



AMERICAN
PSYCHOLOGICAL
ASSOCIATION
Services, Inc.

May 13, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

Re: Reducing burdens on psychologists in Medicare

Dear Administrator Verma:

I am writing to you on behalf of the American Psychological Association Services Inc. (APA Services), the companion organization to the American Psychological Association (APA). APA is the professional organization representing more than 118,400 members and associates engaged in the practice, research and teaching of psychology. APA Services advocates on behalf of psychologists engaged in the practice of psychology in all settings. We are writing to discuss how Medicare can update its current review and auditing practices that negatively impact psychologists and the Medicare beneficiaries they serve.

EXECUTIVE SUMMARY

Regardless of the intent, issuing the Comparative Billing Reports (CBRs) to psychologists as an educational tool failed miserably. Not only was the data gathered in a way that did not accurately reflect the services being provided, but the tone of the letters was confusing at best and menacing at worst.

Psychologists felt they were being singled out because they treated more Medicare beneficiaries than their professional peers (e.g. psychiatrists), and they provided beneficiaries with longer or more frequent services to address the complex conditions that psychologists are so well-trained to provide.

Psychologists were left with the impression that Medicare's goal was for them to reduce the number and length of the services they provided. Many indicated to APA that since receiving the CBR letter they are considering opting out of Medicare.

Value of Psychologists for Medicare Beneficiaries

Psychologists provide Medicare beneficiaries with critical mental and behavioral health services, are the leaders in testing and assessment as well as the preeminent providers of psychotherapy. Psychologists created the health and

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behavior codes to capture behavioral health services that are used to help beneficiaries address physical health issues. Psychologists in nursing facilities routinely instruct staff on how to deal with patients suffering from declining cognitive abilities. In integrated care settings psychologists play several roles as they can serve as consultants, direct care providers, and members of teams with other healthcare professionals.

As the Medicare population grows more beneficiaries will need access to psychologist services. It is critical that the Centers for Medicare and Medicaid Services (CMS) take steps now to ensure that there will be enough psychologists in the program to meet the demand. We wish to help the agency by finding ways to retain psychologists who are currently Medicare providers as well as attracting early career psychologists to the program. One important challenge is that many psychologists view participation in Medicare as being overly burdensome, especially for those in solo and small group practices. Below are some examples of the difficulties psychologists are experiencing as Medicare providers.

The 2018 Comparative Billing Reports

In the fall of 2018 many psychologists received letters from eGlobal Tech containing a Comparative Billing Report (CBR). The CBR was described as an educational tool that compared psychologists' billing and service patterns with others in their specialty both in their respective states and nationwide. The letters were sent to psychologists whose billing patterns exceeded the averages for their peers. The letter stated that while receiving a CBR was not a precursor to being audited, some providers would be referred for additional review and education.

Psychologists across the country told us that they felt threatened upon receiving the CBR letter. Many pointed to language in the letter stating that charges for psychotherapy by psychologists per beneficiary were much higher than psychotherapy charges by psychiatrists. There was no reason for making this statement as it had no bearing on the data gathered for the CBR. Nonetheless it angered psychologists who thought their billing patterns were being compared to psychiatrists. Psychiatrists focus on prescribing and monitoring their patients' psychotropic medications. Psychologists, along with licensed clinical social workers (LCSWs), provide the vast majority of psychotherapy services in Medicare. Psychologists also perform psychological and neuropsychological testing that psychiatrists and LCSWs are not trained to provide.

We also wish to draw your attention to the three categories of data reviewed under the CBR:

1. Average number of minutes per psychotherapy visit

In this category, psychologists felt they were being criticized for furnishing more 60-minute services under 90837 than their peers. It is important to note that 90837 is an accepted code under the Medicare physician fee schedule and that many patients require more than what can be accomplished in 45-minutes. The

data analysis did not consider subjective factors such as the condition of the patient and/or the modality of treatment being provided. Another important factor is the setting where the patient is treated. Patients in skilled nursing facilities or other inpatient locations may be bedridden and/or not be able to participate in a psychotherapy session for more than 30 minutes. It is misleading to calculate an average number of minutes for a psychotherapy session without accounting for the differences between institutionalized patients and those capable of traveling to their provider's outpatient office.

2. Average number of visits per beneficiary per year

Psychologists were extremely frustrated to be told that seeing patients more than once a month in most cases caused them to be labelled as outliers. Again, there was no subjective data looking at the patient and his/her need for treatment. In many cases more frequent outpatient visits help avoid the need for the patient to be hospitalized.

3. Average allowed charges per beneficiary

A psychologist who is doing more 60-minute sessions and/or sees patients more frequently than his or her peers will almost always have a higher amount of average allowed charges. In some cases, patients receiving psychotherapy also undergo psychological or neuropsychological testing. Because such testing may be done in batteries several hours long, a psychologist providing testing in addition to psychotherapy will have higher average charges. Again, the data made no attempt to include information that would have helped to explain some of these difference in billing and practice patterns.

Audits

Psychologists who see a higher percentage of Medicare beneficiaries and/or routinely provide 60-minute psychotherapy services claim they are more likely to be the subjects of a Targeted Probe and Educate (TPE) audit. Psychologists find this especially burdensome for several reasons. Psychologists typically do not have the administrative and billing staff that most physicians have. When psychologists are subject to an audit the responsibility to gather and submit the relevant paperwork often falls directly on them. To illustrate, one practice reported being asked for notes for 40 dates of service, a task that took over 8 hours to complete.

Even more troubling, TPE audits may involve prepayment review. In such cases reimbursement for any services provided is withheld until the audit is completed. This can take considerable time as TPE audits allow for up to three rounds of 20 to 40 claims in each round. The targeted probes are not simply per provider; they can also be per service. This means that if a psychologist provides services for psychotherapy as well as testing, or health and behavior, each service could be subject to a separate probe. The impact on cash flow for a solo practitioner who must go without being paid while the TPE audit is underway can be significant.

Psychologists are often the subjects of TPE audits simply because their billing practices differ from their peers. With Medicare's low rates and somewhat restrictive coverage policies many psychologists see only a limited number of Medicare beneficiaries, treating this as a way of giving back to society. As a result, psychologists who treat a larger number of Medicare beneficiaries become statistical outliers, thus increasing their risk of an audit. Under this structure Medicare does not recognize or reward psychologists who are more willing to treat the elderly, complex, and/or disabled; instead it subjects them to even greater scrutiny. Even after a psychologist completes the audit process and is found to be compliant the grace period lasts for only a year before they are potentially subject to another TPE audit.

Changes Needed to Protect Beneficiary Access

We believe the review processes cited above have a central flaw in that they assume practice patterns that differ from the "averages" must be suspect. For the CBRs, eGlobal Tech reviewed claims data by looking strictly at numbers and did not consider information about the psychologist's practice. The situation is even more ominous when it involves an audit. If contractors conducting audits benefit financially from withholding and/or reclaiming reimbursement, then what is their incentive to spend considerable time and resources examining each case? The burden falls on the psychologist to explain why their billing practices differ, often while undergoing an audit that results in a suspension of payment for their services.

We believe that several changes are needed in the way that Medicare reviews, and audits are conducted for psychologists:

- Claims data for a psychologist's services should be reviewed by a psychologist, not another type of provider.
- Analysis of any data collected should take into consideration information such as, but not limited to, the size and nature of the practice, treatment modalities, location, and the types of patients seen.
- Letters informing psychologists they are under review should state explicitly what the concern is and what information the reviewer needs to address that concern.
- Medicare Administrative Contractors (MACs) should explain in local coverage determinations (LCDs) what information (e.g., documentation) is needed to justify medical necessity. Restrictions or limitations on any services should be clearly stated, preferably with examples.
- Prepayment audits should be done only in cases where there is a reasonable belief that fraud or abuse is involved and should be completed as soon as possible.

We understand the importance of detecting and combating fraud, abuse and waste in Medicare. Our concern is that the current methods being used by CMS and its contractors are so burdensome they threaten to drive psychologists out of Medicare. We want to work with the agency to ensure there will be a sufficient

number of psychologists in Medicare to meet the growing needs of the elderly and disabled in America.

We look forward to hearing that steps will be taken to make Medicare participation fair and less onerous for psychologists. If we can provide any further information please contact our Director of Regulatory Affairs, Diane M. Pedulla, J.D., at 202-336-5889 or by email at dpedulla@verizon.net.

Cordially,

A handwritten signature in black ink, appearing to read "Jared L. Skillings". The signature is fluid and cursive, with a long, sweeping underline that extends to the left.

Jared L. Skillings, PhD, ABPP
Chief of Professional Practice