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September 11, 2017

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Centers for Medicare and Medicaid Services

Department of Health and Human Services

P.O. Box 8016

Baltimore, MD 21244-8013

Attention: CMS 1676-P Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018

Dear Dr. Verma:

The American Academy of Child and Adolescent Psychiatry (AACAP) greatly appreciates the opportunity to respond to the proposed rule on Medicare payment revisions and other policy changes for calendar year 2018. AACAP is the professional home to 9,200 child and adolescent psychiatrists, and our mission is to promote the healthy development of children, adolescents, and families. We have a strong interest in healthcare delivery models that encourage integrated and collaborative behavioral and mental health care and the specific practice patterns and coding needs of our members who treat children and adolescents. We are pleased to see a continued focus on expanding these models in the Medicare program and hope to see more in the near future. We offer our thoughts on several of the provisions in the proposed rule below.

Adjustment to Allocation of Indirect Practice Expense for Some Office-Based Services

The proposed rule notes that for codes in which direct practice expense (PE) inputs for services are very low, the allocation methodology does not allow for a site-of-service differential that accurately reflects the relative indirect costs involved in furnishing services in an office-based setting, and proposes to address this anomaly by slightly increasing the PE, over a four-year transitional period. The proposed rule further notes that primary therapy and counseling services for treatment of behavioral health conditions, including substance use disorders, are disproportionately

affected by this anomaly, with CPT code 90834 being the most commonly affected code of the small number identified.

AACAP supports the proposal to increase the PE for select services over a four-year period to more accurately reflect the PE incurred by psychiatrists and other clinicians who provide counseling services and treat patients with substance use disorders. Given the ongoing opioid crisis and its devastating effects on families and children, AACAP greatly appreciates the commitment of greater resources toward behavioral and mental health services.

Medicare Telehealth Services

CMS has proposed covering telehealth codes for Psychotherapy for crisis, both 60 and 30 minutes (90839 and 90840, respectively), and for Interactive complexity (90785). AACAP strongly supports these additions to the telehealth family of codes and has developed a Clinical Update entitled *Telepsychiatry with Children and Adolescents*¹ that will be published in the *Journal of the American Academy of Child and Adolescent Psychiatry* in October of 2017. In addition to a clinical interest and focus on this topic, AACAP also supports efforts to address some of the systemic issues that prohibit more widespread use of this technology relating to state licensing laws, such as the Interstate Medical Licensure Compact that seeks to streamline the medical licensure process across states in support of expanded use of telehealth services.²

Evaluation and Management (E/M) Guidelines

The proposed rule discusses at length the need to modernize the Evaluation and Management (E/M) guidelines to reflect changes in technology, such as electronic health records, and how medicine is practiced, particularly as they pertain to documenting history and the physical exam portions of a visit. The proposed rule further states that there is concern that the current guidelines result in documentation that does not adequately distinguish meaningful differences between the code levels. As such, the agency is seeking public input on its proposal to place less emphasis on history and the physical exam, while placing more emphasis on medical decision-making and time.

AACAP agrees that emphasizing medical decision making and time in selecting the level of E/M services would be positive changes, given that psychiatric patients, particularly children and youth, are very complex, requiring multiple interventions that include the patient, the parents, schools, and other clinicians.

AACAP is therefore strongly supportive of revisions of the E/M Guidelines and agrees with the goals of reducing the associated burden and better aligning with the current practice of medicine. We recommend the following consideration in this complex undertaking:

1. E/M codes are difficult codes to use and interpret and are high in importance as they form the backbone of coding for cognitive services. Even minor changes in the Guidelines are

¹ Clinical Update Series: Telepsychiatry with Children and Adolescents. [http://www.jaacap.com/article/S0890-8567\(17\)30333-7/abstract](http://www.jaacap.com/article/S0890-8567(17)30333-7/abstract). Accessed August 29, 2017.

² Interstate Medical Licensure Compact. <http://www.imlcc.org/>. Accessed August 29, 2017.

likely to have major ramifications in the use of these codes. AACAP recommends that CMS collaborate with a formal workgroup of stakeholders, of which AACAP is glad to be a part. Preferably this collaboration is accomplished through the CPT Editorial Panel, which can make editorial changes to the CPT E/M Guidelines to correlate with changes in the CMS E/M Guidelines.

2. The complexity of the codes and required documentation, with nested tables, is a large part of the burden of using these codes. AACAP recommends that changes result in simplification.
3. AACAP agrees that the guidelines for history and physical exam are outdated and that medical decision making (MDM) is more important in distinguishing the level of E/M visits. Nonetheless, AACAP does NOT recommend removal of the documentation requirements for history and physical exam without significant changes otherwise:
 - a. Often the provider does not know the complexity of MDM until much or all of history and exam have been performed. This applies to all visits at all levels but is particularly important for initial/new visits in which the completeness of the evaluation drives the work of the visit at least as much as what is found during the evaluation.
 - b. Of the three key components, complexity of MDM is the most difficult to meaningfully measure. The current system of measurement does not have concrete criteria for two of the three MDM elements (number of diagnoses and management options and amount and/or complexity of data to be reviewed) in either CPT or the CMS E/M Guidelines, in practice relying heavily on the unofficial, common-use, "Marshfield" criteria. Revisions that increase the weight of MDM should be associated with improvements in measuring MDM complexity.
4. If only minor revisions will be considered at this stage, AACAP is glad to work with the American Psychiatric Association to recommend changes to the psychiatry single specialty physical examination to bring it in better alignment with current clinical practice.

New Care Coordination Services and Payment for Rural Health Clinics and Federally Qualified Health Centers

For 2018, the proposed rule includes provisions that would cover three chronic care management codes, and the general behavioral health integration (BHI) code in both Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). These proposals will bring needed chronic care management and behavioral and mental health services to individuals who, in many cases, have complex needs and few resources.

The establishment of the General BHI code, in addition to the Psychiatric Collaborative Care Management Codes, reimbursed as G-codes in the Medicare program in 2017, is a start in the right direction in recognizing the importance of treating behavioral and mental health conditions as part of effective and patient-centered care, but more needs to be done to create coding options that would encourage adoption and use by child and adolescent psychiatrists. Consultative models, wherein a child and adolescent psychiatrist guides a treating primary care physician in treating behavioral and mental health conditions are proliferating, yet appropriate reimbursement

models have not caught up to this positive development. Successful programs taking place throughout the country rely on grant monies or state funding, and they provide rich examples of what is possible to ensure that more children and youth in need of behavioral or mental health interventions receive the care they need. These models also serve as efficient ways to address severe child and adolescent psychiatrist workforce shortages in most areas of the country.

We invite you to learn more about these innovative models by visiting the Integrated Care for Kids website³, the product of my Presidential Initiative on Integrated Care. This living resource represents the collective wisdom of medical, behavioral and mental health experts, and supports and encourages collaborative partnerships with pediatric medical homes. Summaries of several innovative programs and projects taking place around the country are available at the website, highlighting the value of the consultative model and care teams, among other innovative approaches.

Thank you for your serious consideration of our comments. Please do not hesitate to contact Karen Ferguson, Deputy Director of Clinical Practice at kferguson@aacap.org should you have questions.

Sincerely,

A handwritten signature in black ink that reads "Gregory K. Fritz, MD". The signature is written in a cursive style with a large initial 'G'.

Gregory K. Fritz, MD
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³ Integrated Care for Kids. <http://integratedcareforkids.org/>. Accessed September 5, 2017.