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September 10, 2021

Administrator Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244

Re: 2022 Payment Policies under the Medicare Physician Fee Schedule
and Other Changes to Part B Payment Policies (CMS-1751-P)

Electronically Submitted to regulations.gov

Dear Administrator Brooks-LaSure:

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 for 2022. AACAP is the professional home to 10,000 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 policies and payment issues that affect how psychiatric services are delivered, documented, and reimbursed, as elements of the regulatory framework in the Medicare program are frequently adopted by private payers, as well as the Children's Health Insurance Plan (CHIP) and Medicaid. We offer the following comments in the context of continuing workforce shortages in mental and behavioral health providers, coupled with significant unmet needs for mental and behavioral health services for both children and adults.

AACAP is encouraged by the thoughtful questions in the proposed rule addressing the provision of telehealth services, and the desire to strike the correct balance between increased patient access to mental health services, health equity, patient safety, and program integrity.

Telehealth services have long been a focus at AACAP, and we have a very active Telepsychiatry Committee that has developed numerous materials over the years, including a Toolkit¹ a Clinical Update², and many other materials, all available on our website. We invite CMS to consult these resources as it seeks to promulgate an appropriate regulatory framework for the delivery of mental and behavioral health services via telehealth.

Split, Or Shared, Visits

In the proposed rule, the Centers for Medicare and Medicaid Services (CMS) addresses confusion around evaluation and management (E/M) visits that are furnished by more than one clinician and proposes several important clarifications. AACAP agrees that the practitioner who provides the substantive portion of the visit (more than half of the total time) should bill for the visit, and that split visits should be reportable for both new and established patients. We also agree that requiring a modifier along with clear documentation in the medical record identifying the two individuals who performed the visit would be appropriate to help ensure program integrity. These proposals are reasonable and AACAP appreciates the clarification they would provide, if finalized.

Teaching Physician Services

Under existing regulations, if residents participate in the provision of a service furnished in a teaching setting, a teaching physician is permitted to bill for this service only if they are present for the key or critical portion of the service. Under the “primary care exception,” however, Medicare will pay for services furnished by a resident without the presence of a teaching physician. CMS is proposing that when services are provided under the primary care exception specifically, only medical decision-making could be used to select the visit level to prevent possible inappropriate coding that may reflect a resident’s inexperience or inefficiency in the provision of the service. AACAP agrees that these proposals are reasonable and would simplify and clarify the regulatory framework around teaching physician services.

Telehealth Services under the Physician Fee Schedule

AACAP has greatly appreciated the regulatory flexibilities granted by the agency during the ongoing Public Health Emergency (PHE) and has commented previously about how the telehealth and audio-only visit policies have improved patient access to urgently needed mental health services as we continue to face critical shortages of mental health professionals coupled with an increasing need for mental and behavioral health services. In some cases, these flexibilities have provided an entry point for patients who otherwise would not have received mental and behavioral health services. Patients, especially those with complex chronic mental illnesses, often experience formidable access issues and may be less likely to pursue office

¹ AACAP’s Telepsychiatry Toolkit: [Clinical Update: Telepsychiatry with Children and Adolescents - Journal of the American Academy of Child & Adolescent Psychiatry \(jaacap.org\)](#)

² Clinical Update: Telepsychiatry with Children and Adolescents: [Clinical Update: Telepsychiatry with Children and Adolescents - Journal of the American Academy of Child & Adolescent Psychiatry \(jaacap.org\)](#)

visits. Telehealth visits offer them a lifeline. We appreciate being able to respond to proposals that would make permanent many of the flexibilities for the delivery of mental health services offered during the continuing PHE.

Congress further affirmed the need to continue providing telehealth and audio-only services for mental health services when they passed the Consolidated Appropriations Act (CAA) in December 2020. Section 123 of the CAA removed geographic restrictions and added the home of the beneficiary as a permissible originating site for telehealth services when used for the purposes of diagnosis and evaluation of mental health conditions. The legislation also requires patients to obtain an in-person, non-telehealth visit with the physician or practitioner within six months prior to the initial telehealth service, and thereafter, at intervals that will be determined by the Secretary of Health and Human Services. Aside from the statutorily required in-person visit requirements, these changes represent a long-overdue modernization of telehealth law and regulation and AACAP is appreciative. However, we are concerned that any sudden adoption of the 6-month-prior rule is likely to threaten continuity of care, creating access issues for many vulnerable patients who have been attending only telehealth appointments for the duration of the PHE and may have difficulty traveling to in-person visits for any number of reasons. We request that CMS use its considerable discretion in implementing this provision by permitting an audio-visual telehealth visit to meet the requirement for an in-person visit.

CMS is seeking public comment on whether an interval different than the six months required by the CAA would be more appropriate for in-person visits with patients after treatment by telehealth has begun, including audio-only visits, addressed in greater detail below. Once telehealth treatment has begun, AACAP believes that the six-month in-person visit requirement is arbitrary and could impede access to services for certain patients, as mentioned above. Furthermore, this requirement creates an administrative burden since, at the time of scheduling appointments, both patients and schedulers may lack access to knowing whether the patient is due for their 6-month in-person visit. Other times, when it is known that the patient is due for an in-person visit, the patient may lack access to an urgently needed appointment. We recognize that the CAA statute requires the agency to implement an in-person visit requirement for ongoing telehealth services, but we believe that the physician or practitioner should have as much discretion as possible as to the timeframe for these visits, given these serious concerns. AACAP members have experienced far fewer missed appointments and have found that for patients with certain diagnoses who may be severely impaired, being able to see them via telehealth has improved access to needed services, and even infrequent in-person visits could threaten continuity of care. We recommend that physicians and practitioners be permitted to use their clinical judgement to the extent possible concerning the length of time between in-person visits once telehealth services have been initiated.

CMS is also proposing to amend the current regulatory requirements for interactive telecommunications systems, which is currently defined as multimedia communications equipment that includes, minimally, audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site physician or practitioner, to include audio-only communication technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes. AACAP is supportive of the amendment to the current regulatory requirements that will include audio-only communication technology since many patients currently do not have access to internet services and this policy proposal will help address existing disparities.

In addition, CMS proposes to limit the use of audio-only interactive telecommunications to mental health services furnished by physicians or practitioners who have the capability to furnish two-way, audio-video communications but their patients do not have the capability to use it, or do not consent to its use, in addition to requiring the use of a modifier to distinguish audio-only services. CMS is asking for stakeholder feedback on whether they should require additional documentation in the patient's medical record to support the clinical appropriateness of this modality and notate that the patient elected to receive audio-only services. AACAP is strongly supportive of allowing audio-only interactive telecommunication to improve access for a significant minority of patients and supports thorough documentation of these services.

However, numerous studies have demonstrated the efficacy of audio-video, interactive encounters and we are concerned that the use of audio-only encounters is not similarly supported by the literature. We strongly recommend that CMS focus on collecting data on the efficacy and quality of audio-only services over time to create and support standards of care for these services while retaining access for those who need them. AACAP would be willing to work with CMS to develop such standards of care as we learn more. Without this, we are concerned that making this audio-only allowance permanent for office visit E/M codes (99202-99215) could lead to a deterioration of the standard of care for these services as well as billing confusion, such as reporting an office E/M code for a phone call that, in the past, would have been part of a prior office visit service. AACAP agrees that it would be appropriate to require a statement in the patient's medical record indicating why the patient has elected to receive audio-only services. We also agree that use of a modifier to identify this service would be reasonable and recommend that the final requirements be in alignment with existing telehealth requirements for the sake of consistency and efficiency. AACAP also supports the retention of the telephone service codes (99441-99443), which should then be valued and reimbursed appropriately.

CMS requests additional stakeholder feedback about whether audio-only telehealth for some high-level services, such as level 4 or 5 E/M visit codes, or psychotherapy for crisis, should be precluded from eligibility for audio-only services. AACAP does not support such restrictions on the delivery of audio-only services since we believe they would serve to restrict access to

services for high-need patients who do not have access to internet services or may not have the ability to use them. In addition, once a clinical encounter begins, it is difficult to predict exactly what will happen and the visit could become a high-level E/M visit or psychotherapy for crisis even if it had not been planned.

CMS is also seeking comment on whether the required in-person, non-telehealth service could also be furnished by another physician or practitioner of the same specialty and same subspecialty within the same group as the physician or practitioner who furnishes the telehealth services. The language in the CAA states that the physician or practitioner furnishing the in-person, non-telehealth service must be the same person who furnishes the telehealth service. There are situations where CMS has historically treated the billing physician or practitioner and others of the same specialty or subspecialty in the same group as if they were the same individual, for example, when making a determination about whether the patient is new or established, and AACAP agrees with this approach. AACAP recommends that CMS finalize a policy that mirrors the Common Procedural Terminology (CPT) rules on new and established patients for the sake of consistency.

AACAP appreciates the opportunity to provide input on these important policy proposals. Should you have questions or would like more information, please do not hesitate to reach out to Karen Ferguson, Interim Director of Government Affairs and Clinical Practice at kferguson@aacap.org.

Sincerely,

A handwritten signature in black ink that reads "Gabrielle A. Carlson". The signature is written in a cursive style with a large, sweeping flourish at the end.

Gabrielle A. Carlson, MD
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