81
Vascular surgery	47	28	66	74

Legend:
N/A: not applicable

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-19-557

Note: Due to low utilization, not all specialties are included above, but factor into the all-specialty average.

Appendix VI: Longitudinal Comprehensive Care Planning (LCCP) Services: Stakeholder Perspectives on Potential New Billing Code

We interviewed 19 stakeholders including national umbrella groups of physicians and other providers to obtain their perspectives on the structure of a new billing code for LCCP-type services as defined in the Balanced Budget Act of 2018 (2018 BBA), regardless of whether they supported the creation of a new code. Stakeholders were generally in agreement that a new billing code for LCCP-type services as defined in the 2018 BBA, if implemented, should be broadly defined. Specifically, stakeholders stated that it should not be tied to a specific condition, should allow for both in-person and non-face-to-face services performed when the beneficiary was not present, should be billable more than once, should be available for billing by both primary care physicians and specialists, and should have restrictions to avoid duplicative billing with existing billing that provided overlapping services.[1] However, stakeholders had more mixed views about what these specific restrictions should be. Stakeholder views about the various structural components or restrictions included the following:

- *Applicable medical conditions:* The majority of stakeholders (13 of the 17 who responded to this question) stated that the new code should be broadly defined although they differed in their opinions of what broadly-defined meant; one stakeholder cautioned against an overly broad definition, and one suggested pilot testing with a discrete list of conditions.
    - Of the 13 stakeholders in favor of a broad definition, 12 stated that the new billing code should not be tied to any particular specific illness or medical condition but should be flexible in structure. Three stakeholders stated that the extent of beneficiaries' daily functioning or quality of life should also be considered when defining applicable medical conditions. For example, a beneficiary who is not necessarily suffering from a life-threatening illness but is unable to perform the functions of daily living (such as bathing and eating) needs extensive care planning and should therefore be covered under the new LCCP-type service. Three stakeholders stated that the new code should be billable if a beneficiary's existing diagnosis of a serious illness changed. Three stakeholders stated that a potential new code could be modeled along the lines of existing billing codes—specifically the advance care planning (ACP) or chronic care management (CCM) codes—which do not specify any particular medical condition.

[1]Not all of the 19 stakeholders provided responses on each specific aspect of the new billing code.

- Two stakeholders said that a new code should not be so broad that it could apply to a vast majority of beneficiaries. For example, one stakeholder stated that the American Medical Association would likely not approve a code for a generic serious condition because it would be difficult to differentiate that code from an existing billing code, such as an evaluation and management (E/M) code, which may be used for any medical condition including serious, life-threatening conditions.
- One stakeholder suggested pilot testing the code with a discrete list of conditions, with the intention of expanding the list afterwards.

- *In-person or non-face-to-face:* The majority of stakeholders (12 of the 15 that responded to this question) stated that a potential new code should allow for both in-person and non-face-to-face activities (such as virtual or telehealth—providing clinical care remotely by two-way video, phone calls with the beneficiary or to arrange referrals or coordinate care with other providers when the beneficiary was not present); three said it should only include face-to-face activities.
  - Twelve stakeholders stated that the visit should include both types of activities. For example, one stakeholder said the initial visit for LCCP-type services should be in-person, and follow up activities such as updating a care plan or remote patient monitoring (monitoring of patients outside of conventional settings) could be non-face-to-face.
  - Three stakeholders said it should only include face-to-face activities either because of concerns about the potential for overbilling if the new code included non-face-to-face activities which might be difficult to verify or because other existing codes, such as CCM, already cover non-face-to-face activities.
- *Frequency of billing:* All of the 16 stakeholders responding to this question concurred that the new code should be billable more frequently than on a one-time basis, although opinions varied on the exact frequency.
  - Nine stakeholders said the code should be billable on an ongoing basis as the beneficiary's condition changes. For example, one said that the new code should be on-going because the care planning and treatment would continue to evolve over time as the beneficiary's condition changes.
  - Seven other stakeholders said that while it should not be an ongoing service, it should be billable more frequently than once. For example, one stakeholder specified that it could be billed once

per month or over every three months, but that a target end date must be specified; otherwise, it would be too similar to existing billing codes such as the CCM code that may be billed monthly. Two other stakeholders said it could be billed up to 4-5 times a year.

- *Other billing restrictions:* All 12 stakeholders responding to this question indicated that restrictions would be necessary to avoid overlap with existing billing codes. For example, three stakeholders suggested that the new code could be billed along with an E/M code for additional services not covered by the E/M code as long as it does not overlap with other existing codes that account for additional time beyond an E/M visit (such as the prolonged E/M visit billing codes). One suggested that it should not be billed along with any of the existing narrowly-defined LCCP-type codes, including CCM, transitional care management, or the ACP codes. One did not specify any particular code with which the new code should not be billed, but cautioned that care should be taken to ensure that time spent with the beneficiary was reported only once.
- *Providers eligible to bill the code:* The majority of stakeholders (13 of the 15 that responded to this question) stated that both primary care physicians and specialists should be eligible to bill the new code. Two of these stakeholders said that there should also be a requirement that the billing physician has an established relationship with the beneficiary. Two stakeholders said that only specialists should bill since they are generally the ones attending to the beneficiary's serious illness. Two stakeholders stated that non-physicians (including social workers) should also be able to bill the code as long as they are currently allowed to bill separately under the Medicare Physician Fee Schedule.

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Jessica Farb at (202) 512-7114 or farbj@gao.gov

Staff Acknowledgments

In addition to the contact named above, Karen Doran, Assistant Director; Iola D'Souza, Analyst-in-Charge; Sarah Belford; Krister Friday; John Lalomio; and Daniel Ries made key contributions to this report. Also contributing were George Bogart and Muriel Brown.