

# AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

W W W . A A C A P . O R G

September 5, 2018

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Attention CMS-1693-P  
P.O. Box 8016  
Baltimore, MD 21244

Re: Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019

*Submitted Electronically*

Dear Administrator Verma:

The American Academy of Child and Adolescent Psychiatry (AACAP) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule on Medicare payment policies for 2019. AACAP is the professional home to 9,300 child and adolescent psychiatrists, some of whom also treat adults. Our mission is to promote the healthy development of children, adolescents, and families. We therefore have a strong interest in policy issues that affect how psychiatric services are delivered, documented, and paid for, because elements of the regulatory framework in the Medicare program are often adopted by private payers, the Children's Health Insurance Plan, and Medicaid. As you know, Medicaid and the Children's Health Insurance Plan provide healthcare coverage to more than 35 million children in the United States<sup>1</sup>. We believe that CMS has an obligation to consider the impact of policy changes on this vulnerable patient population.

AACAP supports the CMS "Patients Over Paperwork" initiative, and the agency's sincere desire to simplify documentation and coding so that physicians can spend more time taking care of their patients and less time on paperwork. CMS has clearly listened to the provider community about the need to minimize administrative burdens. However well-intentioned, the proposed Evaluation and Management (E/M) policy revisions for 2019 would make such sweeping changes to the current framework that we believe they require greater understanding of their true impact on all medical specialties before they are fully implemented. AACAP therefore has the following recommendations with respect to the proposals:

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<sup>1</sup> <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

- **Delay implementation of the E/M payment proposals until 2020 (or 2021, if needed) so that the recommendations of the American Medical Association's CPT/RUC Workgroup can be fully considered.**
- **Retain the current five levels of E/M, because they offer granularity and effectively delineate levels of service.**
- **Implement some of the proposed simplification of documentation requirements in 2019.**

AACAP strongly supports the formation of the American Medical Association's (AMA) CPT/RUC Workgroup, a panel of experts in coding and documentation, convened in response to the proposed rule. This Workgroup plans to have its recommendations ready later this fall, after the public comment period for this proposed rule has passed, but will not be sharing them with the CPT Editorial Panel until February of 2019, after which time recommendations will be made to CMS. Implementation of the E/M proposals any sooner than 2020 would not allow for full consideration of the Workgroup's recommendations, nor for necessary engagement with the stakeholder community, which we believe are essential steps in undertaking such dramatic changes to the current E/M framework.

### **E/M Proposals**

CMS has proposed the merging of codes 99202-99205 and 99212-99215, and instead, provide a single, blended payment rate for these services that is slightly more than the current rates for 99203 and 99213, along with the ability to use add-on codes for prolonged services and complexity. The single level payment amounts were determined by (1) weight-averaging the work RVUs based on specialty utilization for levels 2-5 and (2) establishing a new E/M practice expense pool. Inevitably, the methodology will result in a negative impact on providers who bill level 4 and 5 services more often, while having a positive impact on those providers who most often bill level 2 and 3 services. This system will unfairly disadvantage specialties that manage more complex patients.

AACAP does not support the merging of E/M levels 2-5. We believe that the granularity offered by the existing five E/M levels is necessary and is effective in delineating levels of service provided to psychiatric patients. Collapsing E/M levels 2-5 would not reflect the care routinely provided to the most complex patients seen by child and adolescent psychiatrists. In addition, the base code plus add-on methodology has the potential to become more complex than the current coding system. AACAP believes it is possible to develop a complexity-based coding solution that would substantially reduce physician burden in selecting and documenting codes, while maintaining the granularity of the current E/M codes for all 5 levels.

Further, we do not believe that the documentation and coding proposals are intrinsically linked, as CMS states in the proposed rule. Long-needed simplification to documentation requirements could be implemented in 2019, apart from the payment proposals. CMS is proposing to allow clinicians to choose either medical decision-making (MDM) or time as the basis to determine

the appropriate level of E/M visit. As an alternative, clinicians have the choice to continue their documentation in accordance with existing 1995 or 1997 guidelines. AACAP agrees that time could be an alternate way to select codes (with reasonable typical times), but strongly disagrees that time should be the sole method of code selection.

The proposed rule states that in all cases, for the purposes of payment by Medicare, clinicians would only need to meet the documentation requirements associated with a Level 2 visit for all E/M level 2-5 visits, and AACAP appreciates the flexibility and burden reduction of the CMS documentation proposals. In order to provide immediate relief to clinicians, CMS could implement the following proposals in 2019: (1) change the required documentation of a patient's history for established patients to focus only on the interval history since the previous visit, (2) eliminate the requirement for physicians to re-document information that has already been documented in the patient's record, (3) allow physicians to document office visits based solely on the level of medical decision-making or the face-to-face time for the visit as an alternative to the current guidelines, and (4) eliminate the prohibition on billing same-day visits by practitioners of the same group and specialty.

Children who are being seen for psychiatric services tend to have a high level of complexity, and medical documentation must reflect the complexity of patient care to ensure smooth patient transitions from one clinician to another, or from one treatment setting to another. Medical records are also legal documents. Therefore, child and adolescent psychiatrists will continue to document in accordance with the individual needs of their young patients, and their own needs, but would welcome the ability to simplify documentation in accordance with the CMS proposals enumerated above, where appropriate.

AACAP members with considerable expertise in coding and documentation have been developing a complexity system to simplify MDM that would require substantially less cumbersome documentation than what is currently required and is collaborating with the AMA CPT-RUC Workgroup on these concepts. Once again, AACAP urges the agency to delay implementation of the E/M payment and documentation proposals until the Workgroup has developed its recommendations, and CMS has had the opportunity to fully consider them.

### **Interprofessional Internet Consultative Services**

AACAP supports the CMS decision to adopt the RUC-recommended values for existing interprofessional consultative (ITC) codes, 99446-99499, and to change their Status Indicator to A, for "active." We also support CMS's adoption of the RUC recommendation for one of the two new ITC codes, 994X0, which is appropriately valued at 0.50 work relative value units based on robust survey results. However, AACAP is disappointed that CMS did not accept the RUC recommended value for the ITC code 994X6. The services reflected in code 994X6 are more intense than the service reflected in code 994X0, because the patient is generally new to the consulting physician. The consulting physician must consider patient history, diagnoses, and possible treatments for the first time, making the degree of interaction inherently more complex. We therefore recommend that CMS adopt the RUC-recommended work RVU of 0.70 for CPT code 994X6.

We agree that physicians should inform beneficiaries of their intent to consult with a specialist and obtain patient consent, and we believe that patients should be responsible for only a single co-payment as a result. Given the greater complexity of the work involved, as discussed above, we believe that code 994X6 should trigger the co-payment, rather than 994X0, because the treating physicians who bill 994X0 will be collecting a co-payment of their own for the services furnished to the patient.

ITC services frequently take place between child and adolescent psychiatrists and pediatricians, and we believe their adoption represents progress, because they can eliminate unnecessary travel, expensive visits to specialists, and reflect typical physician work patterns. We commend CMS for modernizing the Medicare program by making these codes available for use.

Thank you for your serious consideration of our comments on the significant changes proposed in this rule. Should you have questions, or seek further information, please contact Karen Ferguson, Deputy Director of Clinical Practice, at [kferguson@aacap.org](mailto:kferguson@aacap.org).

Sincerely,

A handwritten signature in black ink that reads "Karen Dineen Wagner". The signature is written in a cursive, flowing style.

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