MARYLAND PSYCHIATRIC SOCIETY

October 5, 2020

RE: Proposed 2021 Medicare Physician Fee Schedule

The Maryland Psychiatric Society (MPS) supports CMS' proposal to adopt the RUC-recommended values and the new documentation guidelines for outpatient E/M services. We also encourage CMS to adopt the RUC-recommended times. These changes more accurately reflect the work and resources involved in outpatient care. The documentation requirements will be much less burdensome, more intuitive, and will focus care and documentation on what is clinically relevant on the date of service. We urge CMS to adopt these recommendations effective January 1, 2021. We also support congressional action to waive the budget neutrality requirement to limit the reductions set to occur once these policies are finalized.

We are, however, concerned about CMS' proposal to increase the stand-alone psychotherapy codes (CPT codes 90832, 90834, 90837). Unlike the other services CMS proposes to increase, psychotherapy is a procedure that is distinct from the work described by E/M services. There are separate add-on CPT codes for psychotherapy (CPT codes 90833, 90836, 90838 used in conjunction with E/M codes) that are virtually identical to the stand-alone codes. Increasing the value of stand-alone psychotherapy codes will not maintain current relativity; there is no established relativity between psychotherapy and E/M services. Instead, the effect of the proposal would be to lose the current relativity between the two sets of psychotherapy codes, i.e. the two code sets for the exact same work would be valued differently. This lack of relativity will likely reduce Medicare beneficiaries' access to psychiatrists, whose participation is already lower than average. It will also likely be used by commercial payers that tend to mirror the Medicare Physician Fee Schedule in their fees, which will further compound the disparity of reimbursements for psychiatric care in commercial plans and reduce participation by psychiatrists. **We recommend that CMS maintain relativity within the psychotherapy family of codes and apply the increase to all psychotherapy services, including those billed in conjunction with an E/M service.**

The MPS urges CMS to permanently retain several of the recently implemented telehealth flexibilities. We also support Congressional action to remove the geographic restrictions and allow mental health patients to be seen in the home; flexibilities currently in place for those with substance use disorders through the Support Act. These changes would ensure a smooth transition to in-person care and increase access via telehealth and telephone to necessary care. They are especially important for the therapeutic alliance that is critical to effective mental health and substance use care. We also agree that in those instances where existing telehealth services are being replaced with new codes describing the same service, the new codes should automatically be included on the telehealth list.

The MPS supports the CMS proposal to allow supervision of resident physicians via telehealth through the end of the calendar year in which the PHE expires. Over the course of the PHE, physicians used their clinical judgment to decide whether to supervise residents in-person or virtually. We believe that, upon the expiration of the PHE, physicians should still be able to rely on their clinical judgments to make this decision.

CMS has proposed to make permanent some of the flexibilities around visit frequency in specific settings. Arbitrary barriers to care should not be imposed, but rather the system should be driven by medical necessity, with supporting documentation in the record, regardless of the modality with which the care is provided. **We recommend CMS remove all frequency limitations and use medical necessity as the rationale for payment uniformly across the fee schedule**.

The MPS supports the continuation of coverage for audio-only services to allow flexibility to ensure that everyone, especially the most vulnerable, has access to care. However, this should not be a routine substitute for in-person or telehealth services for all beneficiaries, but only used in those instances when there is no reasonable alternative or the patient prefers audio and medical necessity does not require in-person or telehealth care. This accommodates patients with limited access to providers, insufficient broadband infrastructure and/or physical limitations. **In lieu of the proposal, we recommend CMS implement a new modifier for use with existing E/M services that indicates the service was provided via audio-alone.** This would simplify coding, documentation, and payment of services regardless of how the service was provided, and the work performed and the practice expenses incurred are the same.

Thank you for the opportunity to provide comments. Please email mps@mdpsych.org if you have questions.

Sincerely,

Mark J. Ehrenreich, M.D.
President