New York State Psychiatric Association, Inc.

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September 6, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1693–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Centers for Medicare & Medicaid Services 42 CFR Parts 405, 410, 411, 414, 415, and 495 [CMS–1693–P] RIN 0938–AT31 Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; and Medicare Promoting Interoperability Program

Dear Sir or Madam:

I am writing on behalf of the New York State Psychiatric Association, the statewide medical specialty organization, representing over 4,200 psychiatrists practicing in New York. CMS has asked for public comment on proposed revisions to documentation guidelines for evaluation and management ("E/M") services published in the Federal Register on July 7, 2018.

Introduction

The proposed rule contains two interconnected proposals that will have a profound impact on both documentation and payment under Medicare Part B.

First, CMS proposes to permit physicians to select from one of the following three options for documentation of Outpatient/Office E/M codes for both new and established patients (99202-99205 and 99212-99215):

1. Using the current 1995 or 1997 documentation guidelines
2. Using only face-to-face time with the patient
3. Using only the level of medical decision making

For all three options, the physician need only include for Medicare audit purposes the documentation required for the Level 2 E/M service (99202 or 99212).

In addition to these changes, CMS also proposes the following technical changes to the 1995/1997 documentation requirements:

- Removing the need to justify home visits instead of office visits
- Eliminating the need to re-document information that has already been documented in the patient's record (e.g., Past, Family, Social History and Review of Systems)
- Clarifying that documentation of the patient's history and examination of an established patient need only address the changes in history or examination since the last visit.

Proposed Changes to Structure of Fee Schedule

In addition to these significant reductions in the documentation requirements for an outpatient/office visit, CMS proposes to replace the separate fees for each level of E/M service with a single fee for all four E/M services (99202-99205 and 99212-99215). This new single fee is calculated based upon the weighted average fee and would yield a fee of $135 for a new patient and $93 for an established patient (both fees are national averages without geographical adjustments). Thus, under the proposal, physician reimbursement from Medicare for any Outpatient/Office E/M services would be xx for a new patient and xx for an established patient regardless of whether the service is Level 2, 3, 4 or 5.

It appears that CMS is "trading" a reduction in the Medicare documentation requirements for an unprecedented change in reimbursement methodology. While NYSPA can support documentation reform, NYSPA does not support the conflation of four levels of E/M fees into a single fee. We believe that graduated levels of reimbursement for Level 2, 3 4 and 5 should be maintained and that graduated levels of documentation should continue to be required for each Level.

In addition, we have serious concerns about compressing the current fees for Levels 2 through 4 into a single fee for new patient visits and a single fee for established patient visits. The current Medicare Part B reimbursement methodology was enacted into law in 1992. Section 1848(b)(1) of the Social Security Act mandated that Medicare Part B physician fees be based upon three factors: relative value of each service; a conversion factor; and a geographical adjustment factor. Section (c)(2)(A)(i) of the Act directs CMS to develop a methodology reflecting work, practice expense and malpractice expense "to produce a single relative value" for each service. While CMS retains substantial discretion in modifying the Medicare Part B physician fee schedule, the conflation of four Levels of CPT codes into a single code and a single fee clearly conflicts with the intent, if not the letter, of the Social Security Act.

From a public health perspective, the abandonment of the current graduated fee schedule would provide a disincentive for psychiatrists to undertake the treatment of patients with significant symptomatology and dysfunction. A graduated fee schedule reflects the clinical realities of patient variability and provides reimbursement based upon that variability.

Proposed Changes to Documentation Requirements

A. Face-to-Face Time

CMS has proposed three new methods of documentation based solely on face-to-face time with the

patient and has invited public comment on all three. Under the first proposal, the time for a new patient visit (99202-99205) would be fixed at exactly 38 minutes and the time for an established patient visit (99212-99215) would be fixed at exactly 31 minutes. These times would be mandatory minimum times. (As in the new fees for these conflated services, the time for each has been calculated based upon the weighted average time for the four Levels.)

Second, CMS suggests applying the CPT "mid-point" time rule to these fixed times (38 and 31 minutes) and therefore, allow billing for both services after 20 minutes have elapsed for a new patient and after 16 minutes have elapsed for an established patient.

Finally, a third option would utilize the CPT "typical time" for each of the four Levels (2 through 5) as the minimum time required for each service. However, CMS acknowledges that this approach would conflict with its proposal to adopt a single fee for all services in Levels 2 through 5.

NYSPA does not support the use of time as the sole controlling factor in any of the three options. Except where counseling and/or coordination of care is more than 50% of the face-to-face time under the current CPT methodology, time is not an appropriate substitute for either the variability of work or the variability of medical decision-making. Also, the exclusive use of time has unique payment implications for psychiatry. Under changes in CPT coding adopted in 2012, psychiatrists who provide psychotherapy now bill for an office/outpatient E/M codes plus an add-on psychotherapy visit (90833, 90836 or 90838). These add-on codes mandate a minimum face-to-face time as well as a minimum psychotherapy time. **All three CMS proposals for use of time would create significant issues for psychiatrists who provide an E/M service plus psychotherapy.**

B. Medical Decision Making

A second alternative offered by CMS for documenting Office/Outpatient E/M services is one focused on Complexity of Medical Decision Making (MDM) – the third element in CPT (together with history and examination) used to select the correct level of E/M code. In our view, only one element of MDM, Risk of Complications and/or Morbidity or Mortality ("Risk") may be appropriate for determining the level of E/M codes, but MDM as presently constituted is not. Time should only be used for audit purposes for those services when counseling and/or coordination of care represents more than 50% of the patient encounter (face-to-face time in the office and floor time in the hospital).

By way of background, there are three elements of each E/M code: History, Examination and Complexity of Medical Decision Making. Each set of E/M codes (e.g., outpatient new patient, outpatient established patient, new inpatient, subsequent hospital care) require different levels of history, examination and medical decision making. Under the current CPT coding system as the level increases, the level of documentation increases. New patient visits require that the physician document all three elements at the required level. For established patients, only two of three elements must be documented.

In the case of the E/M elements of history and examination, the current documentation requirements are clear and precise as set forth in DHHS publication "Evaluation and Management Services Guide" November 2014 ICN 006764CMS (the "E/M Guide"). Every level of history and examination has a very specific list of required elements to be included. The E/M Guide provides

explicit and unambiguous documentation requirements for each level of E/M code. CPT sets forth the required level of history and examination required for each E/M code and the E/M Guide explains in precise detail the extent of documentation needed to meet the history and examination elements required for each CPT code. The new CMS proposed technical adjustments for documenting history and examination discussed above (modifying the 1995/1997 documentation guidelines) will eliminate unnecessary and duplicative paperwork and increase physician time available for patient care.

However, when we turn to medical decision making, the documentation standards are, with one important exception, vague and not well defined. MDM, one of the three elements of each E/M code, is itself divided into three sub-elements:

Sub-Element 1: Number of Diagnoses or Management Options which itself is divided further into four levels – minimal, limited, multiple or extensive.

Sub-Element 2: Amount and/or Complexity of Data to be Reviewed which is divided further into four levels – minimal or none, limited, moderate or extensive.

Sub-Element 3: Risk of Complications and/or Morbidity or Mortality ("Risk") which is again divided into four levels – minimal, low, moderate or high.

Unfortunately, the E/M Guide provides no definitive criteria for determining the level of the Number of Diagnosis or Management Options. The E/M Guide offers no clear or explicit explanation of what is a minimal, limited, multiple or extensive number of diagnoses or management options.

Similarly, the E/M Guide provides no definitive criteria to differentiate the amount or complexity of data to be reviewed and how to distinguish between minimal, limited, moderate or extensive amounts or complexity of data to be reviewed.

These two sub-elements are highly subjective, and thus, only create confusion for physicians and subject physicians to substantial audit risk.

Yet, the E/M Guide for the third element of MDM, Risk of Complications and/or Morbidity or Mortality includes a very helpful Table of Risk (p. 37 in the E/M Guide, copy enclosed). The Table of Risk divides Risk into three further sub-categories: Presenting Problem(s), Diagnostic Procedure(s) Ordered and Management Options Selected. The Table of Risk then identifies specific examples and explanations of factors that satisfy each of four levels of Risk, i.e., minimal, limited, multiple and extensive. The E/M Guide states that "highest level of risk in any one category (presenting problem(s); diagnostic procedure(s), or management options) determines the overall level of Risk."

Thus, this third sub-element of MDM is unique in that only in this category of MDM are physicians provided guidance on documentation requirements that is comparable to the guidance provided for history and examination.

More important, the element of Risk more accurately reflects the key issue of medical necessity – why the patient needed to be seen – including presence of negative symptoms, impairment in bodily

organs and dysfunction in activities of daily living. We suggest that CMS refocus its analysis of documentation requirements to documentation of medical necessity as the key factor in determining the level of E/M service. The Table of Risk is particularly helpful as it refocuses attention on medical necessity.

Thus, we suggest that, if CMS is considering allowing MDM documentation as the sole mandatory documentation, then CMS should require only one element of MDM to be documented or, more appropriately, only require documentation of the Risk sub-element for audit purposes. Risk as explained in the E/M Guide and set forth in the Table of Risk, provides a clear and straightforward standard for documenting MDM.

Any discussion regarding change in documentation requirements for E/M codes must first consider that any change in Medicare documentation requirements inevitably will become the standard, not only for Medicare, but for Medicaid and all payers. The current 1995/1997 Medicare documentation guidelines are currently used by all commercial health plans and Medicaid programs to audit physician records to identify overpayments. Thus, any change in Medicare documentation requirements inevitably will become the standard, not only for Medicare, but for Medicaid and all third party payers.

In addition, the proposed changes will render many, if not all, EHR software programs obsolete for Medicare Part B and require physicians to maintain two separate documentation programs. Adoption of any of the very dramatic changes in fees and documentation when the final rule is adopted in November of this year will not provide sufficient time for physicians to revise EHR and billing programs for implementation on January 1, 2019. Physicians will need more time to implement any significant changes. Given the numerous alternatives and options in the proposed rule, it appears to us that CMS itself would benefit from additional time to secure input from various sources before moving forward.

In conclusion, CMS should work closely with the AMA to integrate any significant changes into CPT and avoid creating a two-track system for documenting Office/Outpatient E/M services - the most typical physician service among all physician services.

Sincerely,

Seth P, Stein, Esq.
Executive Director and General Counsel