

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

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

October 2, 2020

Administrator Seema Verma
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, CMS-1734-P

Submitted Electronically

Dear Administrator Verma:

On behalf of the American Academy of Child and Adolescent Psychiatry (AACAP), I am writing today to provide comments on the Centers for Medicare and Medicaid Services Medicare Physician Fee Schedule (PFS) Proposed Rule. AACAP is the professional home to 9,800 child and adolescent psychiatrists, some of whom also treat adults and transitional age youth (age 18 years and above). Our mission includes promoting the healthy development of children, adolescents, and families. We therefore have a strong interest in the public policy and payment issues that affect how psychiatric services are delivered, documented, and reimbursed, as elements of the regulatory framework in the Medicare program are often adopted by private payers, as well as the Children's Health Insurance Plan (CHIP) and Medicaid. We offer the following comments against the backdrop of urgent shortfalls in, and an increasing need for, mental and behavioral health services for both children and adults.

Telehealth and Other Services Involving Communications Technology

AACAP supports the proposed additions to the Medicare Telehealth Services List mentioned in Table 8, which include 90853, group psychotherapy; 96121 neurobehavioral status exam; and 99XXX (99417); prolonged office or other outpatient E/M. Continued expansion of telehealth services will help reduce barriers to urgently needed mental health care.

We note that several proposed telehealth services are only being kept in place for the duration of the Public Health Emergency (PHE), listed in Table 10. These include 96130-33, Psychological and Neuropsychological Testing Evaluation Services. The PHE has highlighted the need for

greater flexibility in the delivery of health care of all kinds, and telehealth services are bridging many of these gaps and can work especially well for mental and behavioral health care.

AACAP members have reported fewer missed appointments among their patients during the PHE because telehealth has reduced barriers to treatment such as transportation challenges and suspected infectious disease such as COVID-19. Moreover, some patients, who have been diagnosed with anxiety disorders, autism spectrum disorders, and others, are more comfortable receiving treatment in their homes via telehealth. Child and adolescent psychiatrists feel many services are more effectively delivered via telehealth. **Going forward, we would like to see a continued expansion of telehealth services to assure greater access to needed services and continuity of care, during the PHE and beyond.**

While not proposing to make permanent for 2021, CMS has also asked for stakeholder feedback on whether separate payment for 99441-43, Audio-Only Telephone Evaluation and Management services, should be a provisional policy to remain in effect for some period after the end of the PHE, or if it should be a permanent payment policy. The pandemic has shed light on the fact that many citizens across the country do not have access to high-quality broadband internet services, nor appropriate devices in which to access it. Still others may not have the ability to utilize the technology to access healthcare even if they have it. **Given these disparities, AACAP supports the permanent addition of audio-only telephone services, 99441-43.**

Psychiatric Evaluation and Psychotherapy Services

CMS is proposing to increase the values for some psychotherapy codes to maintain relativity with E/M codes, whose values are due to increase in 2021 to better value the resources involved in office visits. Specifically, CMS has proposed that CPT codes 90791, 90792, 90832, 90834, and 90837 receive a 28% increase to bring them in line with the valuation of E/M codes. Psychotherapy services provided by psychiatrists are often furnished using an E/M code and an add-on psychotherapy code (CPT 90833, 90836 or 90838); and these psychotherapy services are not increased. The AMA RUC cites the need to support access to behavioral health services through appropriate payment, but also to maintain relativity within the code family. AACAP shares the AMA RUC's concerns about the CMS-proposed adjustments to the standalone psychotherapy codes that a general percentage increase is not resource-based, nor accurately accounts for the physician or qualified healthcare professional's work, time, and intensity inherent in furnishing these services. This methodology creates a rank order anomaly with identical codes and can be viewed as discriminatory toward psychiatrists and child and adolescent psychiatrists who have completed medical school followed by 4-5 years of additional training in a wide variety of psychotherapy techniques. While AACAP strongly agrees that measures to increase access to mental and behavioral health services are urgently needed and should be employed, we strenuously disagree with this approach.

Psychotherapy is the same service whether it is provided the same day as an E/M service and regardless of who provides it, assuming the clinician has been appropriately trained to do that service. When possible, psychotherapy performed by psychiatrists is beneficial to the most seriously ill patients, who have better outcomes by receiving both psychotherapy and medication management performed by a psychiatrist, rather than care provided by two separate clinicians whereby psychotherapy is performed by a psychologist or social worker and medication is managed by a psychiatrist. When complex patients receive care in two different settings, one for psychotherapy and one for medication management, communication between the two providers may not be adequate.

Moreover, psychiatrists, and especially child and adolescent psychiatrists, are in critically short supply at a time when mental health issues are growing dramatically worse.¹ At the same time, child and adolescent psychiatrists traditionally experience some of the lowest rates of reimbursement in medicine. We fear that reducing the value of psychotherapy provided by child and adolescent psychiatrists will also create a disincentive to medical students to enter the profession.

AACAP therefore respectfully requests that if the standalone psychotherapy codes are given a 28% increase in value for 2021, that this increase is applied to all the psychotherapy codes.

Code 99XXX

FR pages 50138-50139 state: “The intent of the CPT Editorial Panel was unclear because of the use of the terms “total time” and “usual service” in the CPT code descriptor... Having reviewed the policy we finalized last year, we believe that allowing reporting of CPT code 99XXX [99417] after the minimum time for the level 5 visit is exceeded by at least 15 minutes would result in double counting time. As a specific example, the time range for CPT code 99215 is 40–54 minutes. If the reporting practitioner spent 55 minutes of time, 14 of those minutes are included in the services described by CPT code 99215. Therefore, only 1 minute should be counted towards the additional 15 minutes needed to report CPT code 99XXX and prolonged services should not be reportable as we finalized last year (see Table 33 of the CY 2020 PFS final rule (84 FR 62849)). Therefore, we are proposing that when the time of the reporting physician or NPP is used to select office/outpatient E/M visit level, CPT code 99XXX could be reported when the maximum time for the level 5 office/outpatient E/M visit is exceeded by at least 15 minutes on the date of service.”

AACAP believes that there are several problems with this proposal:

One of the major reasons for developing new code definitions was to reduce administrative burden. Adoption of this proposal at this late date will likely significantly increase burden by creating a dichotomy between CPT criteria and CMS criteria, leaving clinicians trying to figure

¹ AACAP Workforce Maps by State:

https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

out which is correct for each of Medicare and other payers. We wonder why this could not have been brought up one year ago or, better yet, during the code development process (our understanding is that CMS participated every step of the way).

This proposal disincentivizes physicians to care for the sickest and most complex patients, who require extra time for coordination of care, discussion with family members, and/or review of a large amount of outside records.

The proposal is inconsistent with CPT convention:

- Most code sets with a prolonged service option use exact time, with the base code and the prolonged service code each being defined by a single time number and then, simply put, rounded to the closest code or code combination. Per CMS request, the complex chronic care codes use minimum time, with the base code and the prolonged service code both being described using minimum time. The CMS 99XXX (99417) proposal uses neither of these methods.
- CMS states, “The intent of the CPT Editorial Panel was unclear because of the use of the terms “total time” and “usual service” in the CPT code descriptor.” We do not understand this. The intent of the Panel is clearly that both the base code and the prolonged service code use minimum time. This is clear from the CPT Manual and was stated repeatedly during E/M Workgroup meetings with which, again, CMS participated.
 - Note also that the language, “usual service,” is used for 99354 and 99356 to distinguish prolonged service from service associated with base codes and does not seem to have caused any confusion. The language, “total time,” is well defined in the E/M Guidelines.
- This proposal introduces the concept of “maximum time.” “Maximum time,” to our understanding, is new to CPT to describe a base code that may have a prolonged service code. Furthermore, the proposal uses “maximum time” for the base code and minimum time for the prolonged service code, thus leaving a block of time undefined.
- This proposal is not internally consistent.
 - For example, the CPT-stated time range for 99215 is 40-54 minutes. CPT states that, at 55 minutes, 99215 plus 99417 is reported because 55 minutes is at least 15 minutes greater than the minimum time (40 minutes) for 99215.
 - The CMS proposal states that the time for 99417 does not start accruing until 54 minutes (the maximum time for 99215 alone) is exceeded and thus 99215 plus 99417 is reported at 54+15=69 minutes.
 - However, this makes the true range for 99215 alone 40-68 minutes. The true maximum time for 99215 alone is thus 68 minutes and, by CMS logic, 99215 plus 99417 should not be reported until 69+15=84 minutes.
 - This, then, revises the true maximum time for 99215 alone to 83 minutes, and so forth.

We request that CMS adopt the time rules as stated in the CPT Manual.

Codes 99358 and 99359

AACAP believes that doing away with codes 99358 and 99359, starting in 2021, also penalizes physicians who care for the sickest and most complex patients. These codes are needed to describe non-face-to-face care management services for complex patients that most often takes place outside of the calendar day of patient visits. 99417 will not adequately capture this work, given that its use is limited to the calendar day of the patient visit. The rationale that the new E/M code valuation is based on pre- and post-time before and after the calendar day does not make sense either given that the current E/M codes are also valued on that basis and may be associated with 99358 and 99359. **We urge the agency to reexamine its rationale for the discontinuation of these two codes.**

Budget Neutrality

Lastly, AACAP urges CMS to utilize its authority under the PHE to waive the budget neutrality requirements for 2021. Many physician practices are already experiencing severe financial hardship and instability due to the PHE, and a projected nearly 11% decrease in Medicare reimbursements will only exacerbate the problem, threatening their ability to remain operational. In addition, the magnitude of this decrease offsets the anticipated 2021 increases in E/M outpatient office codes for many physician specialties, including psychiatry.

Once again, AACAP appreciates the opportunity to provide comments on the PFS Proposed Rule during this challenging time. Should you have questions, please do not hesitate to reach out to Karen Ferguson, Deputy Director of Clinical Practice, at kferguson@aacap.org.

Sincerely,



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