AMERICAN PSYCHIATRIC ASSOCIATION

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Seema Verma, MPH
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS–3346–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Dear Administrator Verma:

The American Psychiatric Association (APA), the national medical specialty society representing over 37,800 psychiatric physicians and their patients, would like to take the opportunity to comment on the CY 2019 proposed rule for the Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction. Our comments focus specifically on issues that impact the care of patients with mental health and substance use disorders (collectively referred to as "behavioral health" disorders), particularly on the documentation of patient care in psychiatric hospitals.

Special Requirements for Psychiatric Hospitals (§ 482.61(d))

Section 482.61(d) of the Medicare Conditions of Participation, requires that progress notes be documented by the physician (MD or DO) who is responsible for the care of the patient and, when appropriate, others significantly involved in active treatment modalities. In this proposed rule, CMS goes on to explain that it has concerns that the existing regulations are unclear to some parties: *"We believe that non-physician practitioners, including physician assistants, nurse practitioners, psychologists, and clinical nurse specialists, when acting in accordance with State law, their scope of practice, and hospital policy, should have the authority to record progress notes of psychiatric patients for whom they are responsible. Therefore, we propose to allow the use of non-physician practitioners or MD/DOs to document progress notes of patient receiving services in psychiatric hospitals."*

The American Psychiatric Association appreciates and supports CMS's clarification that other medically trained providers -- physician assistants, nurse practitioners and clinical nurse specialists – can document progress notes in addition to physicians. APA agrees with CMS that "Progress notes are recordings in the medical record that are written by persons directly responsible for the care and active treatment of the patient. Progress notes give a chronological picture of how the patient is progressing toward the accomplishment of the individual goals in the treatment plan. These are frequently shift notes, weekly

notes, or monthly notes."[1]

We, however, oppose the inclusion of psychologists in this list. CMS may not have considered the limitations on the scope of services psychologists are licensed to provide. Unlike nurse practitioners, physician assistants, and clinical nurse specialists, psychologists do not have medical training and they are not licensed to evaluate and manage medical conditions. In acute care hospitals, the daily progress note reflects an assessment of the totality of the patient's care, including medications or other medically-based treatments (e.g., electroconvulsive therapy, transcranial magnetic stimulation), and must be documented by a physician or other qualified medical provider. This critical responsibility is not within the scope of practice for psychologists.

Psychologists can currently document the services they provide (psychotherapy, psychological/neuropsychological testing notes), but should not be given the authority to write medical progress notes. Under current Medicare regulations, psychologists, even with admitting privileges, cannot be the attending physician, responsible for the overall care of the patient. This is confirmed in statute: 42 CFR 482.12 c(1)(vi) provides clarity regarding the care of patients with respect to psychologists, in that they are limited to psychologist services as defined in § 410.71 of this chapter—and only to the extent permitted by state law.

Furthermore, CMS previously stated in the 2013 Medicare Fee Schedule final rule, with particular reference to CPT code 90863, *medication management:*

> We have discussed in previous rulemaking that Medicare does not recognize clinical psychologists to bill E/M services because they are not authorized to furnish those services under their state scope of practice (62 FR 59057). While clinical psychologists have been granted prescribing privileges in Louisiana and New Mexico, they are not licensed or authorized under their State scope of practice to furnish the full range of traditional E/M services. CPT code 90862 describes pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy. This descriptor reference to ''medical psychotherapy'' implies that the service furnished under CPT code 90862 is an E/M service, and therefore, clinical psychologists cannot bill Medicare for CPT code 90862. We also believe that clinical psychologists would continue to be precluded from billing Medicare for pharmacologic management services under new CPT code 90863, even in the absence of the reference to ''medical psychotherapy'' because pharmacologic management services require some knowledge and ability to perform evaluation and management services. Even though clinical 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. [CY 2013 Medicare Physician Fee Schedule, Final Rule, 77 Fed. Reg. 69062 (November 16, 2012)]

[1] State Operations Manual: Appendix AA – Psychiatric Hospitals – Interpretive Guidelines and Survey (Revision 149, 10-09-15). Centers for Medicare and Medicaid Services.

The regulatory relief CMS seeks could effectively come from allowing medical professionals (NPs, PAs, CNSs) working collaboratively with psychiatrists to write daily progress notes, as the medical provider, so long as it is made clear that the attending psychiatrist is always responsible for the overall care of the patient.

Burden Reduction

There are other aspects of documentation that CMS should consider in pursuit of regulatory relief for physicians and facilities:

Patient admissions and continued hospitalization: In the past, when a physician determined a patient's need for admission to the hospital, the physician's order (or an order by a resident or nurse practitioner, if employed by the hospital) was sufficient justification and documentation for the admission. Presently, however, CMS requires an attending physician to write the order to admit using CMS prescriptive language. This places an arbitrary restriction on the admission process and burden on attending physicians whose time is already allocated to other clinical and administrative obligations. Compounding this burden is CMS' requirement that physicians must document continued justification for a patient's inpatient stay, at regular intervals. One way that some practices have adapted to this requirement is by generating additional documentation outside of the regular progress note, to ensure that the required documentation is clearly identifiable to CMS for justification purposes. In conjunction with managing multiple patients simultaneously—and not always knowing whether said patients are Medicare/Medicaid beneficiaries at the time of admission—this time-consuming documentation process is increasingly burdensome to psychiatrists operating within a healthcare system in which there are limited professionals with their expertise. APA contends that the admission history alone should provide enough evidence for an initial order to admit and that subsequent progress notes should provide enough justification of a continued need for hospitalization.

Interdisciplinary Treatment Plans (ITP): Presently, CMS's reviewing requirements dictate that psychiatrists complete a patient-centered interdisciplinary treatment plan for the patient. While this is required, to some extent, by CMS in other settings (e.g., the patient centered medical home, general medical-surgical, long-term care) the specific details required by psychiatrists caring for patients in the inpatient setting are more burdensome than those in other treatment settings. For instance, some requirements of the interdisciplinary treatment plan (e.g., sub-objectives) are more onerous and duplicative than those required for patients in other settings. Long- term goals in the patient's own words, as well as long-term goals described by the staff; multiple, specific, individualized objectives for the patient, as well as multiple, individualized staff interventions are required, including descriptions of type, amount, frequency, and duration; with the expectation that progress notes of all disciplines tie back to these goals, objectives, and interventions. These now have been expanded beyond mental health and substance use issues, to include separate problems identified related to pain, co-morbid medical conditions, and seclusion and restraint; each of which requires the full development of long-term goals, objectives, staff interventions, etc. These "requirements" are based not on the statutory requirements

under the Conditions of Participation for Psychiatric Facilities, but rather on the Interpretive Guidelines published by CMS (HCFA) in the 1960s and further amplified by surveyors' preferences developed and expanded over the years. These place a significant time burden on the entire behavioral health treatment team, including the physicians, in addressing the needs of patients who may only be hospitalized for 3-10 days. Further, most of what is required of psychiatrists within the ITP is already captured in the psychiatric progress note. Part of the confusion and redundancy in the ITP is an outgrowth of the various levels of multi-entity, institutional oversight that monitor its implementation and documentation—i.e., different entities (The Joint Commission; state health agencies) are implementing these CMS standards in different ways. Moreover, as these various entities attempt to implement these CMS requirements, electronic health records (EHR) vendors struggle to link all this information within their systems reliably, which results in a more convoluted documentation and treatment process for providers and patients. While APA appreciates that this has been an attempt by CMS to make treatment more patient-centered, there is no evidence that this is the case. If the focus is to be on patient centered care, it would make more sense for this requirement to be replaced with an appropriate outcome measure rather than burdening the physician and rest of the treatment team with additional process documentation, which far exceeds that required for any other medical specialty.

Thank you for the opportunity to review this proposed rule and for the consideration of these comments. If you have any questions or would like to discuss any of these comments, please contact Debra Lansey, M.P.A., APA Associate Director for Payment Policy at dlansey@psych.org or (202) 609-7123.

Sincerely,

Saul Levin, MD, MPA, FRCP-E
CEO and Medical Director