December 26, 2012

Marilyn Tavenner
CMS Acting Administrator
Chief Operating Officer
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1524-FC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD. 21244-1850

Re: CMS-1590-FC Medicare Program; Revisions to Payment Policies
Under the Physician Fee Schedule

Dear Acting Administrator Tavenner:

The American Academy of Child and Adolescent Psychiatry (AACAP), the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-12 million American youth under 18 years of age affected by emotional, behavioral, developmental and mental disorders, appreciates the opportunity to submit comments in response to CMS’s final rule on the Medicare Physician Fee Schedule CY 2013.

CHRONIC CARE COORDINATION
AACAP applauds CMS for responding to the American Medical Association (AMA) Relative Value Update Committee’s (RUC) Chronic Care Coordination Workgroup (C3W) recommendations to better recognize essential care coordination services within the existing fee-for-service system. We appreciate CMS’ acceptance of the RUC recommendations for Transitional Care Management (TCM) services, CPT codes 99495 and 99496, and are pleased that Medicare will begin payment for the care of transitioning patients from a hospital or skilled nursing facility to the home.

The C3W also created three new codes to describe complex chronic care coordination (CCCC) services that are patient centered management support services provided by physicians and other qualified health care professionals to an individual who resides at home, in a domiciliary rest
home or assisted living facility, per calendar month. CCCC services are provided to patients who typically have multiple co-morbidities, and frequently, multiple medications requiring ongoing non face-to-face care coordination. The choice of code is driven by the clinical staff time over the period of a calendar month. Unlike TCM services, a recent hospital discharge is not a CCCC code criterion, but the typical patient has several chronic conditions, sees multiple care providers, requires a variety of therapeutic and diagnostic services and has a management plan that requires frequent revisions. While the goal of TCM is to prevent re-hospitalization, the goals of CCCC are broader, which include efficiently integrating care, maximizing the patient’s potential function and well-being, and preventing hospitalization. CMS has postponed implementation of payment for these services allowing for additional discussion regarding the appropriate application of the services; however, relative values have been published. AACAP appreciates CMS publishing the RUC recommendation values for these codes for other payers to utilize in 2013. We welcome the ability to work with CMS and the AMA to address any remaining issues as implementation of the CCCC services is considered.

**PSYCHIATRY - PSYCHOTHERAPY**
In reviewing the new psychotherapy family of codes CMS states,

> “It is our policy to value a family of codes together to ensure more accurate valuation and proper relativity. We will take into consideration the AMA RUC and HCPAC recommendations, specialty society recommendations, public comments, Medicare utilization data, and other available information. For CY 2013, our general approach was to maintain the current CPT code values, or adopt values that approximate the values for the current CPT codes after adjusting for differences in code structure between CY 2012 and 2013, for all psychiatry services on an interim basis, pending a final review of the values for the entire family of CPT codes.”

CMS’s decision to delay the entire series of psychotherapy codes based on the joint RUC and specialty societies’ decision to carrier price three CPT codes is perplexing. The CPT Editorial Panel, RUC and specialty societies spent several years creating and valuing these services. The finalized coding structure, and subsequent RUC recommendations, represents a comprehensive solution that should not be ignored. In fact, the RUC recommendations represent 91% of the work of the entire psychiatry code set that were up for review. For CPT codes 90785, 90839 and 90840, the RUC recommended to CMS that these services be carrier priced to allow providers to gain experience with the codes prior to conducting a RUC survey. After a year of experience with the new coding structure the specialties will conduct RUC surveys for these services. In addition to not accepting the RUC recommendations, CMS chose to construct a crosswalk based on the new coding framework using existing values, which the RUC has deemed are no longer accurate and was one of the main reasons for restructuring of the psychiatry codes correcting this inaccurate valuation. We are particularly concerned about the interim nature of the values, the decisions made to maintain budget neutrality, and the resulting impact these policy decisions will have with other payers. Given this information, AACAP requests that CMS accept the RUC recommendations for the psychotherapy family of codes for CY 2013.

**Interim Status**
There appears to be discriminatory treatment on the part of CMS in the finalization of the values assigned to the revised CPT Coding framework for psychiatry services. In the rule, CMS states its policy to value a family of codes together to ensure more accurate valuation and proper relativity. CMS goes on to state that the values assigned to the revised codes in the psychiatry section were not finalized pending the surveying of the remaining codes, which are currently carrier priced.

As participants in the RUC process we have seen any number of organizations subdivide families of codes for review by the RUC and have the values finalized by CMS in the subsequent Final Rules. One prime example is the surveying of the E/M codes. The initial group of codes were surveyed and reviewed by the RUC in February 2006 with CMS finalizing the values in the Final Rule for the 2007 Physician Fee Schedule. This was followed by a survey and review of the E/M codes for the Nursing Home setting, which were reviewed and valued by the RUC in February 2007 and reviewed with final values assigned by CMS in Final Rule for the 2008 Physician Fee Schedule. At a recent meeting convened by the AMA, CMS officials confirmed that specialty societies could survey groups of codes over a series of RUC meetings and that the finalization of the values would not be contingent on the completion of all surveys.

The specialty societies surveying this family of codes indicated in the level of interest (LOI) form submitted prior to the April 2012 RUC meeting that there was interest in surveying the majority of the code set with the exception of four specific codes, 90785, the code that describes interactive complexity, 90839 and 90840 (crisis psychotherapy and its prolonged services), and 90863, pharmacologic management when performed by an a professional unable to report an E/M code, all of which we asked to have carrier priced. We reported during the LOI process and again at the RUC meeting that the rationale for carrier pricing was to allow clinicians the opportunity to be educated on the codes including revised indications for use, and have some actual experience in using the codes prior to completing a survey. There was no indication from the AMA or CMS, or reason for us to believe, that the request to carrier price a small group of codes would jeopardize the finalization of a majority of the family of codes.

In its attempt to maintain budget neutrality within the family for yet another year, CMS has adjusted the values of the codes with medical components, creating the irrationality of having the psychiatric diagnostic evaluation with medical services (90792) valued below the diagnostic evaluation without medical services (90791). CMS chose to cross-walk the existing practice expense values of 90801 to 90791 while, for some reason, adjusting down the practice expense values for 90792.

This interim status perpetuates the current values, which were inappropriately low. It creates a ripple effect in terms of actions by private payers, and, as a result, may further exacerbate access to care at a critical time for the nation’s mental health system and the people in need of treatment. We ask CMS to reconsider their actions and finalize the values of those services already valued, which make up 91% of the services billed under the new framework.

**RUC Recommendations and Compelling Evidence**

AACAP supports the RUC recommended values for all of the codes that have been reviewed by the RUC over the course of the past two years. We were extremely surprised that CMS chose to
delay finalization of the values for these codes, especially in light of the clear compelling
evidence that the work is undervalued, which was presented evidence to CMS and the RUC in
letters submitted as part of the five year review process and during our RUC presentation. The
RUC endorsed the compelling evidence arguments twice, first in October 2010 and again in
April 2012. Furthermore, in 2008, Congress took the step of passing legislation that increased
payments for psychotherapy services, again, recognition of the fact that these services have been
undervalued. This payment adjustment remained in effect until earlier this year.

Other than the temporary Congressional action noted above, the values tied to the psychotherapy
codes have not been changed since 1998. The specialty societies provided data showing that the
patient population receiving these services has dramatically changed since the codes were last
reviewed. According to a recent National Comorbidity Survey, 56% of patients receiving
psychotherapy have multiple comorbid conditions, meaning they suffer from more than one
mental or physical disorder, including substance abuse. Due to the prevalence of comorbid
patients, the work of the provider has become more complex. Further, the specialties showed that
the site of service for patients receiving many of these services has changed. Patients, who were
once treated in the hospital setting, are now more frequently being treated in the office setting
because the number of psychiatric beds has dropped by more than 60% between 1970 and 2000.
Additionally, data shows there has been a reduction of wrap-around services that have
traditionally provided additional support for those individuals suffering from severe mental
illness and/or substance use disorders. The RUC accepted these compelling evidence arguments
and moved forward with recommendations that increased the current values of these services.

Specific Concerns about the Rule
We would like to provide further comment on specific details contained in the rule:

Differential between the RVW for 90791 and 90792 – In the assignment of the interim work
values, CMS valued code 90792, Psychiatric diagnostic evaluation with medical services, only
0.16 RVWs above the 90791, Psychiatric diagnostic evaluation, although it is, by definition, the
same service without any medical or E/M work. We strongly disagree with CMS’s assessment
that 0.16 “is the appropriate differential between the diagnostic evaluation with medical services
and diagnostic evaluation without medical services.” AACAP has historically found this
differential, which previously was the differential between psychotherapy and psychotherapy
with E/M services, to be meaninglessly low even when describing the differences between
psychotherapy with or without E/M services. Any analysis derived from existing values,
including this differential, is not credible with compelling evidence supported by the RUC that
the current work values are too low. This was one of the major factors that led to the creation of
the new coding framework for psychiatric physicians. The 0.16 value is equivalent to the work
value of code 99211, Office or other outpatient visit for the evaluation and management of an
established patient that may not require the presence of a physician. Usually, the presenting
problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
This is the lowest level outpatient E/M service for an established patient and does not even
require the presence of a physician. It was inappropriately low for the psychotherapy differential
and it is even more so in terms of a differential when comparing the work involved in the
evaluation of psychiatric disorders, an evaluation that includes all of the elements of the 90791
plus additional work with medical decision making and increased risk. We are aware of no other
example where a value this low is assigned to physicians for E/M work. In fact, CMS’s own
guidance recognizes that those individuals seen for a psychiatric evaluation by a non-medical
professional must either have been referred by a physician following a medical evaluation or
must be seen by a medical professional following the psychiatric examination. There are also no
new patient codes in any setting with a work value as low as 0.16. The lowest RVW for any
group of new patient visits is 0.45 RVWs for 99281, Emergency department visit for the
evaluation and management of a patient, which requires: A problem focused history; A problem
focused examination; and Straightforward medical decision making; usually, the presenting
problem(s) are self-limited or minor and typically has an intraservice time of 7 minutes. Even
accepting this lowest RVW and adjusting for the 5 minute intraservice time leads to an RVW of
0.32 (5/7 x 0.45).

Psychiatrists perform a myriad of medical services during the evaluation process in addition to
the extensive psychological evaluation, which is similar to that performed by our non-medically
trained colleagues who will be billing a 90791. In addition to taking and synthesizing
information on a patient’s general medical history, the psychiatrist gathers additional details
during a review of systems with special attention to side effects observed with all medications
and alternative treatments, and physical exam, with additional items added to address specific
diagnostic concerns. Additionally, since the last review of the codes, there has been an explosion
of neuroscience knowledge leading to new medications and imaging procedures. This necessary
knowledge base is higher than what is required for a diagnostic evaluation, and along with the
other items discussed above were the basis for the recommendation to create medical and non-
medical evaluation codes.

Therefore, we would like to recommend an RVW of 3.32 for 90792, but at minimum support the
RUC RVW recommendation of 3.25 for 90792, and 3.00 RVW for 90791.

“Seen in lieu of the patient” – CMS expresses concerns about the CPT guidelines indicating that
“In certain circumstances one or more other informants (family members, guardians, or
significant others) may be seen [for the psychiatric diagnostic evaluation] in lieu of the patient.”
Specifically, CMS states “we are concerned that multiple diagnostic evaluations with family
members should not replace a detailed evaluation of the beneficiary, and we intend to monitor
the frequency of billing for diagnostic evaluations per patient.” As stated in previous
correspondence with CMS, the guidelines have included the phrase “seen in lieu of the patient”
since published in the first CPT manual. CMS has made clear their concerns as to how this
phrase could lead to an increase in the number of evaluations billed. We believe these concerns
are unfounded. Although the usual scenario involving others as informants will likely be in those
instances when the patient is a child, adolescent, or adult with cognitive impairment or limited
expressive language, this will not be the majority of evaluations. In these situations, the
evaluation will include an evaluation of the patient and include gathering additional information
from others as appropriate which could result in the need to bill for subsequent evaluations. As a
professional society, AACAP will be educating its members as to the appropriate use of the
codes and welcomes the opportunity to work with CMS to address any concerns that arise.

“patient and/or family” – CMS expresses concerns about the ability to bill for time spent
gathering “information from relatives or close associates,” stating that while it is appropriate to
obtain information from others in “some circumstances,” this “should not substitute for direct treatment of the beneficiary. We would expect psychotherapy to be billed only when the beneficiary is present for a significant portion of the service.” As a society we promote treating the patient; however, with minor children or cognitively impaired or severely mentally ill adults, the family must be incorporated in the care to obtain optimum results. AACAP will address this in its education to its members.

Differential between psychotherapy and the psychotherapy add-on codes – We do not believe the differential calculated by CMS is appropriate. As stated previously, we support the RUC recommended values.

Interactive complexity – CMS assigned an interim work value of 0.11 to the CPT code 90785, Interactive Complexity, an add-on code used to describe situations that complicate the delivery of a service. Unlike the former codes for interactive diagnostic interview (90802) and interactive individual psychotherapy (90810 – 90815) that described only one criterion for a communication problem, Interactive Complexity (90875) defines four:

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates delivery of care.
2. Caregiver emotions or behavior that interferes with the caregiver’s understanding and ability to assist in the implementation of the treatment plan.
3. Evidence or disclosure of a sentinel event and mandated report to third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.
4. Use of play equipment, other physical devices, interpreter, or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a patient who:
   a. Is not fluent in the same language as the physician or other qualified health care professional, or
   b. Has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment, or the receptive communication skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication

AACAP thanks CMS for noting that solely using an interpreter or translator to meet a criterion for 90785 violates federal law. The AACAP will propose a CCP (editorial change) to strike “interpreter or translator,” as well as paragraph 4a from criterion. The old 2012 “Interactive” definition is based strictly on criterion #4. Criteria #1 and #2 are likely to be the basis for the vast majority of 90785 uses.

The RVU for 2012 “Interactive” did not come from surveys, but is a calculated number that does not capture most of the work. That said, this number for non facility (the typical setting in which interactive complexity is expected to be reported) is still higher than the total RVU of 0.14 that CMS cross-walked from 2012 (all much higher except for 90810 minus 90804, which appears to be an anomaly):
Criteria #1 and #2 may be conservatively calculated by the difference between 90846 (just parents and therefore less interactive) and 90847 (typically interactive). This measure of intensity is conservative as criteria #1 and #2 describe the higher end of intensity of 90847.

In addition to the increase in intraservice intensity, all four interactive intensity criteria are associated with substantially more pre- and post-time. Criterion #1 is associated with the need to speak with participants after the visit to settle the anxiety or conflict, criterion #2 with further assisting the caregiver in implementing the treatment plan, criterion #3 with making the mandated report and further processing with affected parties, and criterion #4, detailed in the Federal Register, with the typical patient being a young child who requires much greater coordination of care.

The amount of pre- and post-time, which is greater than that for the primary procedure, is estimated at 10-15 min, corresponding to an additional RVU of 0.22-0.34 (the mean of 0.28 was used for the calculation below).

Therefore, AACAP recommends an RVW for 90785 of: 0.38 (90847 minus 90846) plus 0.28 (12.5 minutes of pre and post time) = 0.66.

Definition of Evaluation and Management services - AACAP would like to commend CMS for its unequivocal clarification on the provision of evaluation and management services by providers who are not, by statute, authorized to provide medical evaluation and management services. As CMS is aware, a limited number of psychologists (estimated at less than 100 in the nation) are licensed to prescribe a limited number of medications under limited clinical conditions. The majority of these prescribing psychologists are in the only two states that currently allow psychologists to prescribe under their state scope of practice. We concur with CMS’s assessment that “even though psychologists in Louisiana and New Mexico have been granted prescribing privileges, clinical psychologists in those and other states are not licensed or
authorized to furnish E/M services (which requires an ability to evaluate and manage medical services).” We support CMS’s decision to give the service described by 90863 a status indicator of I, not valid for Medicare purposes, and encourage them to maintain that status going forward.

Practice Expense Values

As noted previously, AACAP is extremely concerned about CMS’s decision not to finalize the values for the codes that describe over 91% of the psychiatric services provided in this country because four codes have not yet been surveyed. As a result, CMS implemented values in a budget neutral fashion creating an anomaly in the practice expense values for those services that include medical services. Specifically, CMS assigned differing values to the practice expense values assigned to the two codes that describe psychiatric diagnostic evaluations (90791, Psychiatric diagnostic evaluation and 90792, Psychiatric diagnostic evaluation with medical services) in spite of the fact that the RUC recommendations assigned the same practice expense values to both services. This has created a bizarre situation where clinicians who provide evaluations with medical services are paid less than those clinicians who provide the same evaluations without medical services. We believe this incorrect assignment of values should be corrected via a technical correction. Otherwise, in 2013 our members are penalized for providing medical services; they are paid less than if they provide the same evaluation without the medical services. We have heard from large numbers of our members who are struggling to understand why the Medicare fee for the psychiatric evaluation with medical services (90792) falls below that for the psychiatric evaluation without medical services (90791). We believe this anomaly could result in incorrect coding until such time as the values are finalized.

Overall, there has been wide agreement that psychiatric services have been undervalued. Recent national events have greatly emphasized the need for more available and effective psychiatric care and valuation for psychiatric services consistent with the RBRVS is essential for that.

Thank you for the opportunity to comment. We would be happy to speak with you further about our comments. Please contact Kristin Kroeger Ptakowski, Director of Government Affairs and Clinical Practice at kkroeger@aacap.org, 202.587.9666.

Sincerely,

Marty Drell, M.D.
President