CODING, BILLING AND DOCUMENTING PROFESSIONAL PSYCHOLOGICAL SERVICES

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Disclaimer

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Acknowledgments: Organizations

- North Carolina Psychological Association
- American Psychological Association (APA) Practice Directorate (PD)
- American Medical Association (AMA) CPT Staff
- National Academy of Neuropsychology (NAN)
- Division of Clinical Neuropsychology of APA (40)
- Center for Medicare & Medicaid Services (CMS) Medical Policy Staff - Medicare
- National Academies of Practice (NAP)

(presented in chronological order of engagement of support for the work outlined)
Acknowledgments: Individuals

• **AMA**: Marie Mindenman, Tracy Gordy, Peter Hollman

• **APA**: *Randy Phelps*, Norman Anderson, Diane Pedulla along with Marilyn Richmond and Katherine Nordal (APA Testing & Psychotherapy Groups)

• **NAN**: PAIC Former and Present Committee

• **NAP**: Marie DiCowden

• **National Psychologist**: Paula Hartman-Stein

• **Other**: *James Georgoulakis, Neil Pliskin, Pat DeLeon* (highly instrumental in recent CPT activities)
Support Provided

• AMA = AMA pays travel and lodging for AMA CPT activities 2009-present (no salary, stipend and/or honorarium; stringent conflict of interest and confidentiality guidelines)
• APA = Expenses paid for travel (airfare & lodging) associated with past CPT activities (no salary, stipend and/or honorarium historically nor at present)
• NAN = (from PAIO budget) Supported UNCW activities (no salary/honorarium obtained from stipend/paid to the university directly; conflict of interest guidelines adhered to) from 2002-2009
• UNCW = University salary & time away from university duties (e.g., teaching) plus incidental support such as copying, mailing, telephone calls, and secretarial/limited work-study student assistance

Summary = CPT activities, travel/lodging support but no salary/stipend. Any monies obtained, such as honoraria for presentations, are diverted to the UNCW Department of Psychology for graduate psychology student training. No funds are used to supplement the salary or income of AEP.
Personal Background (1988 – present)

- North Carolina Psychological Association (e)
- *NAN’s Professional Affairs & Information Committee (a); Division 40 Practice Committee (a)*
- *National Academy of Practice (e)*
- APA’s Policy & Planning Board; Div. 40; Committee for Psychological Tests & Assessments (e)
- *Consultant with the North Carolina Medicaid Office; North Carolina Blue Cross/Blue Shield (a)*
- Health Care Finance Administration’s Working Group for Mental Health Policy (a)
- Center for Medicare/Medicaid Services’ Medicare Coverage Advisory Committee (fa)
- American Medical Association’s Current Procedural Terminology Committee Advisory Panel – HCPAC (IV/V) (a)
- *Joint Committee for Standards for Educational and Psychological Tests (a)*

legend: a = appointment, fa = federal appointment, e = election; italics implies current appointment/elected position
Standards & Guidelines for the Practice of Psychology

• APA Ethics Code (2002)
• HIPAA and other federal regulations
• State or Province License Regulations
• Contractual Agreements with Third Parties
• Professional Standards (e.g., Standards for Educational and Psychological Tests, 1999; in revision)
HIPAA Compliance

• Effective 01.01.12, all providers must comply with HIPAA Version 5010
• Problems have arisen and enforcement may be postponed
• Examples -
  – No longer allows post office box
  – How one identifies family members
  – Must use PMS upgrade

www.aasn.org/go/5010
4010 to 5010 Change

- Transition Effective 01.01.12
- Increased Pending Claims
- Increased Rejected Claims
- Inaccurate Payments
- Decrease Spending
- Increase Cash Reserve
Primary Goals & General Outcomes

• **Goal (25 year plan; began in 1988)**
  – Parity with Physicians
  – Expansion of Scope of Services Reflective of Science and Practice

• **Outcome (presently)**
  – Intended/Anticipated/Hoped
    • Similar reimbursement as physician services
    • General increase in the scope of practice
    • Greater inclusion into health care system
  – Less Anticipated
    • Transparency
    • Accountability
    • Uniformity
    • Potential impact on certain practice patterns
    • Development of a highly complex and volatile system of practice and payment
Why This Information is Important?

• Medicare Cuts Still Slated
• A New Health Care Plan Recently Passed by Congress Will Change Health Care (largest change in 25-50 years)
• An Entirely New Diagnostic System Will be in Place in Two Years
• Medicaid Started Using Medicare NCCI Edits Effective 04.01.11
Outline

• Part I: Coding, Billing & Documentation
• Part II: Economics
• Part III: Challenges & Solutions
• Part IV: Resources
Part I: Coding, Billing & Documentation

• Part I:
  – A. Medicare
  – C. Diagnosing
  – D. Medical Necessity
  – E. Documentation
  – F. Time
  – G. Location of Service
  – H. Technicians
  – I. Supervision
  – J. Correct Coding Initiative
A. Medicare: Why?

- **The** Standard for Universal Health Care:
  - Coding (what can be done)
  - Value (how much it will be paid)
  - Documentation (what needs to be said)
  - Auditing (determination of whether it occurred)

Note: While Medicare sets the standard, there is no point-to-point correspondence with private carriers, forensic or consulting activity but it does set the foundation.
What Drives Medicare

• Quality
• Expansion of Services
• Patient Experience
• Focus on Primary Care
• Affordability
• Preserving Medicare Trust
Current Goals for Medicare According to CMS

- Lower Prescription Costs
- Addition of Preventative Care
- Doctor Incentives to Coordinate and Perform Better

– Don Berwick, CMS Administrator, 09.02.11
Medicare: Psychology’s Involvement

- First Published Article by Psychologist
  - John McMillan, American Psychologist, 1965
- First Public Hearing
  - Arthur H. Brayfield, House Committee on Ways and Means, 1967
- First Publication by Elected Official
Definition of a Psychologist

• Medicare
  – clinical psychologist

• According to Social Security Act (1989)
  – Not defined as a physician
  – Therefore defined as a technician
  – Professional does cognitive work whereas a technician does technical work under supervision

• According to CPT system
  – Qualified Health Provider
  – Implied it is a doctoral level provider
Medicare: The Standard?
(New York Times, August 12, 2007)

- World Health Organization Ranking of 191 Nations
  - # 1 = France and Italy
  - # 37 = United States
- 45 Million (out of 300) Do Not Have Health Insurance
- Greatest Disparity Between Rich and Poor
- Poor Life Expectancy
Medicare: Immediate Impact

• As a Consequence, the Benchmark for:
  – All Commercial Carriers (e.g., HMOs)
  – As Well as:
    • Workers Compensation
    • Forensic Applications
    • Related Applications (e.g., industrial, sports)
Medicare: Long-term Impact

• Currently, $300 billion annually
• By 2015, Medicare will represent approximately 50% of all health care payments in the United States
• Eventually, a national (US) health insurance will be established
• One possible model will be to introduce Medicare to younger citizens will be in age increments (e.g., 60-64, then 50-59, etc.)
• Hence, Medicare will come to set the standard for all of health care
Medicare: Local Review

• Medical Review Policy
  – National Policy Sets Overall Model
  – Local Coverage Determination (LCD) Sets Local/Regional Policy
    • More restrictive than national policy
    • Over-rides national policy
    • Changes frequently without warning or publicity
    • Applies to Medicare and private payers
    • Information best found on respective web pages
Medicare Provider

• If you are a provider before 03.25.11, you will have to re-enroll with your Medicare Administrative Contractor (MAC) by 03.23.13)
• You must wait to hear from the MAC
• Form CMS-855 (completely AND correctly completed)

- Background
- Codes & Coding
- Existing Codes
- Model System X Type of Problem
CPT: Copyright

- CPT is Copyrighted by the American Medical Association
- CPT Manuals May be Ordered from the AMA at 1.800.621.8335
What Is a CPT Code?

• A Coding System Developed by AMA in Conjunction with CMS to Describe Professional Health Services
• Each Code has a Specific Five Digit Number and Description as well as a Reimbursable Value
• Professional Health Service Provided Across the Country at Multiple Locations
• Many “Physicians” or “Qualified Health Professional” Perform Services
• Clinical Efficacy is Established and Documented in Peer-Reviewed Scientific/Professional Literature
• Regulatory and Royalty Based
CPT: Background

• American Medical Association
  – Developed by Surgeons (& Physicians) in 1966 for Billing Purposes
  – 8,000+ Discrete Codes
  – CPT Meets a Minimum of 3 Times/Year

• Center for Medicare & Medicaid Services
  – AMA Under License by CMS
  – CMS Now Provides Active Input into CPT
  – It is Regulatory and Would Take Congressional Action to Change
CPT & Providers

(Corrections Document- CPT 2012; front matter)

• “It is important to recognize that the listing of a service or procedure of this book (i.e., CPT) does not restrict is use to a specific specialty”.

• “A “physician or other qualified health professional” in an individual who is qualified by education, training, licensure/regulation(when applicable) and facility privileging (when applicable) who performs a professional service within his/her score of practice and independently reports that professional service.”
CPT & Clinical Staff

( Corrections Document- CPT 2012; front matter )

• “A clinical staff member is a person who under the supervision of a physician or other qualified healthcare professional and who is allowed by law, regulation and facility to perform or asset in the performance of a specific professional service, but who does not individually report that professional service.”
CPT: Rationale

• History
  – Outgrowth of the development of Medicare system in mid 1960s

• Purpose
  – Provide a uniform system for all health care procedures
  – Developed, approved and used by all health care professionals and third party carriers (including Medicare/Medicaid)
Anatomy of a CPT Code

• Number (5 digits)
• Inclusion Criteria
• Exclusion Criteria
• Reference
• Description (2-3 lines)
CPT: Composition

- AMA House of Delegates
  - 109 Medical Specialties
- HCPAC
  - 11 Allied Health Societies (e.g., APA)
- CPT Editorial Panel
  - 17 Voting Members
    - 11 Appointed by AMA Board
    - 1 each from BC/BS, AHA, HIAA, CMS
    - 2 Voted on by HCPAC
      - Physician’s Assistant
      - Psychologist (AEP)
CPT: Theory

• Order of Value - Personnel
  – Surgeons, Physicians, Doctorate Level Allied Health, Non-Doctorate Level Allied Health

• Order of Value - Costs
  – Cognitive Work, Expense, Malpractice
  – X a Geographic Location Factor
  – X a Conversion Factor Set by Congress Yearly
CPT: Categories

• Current System = CPT 5; 2008 Version
• Categories
  – I = Standard Coding for Professional Services
    • Codes of interest
  – II = Performance Measurement
    • Emerging strongly; will be the future of CPT
  – III = Emerging Technology
    • New technology and procedures
CPT: Code Book

• Basic Information = Codes

• Appendices
  – A = Modifiers
  – B = Additions, Deletions and Revisions
  – C = Clinical Examples (Vignettes)
  – D = Add-on Codes
  – H = Performance Measures by Clinical Condition or Topic
CPT: Abbreviated Glossary

• **CPT**
  – Current Procedure Terminology = professional service code

• **Qualified Health Professional**
  – The person who has the contract with the insurance carrier
  – Defined by training (e.g., see Division 40, NAN % APA statements), state (e.g., licensing boards) and federal statutes/laws/regulations (e.g., Medicare)
  – May not include Master’s level Associates

• **Technician**
  – Anybody else

• **Facility vs. Non-facility**
  – Non-facility = all settings other than a hospital or skilled nursing facility

• **Units**
  – Time based factor which is applied as a multiplier to the RVUs agreed to by AMA CPT and CMS

• **Face-to-face**
  – In front of the patient
CPT: Development of a Code

- **Initial**
  - Health Care Advisory Committee (non-MDs)

- **Primary**
  - CPT Work Group (selected organizations)
  - CPT Panel (all specialties)

- **Likelihood**
  - HCPAC = 72% of codes submitted are approved

- **Time Frame**
  - 2 to 12 years
CNS Assessment Codes Timetable: An Example of Time from Idea to Reality

- Activity x Date
  - Codes Without Cognitive Work Obtained, 1994
  - Request by CMS/AMA to Obtain Work Value, approximately 2000
  - Initial Request for Practice Expense by APA, Summer, 2002
  - APA Appeared Before AMA RUC, September, 2003
  - Initial Decision by AMA CPT Panel, November 7, 2004
  - Call for Other Societies to Participate, November 19, 2004
  - Final Decision by AMA CPT Panel, December 1, 2004
  - Submission of CPT Codes to AMA RUC Committee immediately thereafter
  - Review by AMA RUC Research Subcommittee in January, 2005
  - Review by AMA RUC Panel in February 3-6, 2005
  - Survey of Codes, second & third week of February, 2005
  - Analysis of Surveys, March, 2005
  - Presentation to RUC Committee in April, 2005
  - Inclusion in the 2006 Physician Fee Schedule on January 1, 2006
  - Meeting with CMS, April 24, 2006
  - CMS Transmittal and NCCI Edits published September, 2006
  - AMA CPT Assistant articles published November, 2006
  - AMA CPT Assistant Q & A published December, 2007
  - Presentation to AMA CPT Panel February 9, 2007
  - Presentation to CMS a series of Q and As July, 2007
  - Acceptance and publication of new CPT testing code language, October, 2008
  - Initial acceptance of clarification of testing codes by CMS, October, 2008
  - Continued involvement in the explanation of their use (e.g., AMA CPT presentation, October, 2010)
  - Working on compliance officers interpretation of simultaneous use of professional and technical codes
  - Now contemplating on the possibility of a new code for interpretation
Category I Codes

- Clinical recognized
- Scientifically validated
- National in scope
Levels of Evidence

• Ia - Evidence obtained from meta-analysis of randomized controlled trials
• Ib - Evidence obtained from at least one randomized controlled trial
• Ila - Evidence obtained from at least one well-designed controlled study without randomization
• IIb - Evidence obtained from at least one other type of well-designed quasi-experimental study
• III - Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies
• IV - Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities
• V - Evidence obtained from case reports or case series

(based on AHCPR 1992)
Category II Codes: Introduction

- Performance Codes
- Pre-cursor to Pay for Performance/Quality
- Initially Starts with Documentation
- Will Evolve into Performance and not Service as the Determination of Payment
- At present- Depression is primary focus
- (COULD END WITH ELECTRONIC RECORDS)

Primarily developed by the Performance Measures Advisory Group (2001)
Category II: Information

- Developers
  - National Committee for Quality Assurance
  - Quality Improvement Organizations
  - Physicians Quality Reporting Initiative (CMS)
  - Physician Consortium for Performance Improvement (AMA)

(Note: US is last of 7 countries that use performance measures)
Category II: Direction

• Specialty Society Driven
• Defining the Work Group (due to some of the organizations have not continued)
• May End with Electronic Health Records
Elements for Category II Measures

• Denominator
  – Applicable population

• Numerator
  – Segment of population in compliance with measure

• Exclusions
  – Segment of population not in compliance with measure
Category III Codes
(CPT Assistant, May 2009)

• Temporary Codes for emerging technology, services and procedures
• Intended to eliminate local codes and get those codes to eventually become part of the CPT system (but may produce $)
• Conversion may be requested by a society or by CPT
• 10 year history of Category III
Shifting Codes

• When a significant disruption of service occurs, a new service is then coded.
• Assumption is that the professional would not return relatively soon to the original service that was started.
• A continuous service is then broadly defined as the total number of units completed during the provision of that service.
CPT: Applicable Codes

- Total Possible Codes = Approximately 7,500
- Possible Codes for Psychology = Approximately 60
- Sections = Five Primary Separate Sections
  - Psychiatry (e.g., mental health) *undergoing study & possible revision*
  - Biofeedback
  - Central Nervous System Assessment (testing)
  - Physical Medicine & Rehabilitation
  - Health & Behavior Assessment & Management
  - Team Conference
  - Evaluation and Management
Three Types of Codes

• Psychiatric/Mental Health
• Neuropsychological
• Health and Behavior
• Miscellaneous
Psychiatric Codes

- Neuropsychological
- Health and Behavior
Changes in Psychiatric Codes

• Codes described in slides #48-62 are in effect until 12.31.12
• New codes described in slides #62-100 go into effect on 01.01.13
• No grace period for this change
Psychiatry: Interviewing

• Psychiatry Interviewing
  – 90801
  – One time per illness incident or bout
  – Un-timed (est. @ approximately 1.5 hours but assumes a nurse completing a 45’ interview)
  – Comprehensive analysis of records, observations as well as structured and/or unstructured clinical interview
  – Includes mental status, history, presenting complaints, impression, disposition
Psychiatry: Interactive Interviewing

- Interviewing
  - 90802
  - As 90801 but could be used with:
    - Children
    - Difficult to communicate patients
      - Professional may use physical aids and/or interpreter
Psychiatry: Interview Information

• Mental Health History
  – Chief Complaint
  – History of Present Illness

• General History
  – Family
  – Personal
  – Sexual
  – Medical
Interview Information/Materials

- General Appearance
- Attitude Towards Examiner
- Speech and Stream of Talk
- Emotional Reaction and mood
- Perception
- Thought Content
- Cognition
Psychiatric Interviewing (CPT Assistant, March 2010, Volume 20, #3, 6-8)

• Basic Aspects
  – Medical History
  – Psychiatric History
  – Mental Status
    • Appearance
    • Attitude
    • Mental state
    • Overall behavior
  – Disposition
Psychiatric Interviewing (CPT Assistant, March 2010, Volume 20, #3, 6-8)

• Additional Information
  – May include collateral communication
  – May include information in lieu of patient
  – Extend of mental status depends on condition

• Interactive Interviewing
  – May include physical aids
  – Non-verbal aids
  – Language or sign interpreter
Psychiatric: Intervention

• Outpatient Therapy
  – 20 minutes = 90804
  – 45-50 minutes = 90806*
  – 80-90 minutes = 90808

* = most typical service
Psychiatry: Intervention

• Inpatient Intervention
  – 20 minutes = 90816
  – 45-50 minutes = 90818*
  – 80-90 minutes = 90820

* Most typical service
Psychiatry: Interactive Intervention

- 90810-90815
- 90823-90829
- Similar Principles as Interactive Interviewing Apply
“Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contact with the patient related to the resolving of the dynamics of the patient’s problems and, through the definitive therapeutic communication, attempts to alleviate, the emotional disturbance, reverse or change maladaptive patterns of behavior and encourage personality growth and development.”
Psychiatry: Intervention Variables

- Location of Service
- Time Spent (face to face)
- Specific Time are Included Indicating the “Approximate” Time Spent
Psychiatry: Group Psychotherapy

- Family Psychotherapy - 90846-49
- Multiple Family Psychotherapy – 90849 (once per family)
- Non-Family Group Psychotherapy – 90853 (per patient in group)
- Interactive – 90857

(Note: each individual is billed individually and separate notes are formulated)
Additional Related Interventions

• Psychophysiological Therapy Incorporating Biofeedback 90875-76
Psychiatric Therapeutic Procedures

“Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient, and through definitive therapeutic communication, attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development.”
Psychotherapy - Incident to

• Incident to may be feasible assuming the psychologist provides direction and is regularly involved in the care of the patient.
• Medicare Administrative Contractors have placed limitations on who can provide these services but the prior ban appears to have been lifted.
• Should check specific MAC guidelines as well as state licensing guidelines (e.g., Georgia).
Psychotherapy

• Effective 01.01.2013
• Expect Extensive Changes to:
  – Psychiatric Interviewing (diagnosis)
  – Psychotherapy codes (intervention)
  – More granular
  – Sensitive to:
    • Time
    • Intensity
    • Type of service

2/10/2013

psychologycoding.com
New Psychotherapy Codes

- The codes described in slide #65 - #92 go into effect on 01.01.13

No grace period
Psychotherapy: History of Current Codes

- Mandated by CMS Five Year Review
- Developed by:
  - CPT Panel Planning Psychological and Psychiatric Services (Psychotherapy) Workgroup 2010-11; Puente as one of five members
  - CPT Advisor Workgroup Psychological and Psychiatric Services (Psychotherapy) Workgroup; 2011-12; Neil Pliskin and APA Representatives as members; Puente as an observer (consensus based)
    - Included:
      - Nursing
      - Psychiatrists
      - Psychologists
      - Social Workers
  - APA Internal Psychotherapy Workgroup; 2011-2012 (led by Randy Phelps)

(note: some overlap between the planning and actual workgroup)
Difference In CPT Process

- RUC Recommendations and Input Received
- CPT Editorial Panel Planning & Workgroup Created
- Increased Viability and Accountability
- Unbiased (No Practice Affiliations or Outside Interests) CPT Editorial Workgroup Chairs Appointed
- Consensus Process including Workgroup Surveys
- Workgroup Members Representative from all key Medical Specialty and Professional Groups - Inclusive Vs. Exclusive
Representative Societies in Psychotherapy Workgroup

- American Academy of Child and Adolescent Psychiatry
- American Academy of Pediatrics
- American Nurses Association
- American Psychiatric Association
- American Psychiatric Nurses Association
- American Psychological Association
- National Association of Social Workers
  (led by a podiatrist and physician’s assistant)
Psychotherapy: History (cont.)

- **Last Major Revision**
  - 27 New Codes
  - 9 Code Revisions
  - 8 Code Deletions
  
  Total = 44

- **Current Revision**
  - 11 New Codes
  - 4 Code Revisions
  - 27 Code Deletions

  Total = 42
Psychotherapy: CPT Panel Action

- CPT Panel accepted in 02.2012:
  1) establishment of code for pharmacologic management with concurrent deletion of code 90862;
  2) revision of Psychiatry guidelines;
  3) addition of code 90785 for interactive complexity;
  4) deletion of codes 90804-90809, 90810-90815, 90816-90822, 90823-90829, 90857;
  5) addition of codes 90832, 90833, 90834, 90836, 90837, 90838, 90839, and 90840 for psychotherapy; and,
  6) revision of codes 90875, 90876
Brief Summary of Changes in Psychotherapy Codes

• Psychiatric Diagnostic Interviewing Changed

• Most Frequently Used Psychotherapy Codes Changed

• Two Major Changes
  – Time
  – Intensity

*(documentation suggestions in the psychiatric interviewing and psychotherapy codes are in italics)*
Time & Intensity in Psychotherapy

• **Time**
  - 30 Minutes
  - 45 Minutes
  - 60 Minutes
  - TBD- 90 Minutes

• **Intensity**
  - Standard
  - Interactive
  - Crisis
Psychiatric Diagnostic Interviewing Paradigm

<table>
<thead>
<tr>
<th>Intensity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Complexity</td>
</tr>
<tr>
<td>Interactive Complexity</td>
</tr>
</tbody>
</table>
Psychiatric Interviewing I

• Use **90791** to report psychiatric diagnostic evaluation, an integrated biopsychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources, and review and ordering of diagnostic studies.

• Replaces 90801.
Psychiatric Interviewing II

90791

- History and Mental Status
- Review and Order of Diagnostic Studies as needed
- Recommendations (including communication with family or other sources)

90792

- Examination (CMS psychiatric specialty examination)
- Prescription of Medications when appropriate
- Ordering of Laboratory Tests as needed
Psychiatric Interviewing III

• Codes 90791 and 90972 are used for diagnostic assessment(s) or reassessment(s), if required, and do not include psychotherapy services.

• Psychotherapy services (90832 - 90838), including for crisis (90839, 90840), may not be reported on the same day as 90791 or 90792.
Psychiatric Interviewing: IV

- Re-assessments are permitted
- Report more than once when separate interviews are conducted with the patient and informant(s)
- Do not report with psychotherapy (and crisis codes)
# Psychotherapy Paradigm

<table>
<thead>
<tr>
<th>TYPE of PSYCHOTHERAPY</th>
<th>TIME of PSYCHOTHERAPY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief</strong></td>
<td><strong>Regular</strong></td>
</tr>
<tr>
<td><strong>Standard</strong></td>
<td>30’</td>
</tr>
<tr>
<td><strong>Interactive</strong></td>
<td>30’</td>
</tr>
<tr>
<td><strong>Crisis</strong></td>
<td>30-74’</td>
</tr>
</tbody>
</table>

*2/10/2013 80 psychologycoding.com*
Psychotherapy: Defined I

• The new psychotherapy codes will be used in all settings
  – There will no longer be separate inpatient and outpatient codes

• There will no longer be codes for interactive psychotherapy
  – Instead there is a new add-on code for interactive complexity 90785
Psychotherapy: Defined II

- The psychotherapy service codes 90832-90837 include ongoing assessment and adjustment of psychotherapeutic interventions, and may include involvement of family member(s) or others in the treatment process. The patient must be present for all or some of the service.
- For family psychotherapy without the patient present, use code 90846 (this code did not change).
Psychotherapy Codes: Time I

- Codes **90832-90838** describe time-based face-to-face services with the family and/or patient, with times of 30, 45, and 60 minutes.
- The choice of code is based on the one that is closest to the actual time. In the case of the 30 minute codes, the actual time must have at least crossed the midpoint (16 minutes).
- Psychotherapy is never less than 16 minutes.
Psychotherapy: Time II

- **90832** or **90833-e/m** (30 minutes) for actual psychotherapy time of 16-37 minutes
- **90834** or **90836-e/m** (45 minutes) for actual time of 38-52 minutes
- **90837** or **90838-e/m** (60 minutes) for actual time of 53 minutes or more.
Psychotherapy - Time II

- 30 minutes = 16-37 mins.
- 45 minutes = 38-52 mins.
- 60 minutes = 53 + mins.
- 90 minutes =
  - to be determined for code and time
  - For now, use 60 minute code plus 22 modifier
  - Note that one carrier has accepted prolonged E & M service
Psychotherapy: III

- Site of Service is No Longer Recorded
- May Include Face-to-Face Time with Family Members as Long as Patient is Present for Part of the Session
- Intra-service Time includes:
  - Objective Information
  - Interval History
  - Examination of Symptoms, Feelings, Thoughts and Behaviors
  - Mental Status Changes
  - Current Stressors
  - Coping Style
  - Application of a Range of Psychotherapies
Psychotherapy: IV

• Use 90837 in Conjunction with the Appropriate Prolonged Service Code (99354-99357) for face-to-face Psychotherapy Services with the Patient of 90 minutes or longer)

(tip = current prolonged services codes are E & M and thus not typically reimbursable for non-physicians)
Interactive complexity, reported with add-on code **90785**, refers to specific communication factors that complicate the delivery of certain psychiatric procedures (**90791, 90792, 90832 - 90838, 90853**).

(tip= significant complicating factor)
Psychotherapy: Interactive Complexity II

• To report **90785** at least one of the following factors must be present:
  – Maladaptive communication that interfere with the ability to assist in the treatment plan (e.g., high anxiety)
  – The need to manage maladaptive communication among participants that complicates delivery of care (e.g., translator, interpreter, play equipment, device)
  – Evidence or disclosure of a sentinel event and mandated 3rd party report with discussion of event/report with patient, other participants (e.g., abuse/neglect)
  – The use of play equipment, devices, interpreters and/or translators to assist with inadequate communication abilities on part of the patient

(tip = time is determined by original base code)
Psychotherapy: Crisis (I)

- Psychotherapy provided to a patient in a crisis state is reported using codes 90839 and 90840.
- Codes 90839 and 90840 may not be reported in addition to a psychotherapy code (90832 – 90838) nor with psychiatric diagnostic, interactive complexity or any other code in the psychiatry section.
Psychotherapy: Crisis (II)

- The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, with implementation of psychotherapeutic interventions to minimize the potential for psychological trauma.
- The service may be reported even if the time spent on that date is not continuous.
- However, for the time reported providing psychotherapy for crisis, the physician or other qualified health care professional must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during that time period.
- The patient must be present for all or some of the service.
- Time does not have continuous within a date of service.
Psychotherapy: Crisis (III)

- Codes **90839** and **90840** are used to report the total duration of time spent face-to-face with the patient and/or family by the physician or other qualified healthcare professional providing psychotherapy related to crisis.
- The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.
- Psychotherapy for crisis involves an urgent assessment involving:
  - *a history of a crisis state,*
  - *mental status examination,*
  - *and disposition.*
Psychotherapy: Crisis (IV)

- Codes 90839 and 90840 are time-based codes.
- Code 90839 is reported only once for the first 30-74 minutes of psychotherapy for crisis on a given date, even if the time spent by the physician or other health care professional is not continuous.
- Add-on code 90840 is used to report additional block(s) of time of up to 30 minutes each beyond the first 74 minutes reported by 90839 (i.e., total of 75-104 minutes, 105-134 minutes, etc.).
- Crisis coding (90839) must be at least 30 minutes in duration. Otherwise code standard psychotherapy.
Psychotherapy: Family I

• The codes for family psychotherapy (90846, 90847 and 90849) are not changing in 2013.

• The focus of family psychotherapy is the family or subsystems within the family, e.g., the parental couple or the children, although the service is always provided for the benefit of the patient.
Psychotherapy: Family II

- Use code 90846 to report a service when the patient is not physically present.

- Use code 90847 to report a service that includes the patient some or all of the time. Couples therapy is reported with code 90847.

- Use code 90849 to report multiple-family group psychotherapy.
Psychotherapy: Family III

- Unchanged from 2012
- 90846- when patient is not present
- 90847- when patient is present (partial or otherwise)
- 90849- Multiple Family group
- 90853- Group Psychotherapy
Psychotherapy: Group I

• Code 90785, in conjunction with code 90853, is used to report group psychotherapy for a service that includes interactive complexity (e.g., use of play equipment or other physical aids necessary for therapeutic interaction).

• Interactive complexity services may be for all or just one or more patients in the group, and is only reported for the specific patient(s).
Psychotherapy: Group II

• Use code 90853 to report group psychotherapy. The interactive complexity add-on code 90785, in conjunction with code 90853, is used to report group psychotherapy for a service that includes interactive complexity (e.g., use of play equipment or other physical aids necessary for therapeutic interaction). In a particular group, interactive complexity services may be for all or just one or more specific patients, and is only reported for the appropriate patient(s).

• For multi family group psychotherapy, use code 90849 – see above.
Psychotherapy:
Psychopharmacologic Management I

• Code 90863 add on captures pharmacologic management, including prescription and review of medication, when performed with a psychotherapy service (physicians do not report this code)

• Based on the length of the psychotherapy session, report code 90832, 90834, or 90837 along with the 90863 add-on code
Psychotherapy:
Psychopharmacologic Management II

• For pharmacologic management with psychotherapy services performed by a physician or other qualified health care professional who may report Evaluation and Management codes, use the appropriate E/M codes (99201-99255, 99281-99285, 99304-99337, 99341-99350) with a psychotherapy add-on code (90833, 90836, 90838).
Psychotherapy: Non-Patient

- CPT codes describe time spent with the patient and/or family member (significant other).
- Medicare only pays for services provided to diagnose or treat a Medicare beneficiary.
- Obtaining information from relatives or significant others is appropriate in some circumstances, but *should not substitute for direct treatment of the beneficiary*.

(See Chapter 1, section 70.1 of the *Medicare National Coverage Determinations Manual*, Pub. 100-03 for discussion on caregivers; K. Bryant, CMS, undated)
<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>RVU</th>
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<tr>
<td>90785</td>
<td>Interactive Complexity</td>
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<tr>
<td>90791</td>
<td>Psychiatric Diagnostic Int.</td>
<td>2.80</td>
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<td>90832</td>
<td>Psychotherapy; 30 minutes</td>
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<tr>
<td>90834</td>
<td>Psychotherapy; 45 minutes</td>
<td>1.60</td>
</tr>
<tr>
<td>90838</td>
<td>Psychotherapy; 60 minutes</td>
<td>2.56</td>
</tr>
<tr>
<td>90839</td>
<td>Crisis Psy Rx; first 60 mins.</td>
<td>Carrier Priced (for now)</td>
</tr>
<tr>
<td>90840</td>
<td>Crisis Psy Rx: each 30 mins.</td>
<td>Carrier Priced (for now)</td>
</tr>
<tr>
<td>90863</td>
<td>Pharmacologic Mngmt.</td>
<td>CMS based (tbd)</td>
</tr>
</tbody>
</table>
Psychotherapy: Payment I

• page 69090 of the CY 2013 Medicare Physician Fee Schedule Final Rule with Comment Period (77 Fed. Reg. 68892 (Nov. 16, 2012)).
Psychotherapy: Payment II

- CMS will not change the fees for the short term
- CMS will use a cross-walk for payment, 45 mins. = 45 mins.
- Unclear when they will use the RUC values (probably late 2013)
- Rough estimate – sometime in 2013
Psychotherapy: Payment IV
(from K. Bryant, AMA CPT Symposium, 11.2012)

- CMS needed to establish CY 2013 values for these new codes.
- Received recommendations on some of these new codes, but not all.
- General approach to valuing the new CPT codes 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.
- Assigned interim status pending a final review of the values for the entire family of CPT codes.
Psychotherapy: Payment III

• Individual Therapy
  – Estimated 1-5% reduction

• Group/Family
  – 10-20+ % reduction
Psychotherapy: Summary

- Interview 90791/90792
- Psychotherapy 90832-90838
- Crisis Therapy 90839-90840
- Interactive Complexity 90785
- Psychopharmac Management
New Interventions

Crisis Therapy
90839-90840

Psychopharm Management
<table>
<thead>
<tr>
<th>Service</th>
<th>Interactive Complexity</th>
<th>Psychiatric Diagnostic Evaluation</th>
<th>Psychotherapy</th>
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<tbody>
<tr>
<td>Codes</td>
<td>90785</td>
<td>90791, 90792</td>
<td>90832, 90834, 90837</td>
</tr>
<tr>
<td>Explanation</td>
<td>Add-on code in conjunction with select psychiatric service</td>
<td>With or without medical services; in certain circumstances one or more other informants may be seen in lieu of the patient; codes 9080D1, 9080D2 may be reported more than once for the patient when separate diagnostic evaluations are conducted with the patient and other informants; codes 9080D1, 9080D2 may be reported once per day</td>
<td>The choice of code is based on the one that is closest to the actual psychotherapy time face-to-face with patient and/or family member</td>
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<tr>
<td>Reportable on same day</td>
<td>Primary procedure: 90791, 90792, 90832-90838, or 90853</td>
<td>90785</td>
<td>90785, 90863, prolonged services (99354-99357)</td>
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<tr>
<td>NOT reportable on same day</td>
<td>90791, 90792; E/M when no psychotherapy code reported</td>
<td>E/M, 90832 90834, 90837, 90839, 90840</td>
<td>90839, 90840</td>
</tr>
<tr>
<td>Service</td>
<td>Psychotherapy for Crisis</td>
<td>Family Psychotherapy</td>
<td>Group Psychotherapy</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------</td>
<td>----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Codes</td>
<td>90839, 90840</td>
<td>90846, 90847</td>
<td>90853</td>
</tr>
<tr>
<td>Explanation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>With or without patient present</td>
<td>Does not include a multiple-family group</td>
</tr>
<tr>
<td>Reportable same day</td>
<td></td>
<td></td>
<td>90785</td>
</tr>
<tr>
<td>NOT reportable on same day</td>
<td>90832, 90834, 90837, 90785, 90791, 90792</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2/10/2013 psychologycoding.com
Emerging Issues with New Psychotherapy Codes

• 60 Minutes
  – Pre-authorization required by some companies

• 90 Minutes
  – In E & M section, hence CMS is not covering
  – Other carriers may
Neuropsychological (and psychological testing)

- Psychiatric

- Health and Behavior
CNS Assessment Codes: Rationale for Changes of Testing Codes

- Avoidance of Continuation of Reimbursement Heavily Based on Practice Expense
- Greater Clarification of Activities Including Interviewing and Testing by Professional, Technician and/or Computer
- Recognition of Cognitive Work
- Great Clarity of What Actual is Happening
- Differentiation of Professional, Technical and (non-assisted) Computer Testing
- Most Importantly, a Mandate from CMS
- Testing Codes Available for Use by Physicians and Psychologists Only (includes neuropsychologists)
CPT: CNS Assessment
AMA CPT Assistant, 03.06; AMA CPT Assistant, 11.06, 12.06

- Psychological Testing (e.g., 5 units)
  - Three New Codes
  - New Numbers & Descriptors

- Neurobehavioral Status Exam (e.g., 2 units)
  - New Number & Revised Descriptor

- Neuropsychological Testing (e.g., 10 units)
  - Three New Codes
  - New Numbers & Descriptors
Testing Information

• Federal Register, November 21, 2005 at 70FR 70279 and 70280 under Table 29 and CPT HCPAC Recommendations and CMS Decisions for New and Revised 2006 CPT Codes

• MLN Matters Number: MM5204
Reporting Testing Codes

• A minimum of 31 minutes must be provided to report any per hour code. Services 96101, 96105, 96116, 96118 and 96125 report time as face-to-face time with the patient and the time spent interpreting and preparing the report.

(CPT Changes: An insider’s view, 2011)
Psychological Testing: By Professional (01.01.06)

- **96101** – Psychological Testing
  - Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS) per hour of *psychologist’s or physician’s* time, both face-to-face time with the patient and time interpreting test results and preparing the report.

(estimated total per year Medicare claims = 175,000)
Psychological Testing: By Professional
(Revised 02.09.07; Implemented 01.01.08)
(revisions in italic and underlined)

- **96101** – Psychological Testing
  - Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI, Rorschach, WAIS) per hour of psychologist’s or physician’s time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report

(96101 is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously completed and reported technician- and computer-administered tests.)

(Do not report 96101 for the interpretation and report of 96102, 96103.)
96101 Explained
(AMA CPT Assistant, November, 2006)

• “Code 96101 is reported for the psychological test administration by the physician or psychologist with subsequent interpretation and report by the physician or psychologist. It also is reported for the integration of information obtained from other sources which is incorporated into the interoperation and reports of test administered by a technician and/or computer. This provides the meaning of the test results in the context of all the testing and assessments. The potentially confusing aspect of this code is that when the physician or psychologist performs the tests personally, the test specific scoring and interpretation is counted as part of the time of 96101.
Psychological Testing: By Technician (01.01.06)

- **96102**- Psychological Testing
  - Psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology (e.g., MMPI, Rorschach, WAIS) with qualified health care professional **interpretation and report**, administered by **technician**, per hour of technician time, face-to-face
The qualified health professional has previously met with the patient and conducted a diagnostic interview. The test instruments to be used by the technician under the supervision of the professional have been selected. The qualified health care professional introduced the patient to the technician who conducts the remainder of the assessment. The qualified health professional meets again with the patient in order to answer any last questions about the procedures and to inform him or her about the timetable for the results.”
Psychological Testing: By Computer (01.01.06)

- **96103** - Psychological Testing
  - Psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, (e.g., MMPI) administered by a computer, with qualified health professional interpretation and the report
96103 Explained

(AMA CPT Assistant, November, 2006)

• “The qualified health professional has previously met with the patient and conducted and interview. On the basis of the information gathered from the interview, the professional has selected test instruments that maybe administered by a computer. The qualified health professional installs the computer program/test and instruct the patient on the use of the test. The qualified health professional checks the patient frequently to ensure that he or she is completing the tests correctly. The professional install the next instrument and continuous as before until all tests are completed. The qualified health professional meets again with eh patient in order to answer any last question about the procedures and to inform him or her and about timetable for results.”
Neurobehavioral Status Exam
(01.01.06; Revised 02.09.07; Implemented 01.01.08)

• **96116 - Neurobehavioral status exam**
  – Clinical assessment of thinking, reasoning and judgment (e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual-spatial abilities) per hour of [psychologist’s or physician’s] time, both face-to-face time with the patient and time interpreting test results and preparing the report
96116 Explained

(AMA CPT Assistant, November, 2006)

• “A neurobehavioral status exam is completed prior to the administration of neuropsychological testing. The status exam involves clinical assessment of the patient, collateral interviews (as appropriate and review of prior records. The interview would involved clinical assessment of several domains including but limited to; thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities. The clinical assessment would determine the types of tests and how those tests should be administered.”
Neuropsychological Testing-By Professional (01.01.06)

- **96118** - Neuropsychological testing
  - (e.g., Halstead-Reitan Neuropsychological, WMS, Wisconsin Card Sorting) per hour of the **psychologist’s or physician’s** time, both face-to-face time with the patient and time interpreting test results and preparing the report
  
  (estimated total Medicare claims/year = 500,000)
Neuropsychological Testing: By Professional

(Revised 02.09.07; Implemented 01.01.08)
(revisions in italic and underlined)

- **96118** – Neuropsychological Testing
  - (e.g., Halstead-Reitan Neuropsychological, WMS, Wisconsin Card Sorting) **per hour of psychologist’s or physician’s time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

*(96118 is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously completed and reported technician- and computer-administered tests.)*

*(Do not report 96118 for the interpretation and report of 96119 or 96120.)*
96118 Explained

(AMA CPT Assistant, November, 2006)

• Code 96118 is reported for the neuropsychological test administration by the physician or psychologist with subsequent interpretation and report by the physician, or psychologist. It is also reported for the integration of information obtained from other sources which is then incorporated in the more comprehensive interpretation of the meaning the tests results in the context of all testing and assessments. The administration of the tests is completed for the purposes of a physical health diagnosis.”
96118 Applications

• Administration of Neuropsychological Tests
• Scoring of Neuropsychological Tests
• Integration of Those Tests and Other Information Including but not Limited to:
  – Interview (direct and collateral)
  – Behavior
  – History
• Feedback to the Patient and Integration of Those Findings in the Final Report

(not to be used as a treatment based code)
Neuropsychological Testing:  
By Technician (01.01.06)

- **96119** - Neuropsychological testing  
  -(e.g., Halstead-Reitan Neuropsychological, WMS, Wisconsin Card Sorting) with qualified health care professional *interpretation and report*, administered by a **technician** per hour of technician time, face-to-face
96119 Explained

(AMA CPT Assistant, November, 2006)

• “The qualified health professional has previously gathered information from the patient about the nature of the complaint and the history of the presenting problems. Based on the clinical history, a final selection of tests to be administered is made. The procedures are explained to the patient, and the patient is introduced to the technicians, which administers the tests. During testing, the qualified health professional frequently checks with the technician to monitor the patient’s performance and make any necessary modifications to the test battery or assessment plan. When all tests have been administered, the qualified health professional meets with the patient again to answer any questions.”
Neuropsychological Testing By Computer (01.01.06)

- 96120 - Neuropsychological testing
  - (e.g., WCST) administered by a computer with qualified health care professional interpretation and the report
96120 Explained

(AMA CPT Assistant, November, 2006)

• “Code 96120 is reported for the computer-administrated neuropsychological testing, with subsequent interpretation and report of the specific tests by the physician, psychologist, or other qualified health care professional. This should be reserved for situations where the computerized testing is unassisted by a provider or technician other than the installation of programs/test and checking to be sure that the patient is able to complete the tests. If greater levels of interaction are required, though the test may be computerized administer, then the appropriate physician/psychologist (96118) or technician code (96119) should be used.”
Computerized Testing

- Not time based
- Used once per “testing session”
- To be used for one to multiple tests only once per “testing session”
- CPT Assistant, October 2011, Vol. 21, #10, pg. 10).
Coding Tip

(AMA CPT Assistant, November, 2006)

• “If the service is provided is less than one hour, append Modifier 52, Reduced Services. After one hour has been completed, time is rounded.”

• “It is not unusual that the assessments may include testing by a technician and a computer with interpretation and report by the physician, psychologist or qualified health professional. Therefore, it is appropriate in such cases to report all 3 codes in the family of 96101-96103 or 96118-96120.”
Coding Tip

(AMA CPT Assistant, November, 2006)

• “All of the testing and assessment services also require interpretation in the context of other clinical assessments performed by a qualified professional as well as prior records. The use of the term “interpretation” in the codes is this integrative process. It is not the scoring or interpretation of the result of a specified tests or tests. The scoring process and more limited interpretation is part of the test administration services whether by physician/psychologist, technician and/or computer.”
“Typically, the psychological testing services, 96101-96103-, the neurobehavioral status exam, 96116, and the neuropsychological testing services, 96118-96120, are administered once per illness condition or when a significant change in behavior and/or medical/health condition necessitates re-evaluation.”
Additional Supporting Information

- CMS Manual
- Pub 100-02 Medicare Benefit Policy
- Change Request 5204
- Transmittal 85
- February 25, 2008

- (reference Transmittal 55; Change Request 5204; September 29, 2006)
## Code Frequency Use

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<th>Code</th>
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<td>90801</td>
<td>1,349,524</td>
<td>1,334,007</td>
<td>1,351,838</td>
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<td>96101</td>
<td>176,045</td>
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<td>96119</td>
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# Code Information

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<td>CP</td>
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<td>64%</td>
<td>CP</td>
<td>PPD/Dement.</td>
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</table>
Tests Performed by Technicians & Computers

• Effective January 1, 2006, CPT Codes for psychological and neuropsychological tests performed by technicians and computers (CPT codes 96102, 96103, 96119 and 96120) in addition to tests performed by physicians, clinical psychologists, independently qualified practicing psychologists and other qualified non-physician practitioners.
Simultaneous Use of Professional and Technical Codes

• Currently Allowed by Medicare
  – MLN Matters: MM5204 Revised, Effective December 28, 2006
  – Most conservative; modifier 59 and one test by professional
Psychological & Neuropsychological Testing Codes: Use of Professional and Technical/Computer Codes

- Local Carrier Policy Trumps National Policy
- Possibilities Include
  - No simultaneous use of prof. & technical codes
  - No problem in using both prof. & technical codes
  - Alternatives (e.g., modifier 59)
- The Use of Modifier 59
  - When professional codes and technical/computer codes are used simultaneously
  - The modifier is used with the non-professional code
Simultaneous Use of Testing Codes

1. When the provider administers at least one of the tests, then pre-existing problems with the simultaneous use of two testing codes do not apply (Niles Rosen, M.D., NCCI, Personal Communication, November, 2009)

2. When the professional and the technical services are not provided on the same date.
Simultaneous Codes: NCCI
(AMA Code Manager, 2009; Section M)

• “Two or more codes may be reported on the same date of service if and only if the different testing techniques are utilized for different neuropsychological tests”
Possible Origin to Problems with Simultaneous Use of Testing Codes

- [www.gao/newitems/d09647.pdf](http://www.gao/newitems/d09647.pdf)
- When service are provided together, empirical evidence suggests increased efficiency but increased costs
- 95% reduction to 75% suggests increased savings to Medicare but not objective utilization
- 600 Services have been identified as high volume growth and/or performed together
Potential Problems with Simultaneous Use of Test Codes

• Some insurance companies may be excluding the use of professional and technical codes simultaneously
• Ingenix, McKesson's other computerized edit systems, may be disallowing simultaneous test codes
• Compliance officers at large institutions
Modifier 59 & Testing Codes

• Modifier is not applicable if the professional provides the service.
• If the technician provides the service, it is advisable (pending MAC guidelines) to use the 59 modifier.
• The modifier should be applied to any of the testing codes though probably best to attach to technician and/or computer codes (CMS, September, 2006)
Official Q & As from CMS Regarding Testing Codes


- Probably will not be further revised and additional concerns will be handled at the local carrier level
Information of The Use of Two Testing Codes: I

1. Our neuropsychologists state that they integrate separate reports of tests performed by the technician into a comprehensive report. Can you please clarify for them if they can bill for that time and if so how to bill? (Emory/Epilepsy Foundation Question)

CMS Response: We have a set of seven questions and answers on psychological and neuropsychological tests on the CMS website at http://www.cms.gov/PhysicianFeeSchedule/40_Psych_and_Neuropysch_Tests.asp. Specifically, the question that is pertinent in this case is one that asks, “Can more than one CPT code for psychological or neuropsychological testing be billed on the same date of service for the same patient?”
Two Testing Codes: II

• Our answer ID #9180 is yes. If several different, clinically appropriate tests are administered on the same date to the same patient (whether by a physician/psychologist, technician or by computer), then the appropriate testing codes for psychological testing or neuropsychological testing can be billed together. More than one code can also be billed when several distinct tests are administered to the same patient on the same date of service via technician (96102/96119) or computer (96103/96120), and the physician/psychologist needs to integrate the separate interpretations and written reports for each of these tests into a comprehensive report.
Additionally, the American Medical Association (AMA) provides further guidance for billing CPT codes in the code descriptors. Accordingly, the descriptors for CPT codes 96101 and 96118 and, the parentheticals that follow these codes provide further instruction as to how to use these codes when additional time is necessary for the physician/psychologist to integrate separate interpretations into a comprehensive report.
Two Testing Codes: IV

1. Neuropsychologist integrates separate reports of test performed by the technician into a comprehensive report. Can they bill for that time and if so, how do they bill?

CMS Response: Yes, CPT code 96101 and 96118 can be billed for the integration of separate reports of tests administered by the technician. But, the CPT code descriptor advises that the interpretation of these reports/results should have already been completed and the time used by the psychologist/physician to interpret the tests administered by the technician may not also be billed under CPT codes 96101 and 96118. Specifically, the parentheticals under CPT codes 96101 and 96118 provide AMA guidance that these codes can be used in those circumstances where additional time is necessary to integrate other sources of clinical data, including previously reported technician- and computer-administered tests.
When the technician administers test and bills the amount of time it took to do so with 96119, may the time spent by physician/psychologist interpreting and writing the report on those technician-administered tests be added to the time billed as technician time?

CMS Response: No. The time spent for interpreting and writing the report cannot be added and billed as technician time. The AMA guidance under the descriptors for CPT codes 96102 and 96119 both state that the technician-administered testing includes the qualified health care professional’s interpretation and report.
Take Away Message on the Use of Two or More Testing Codes

• Bill for techs what techs do, period.
• Bill for professionals what professionals do, period (this includes “integrate separate interpretations into a comprehensive report”)
• You CAN bill for both sets of codes together.
Documentation for Two or More Testing Codes

• 11.01.11
• To: Schafer, Jyme H. (CMS/OCSQ); Syrek Jensen, Tamara S. (CMS/OCSQ); Daily, Karen A. (CMS/OCSQ); Pedulla, Diane
• Cc: Ritter, Christina S. (CMS/CMM); Hambrick, Edith L. (CMS/CMM)
• From: Regina Walker Wren
  Health Insurance Specialist
  CMS
Problems Left With Use of Two or More Testing Codes

- CPT Code Audit Systems (McKessons)
- Insurance Carriers, such as WPS and Trailblazers, are in agreement
Simultaneous Use of 90801 and 96116

• Under No Circumstances are the Psychiatric (90801) and Neurobehavioral Status Examination (96116) are to be Used Simultaneously
CNS Assessment Examples

• Neurobehavioral Status with Neuropsychological Testing
  – Interview by the Professional
  – Testing by
    • Professional, and/or
    • Technician, and/or
    • Computer.
  – Interpretation & Report Writing by Professional
  – A Technician or Computer Code are “Typically” Billed Together with a Professional Code Assuming that Different Services are Being Provided (since the final product should be a comprehensive/integrative report)
Neuropsychological Testing & CORF

- Neuropsychological testing is not part of the benefit under CORF and therefore it is not covered.

(Page 66299, Federal Register, Vol. 72, No. 227, November 27, 2007)
Other Testing Codes: Developmental Screening

• Developmental Screening (used to be testing) Codes
  – Applicability
    • Children
  – Background
    • Part of Central Nervous System family of codes
    • Hence, no work value (& lower reimbursement rate)
    • Recently “re-surveyed” by pediatricians
  – Specific Changes
    • 96110
      – Continues to have no work value
      – Use for completion of forms (Connors; by parents)
    • 96111
      – Has physician work value
      – Assessment of child’s social, emotional, etc. status (WJ)
Relatively New Code: fMRI

- **96020- Functional Brain Mapping**
  - Neurofunctional test selection and administration during non-invasive imaging functional brain mapping with test administered entirely by a physician or psychologist with review of test results and report

- (vs. diagnostic radiology imaging)
Functional Brain Mapping

• 96020 and 70555 were established to report neurofunctional brain mapping of blood changes in the brain by MRI in response to tests administered by physicians and psychologists correlating to specific brain functions (e.g., motor skills, vision, language and memory).
Functional Brain Mapping

• Functional brain mapping should be used with patients with:
  – Brain neoplasms
  – Arteriovenous malformations
  – Intractable epilepsy
  – Other brain lesions that may require invasive or focal treatment
Functional Brain Mapping

• 96020 is used to report neurofunctional test selection and administration during noninvasive imaging Functional Brain Mapping, with test administration entirely by a physician or psychologist, with review of test results and report.

• Measurement of:
  – Language
  – Memory
  – Cognition
  – Movement Sensation
  – Other neurological functions
New Cognitive Testing Code for Use by OT, ST and Others

- **96125** – Standardized Cognitive Performance Testing
  - (e.g., Ross Information Processing Assessment).
  - (For psychological and neuropsychological testing by a physician or psychologist, see 96101-96103-96118-96120)
New Code for Missed Appointments

(CMS Manual System; Pub 100-04 Claims Processing, Transmittal 1279, June 29, 2007)

- Allows charging for missed appointments
- Missed appointment policy must be applied equally and be explained to patient
- Applies to outpatients and, in most cases, hospital outpatient services
- Medicare does not make any payments for missed appointment
- Fees /Charges are directed to the patient.
Telehealth Services


• Effective 01.01.08, 96116 is available as a TeleMedicine/Telehealth Code; note 22 states have laws regulating telehealth; may require separate licensing and/or credentialing

• Remote patient face-to-face services seen via live video conferencing

• To be used in rural areas or where there are a shortage of providers

• Non face-to-face services that can be conducted either through live vide conferencing or via “store and forward” telecommunication services

• Home telehealth services

• Must be submitted with modifier “GT” (telehealth modifier)

(see APA Good Practice, Summer, 2010)
Telehealth “Medicine”
(from American Telemedicine Association)

- Foundation
  - Remote patient face-to-face via live video conferencing
  - Non face-to-face via live video conferencing or related services
  - Home telehealth services
Telehealth (continued)

- **Location**
  - Office, hospital, clinic, …

- **Services**
  - See related slides

- **Fee**
  - May be eligible for facility fee

- **Providers**
  - Clinical psychologists included
Telehealth Requirements
(www.cms.hhs.gov/telephealth)

- Must Use both Audio and Video at both Sites
- Must Have a Site that Has Professional Shortage or outside of Metropolitan Area
- Could Originate from Practitioner's Office, Hospital, Clinic, etc.
- Assumption is that it is the same service as if it was “face-to-face”
Telehealth Services

- Individual Psychotherapy
- Psychiatric Diagnostic Interviewing
- All Health and Behavior Codes
- Neurobehavioral Status Exam
- Presently discussing Testing Services
CPT: Cognitive Rehabilitation

• Application Rationale
  – Allied Health & Physical Medicine Code

• Acceptability
  – GN – Speech Therapists
  – GO – Occupational Therapists
  – GP – Physical Therapists
  – AH – Mental Health (not applicable)
Health and Behavior

• Psychiatric

• Neuropsychological
• Purpose: Medical Diagnosis
• Time: 15 Minute Increments
• Assessment
• Intervention
H & B: Rationale

- Acute or Chronic Health Illness
- Not Applicable to Psychiatric Illness
- However, Both Could be Treated Simultaneously But Not Within the Same Session
Health & Behavior: Assessment

- **96150**
  - Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires)
  - each unit = 15 minutes
  - face-to-face with the patient
  - initial assessment

- **96151**
  - re-assessment
  - each unit = 15 minutes
  - Face-to-face with the patient
H & B: Assessment Explanation

- Identification of Psychological, Behavioral, Emotional, Cognitive and/or Social Factors
- In the Prevention, Treatment and/or Management of Physical Health Problems
- Focus on Biopsychosocial and not Mental Health Factors
H & B: Assessment Examples

- Health-Focused Clinical Interview
- Behavioral Observations
- Psychophysiological Monitoring
- Health-Oriented Questionnaires
Health & Behavior: Intervention

- **96152**
  - Health and behavior intervention
  - each 15 minutes
  - face-to-face
  - individual

- **96153**
  - group (2 or more patients) (usually 6-10 members)

- **96154**
  - family (with the patient present)

- **96155**
  - family (without the patient present; not being reimbursed)
H & B: Intervention Explanation

• Modification of Psychological, Behavioral, Emotional, Cognitive and/or Social Factors
• Affecting Physiological Functioning, Disease Status, Health and/or Well-Being
• Focus = Improvement of Health with Cognitive, Behavioral, Social and/or Psychophysiological Procedures
H & B: Intervention Examples

- Cognitive
- Behavioral
- Social
- Psychophysiological
• 96152 is the only psychological code for both assessment and intervention (expect np testing) under which CORF psychological services can be billed.
• Such services may be provided by a non-doctoral service provider.
• Testing codes are not part of CORF.

(page 66299; Federal Register, Vol. 72, No. 227, November 27, 2007)
H & B: # of Hours

• Initial Assessment = 4 – 8(?) units
• Re-assessment = 4 - 6 units
• Group = 8 units
• Intervention = 24 to 48 units/day
H & B Limitations with Other Codes

- If a patient requires a psychiatric service (e.g., 90801) and a health & behavior service, the predominant service should be reported.
- In no case, should both sets of services be reported on the same day.
- Patient “has not been diagnosed with mental illness” (interpretation: not current)
- If service is not completed in one day, then the date of service coded should be the one in which the service was finalized.
Team Conference Codes

• Medical Team Conference with Interdisciplinary Team by Non-Physician
• Allows for Billing Professional Work in Interdisciplinary Team Activities Including Diagnostic and Rehabilitative Services
• No Time Allocated but “Team conferences of less than 30 minutes are not reported separately”
• Effective 01.01.08
Team Conference Codes (cont.)

• Codes
  – 99366 (direct contact)/ only one available for non-physician use
  – 99368 (without direct contact)

• Number of Participants Required
  – Minimum of 3 from different specialties
  – Must have performed an evaluation within 60 days
  – Patient/Family/Legal Guardian/Caregiver

• Typical Services Provided
  – Presentation of findings
  – Recommendations for treatment
  – Formulation of integrated care
  – Comprehensive and complex (Vs. standard interactions)
Team Conference Codes (cont.)

• Coding Rules
  – Documentation of their participation & information contributed
  – No more than one individual per specialty may report these codes
  – Professionals should not report these codes when they are contractually obligated by the facility where the team conference is provided
  – Conference starts when the team reviews the individual patient and ends at the conclusion of the team’s review
  – Time is not used for record keeping and report generation is not used
  – Reporting participant shall be presented for all time reported
  – Time is broadly defined as all time used for diagnostic and treatment discussion
CPT: Alternative Codes (probably not reimbursable)

- Evaluation and management codes
  - 99050 – Office, outside regular office hrs.
  - 99051 – Service provided during regular hrs. but Evenings, weekend or holidays
  - 99052 - Service provided btw. 10pm-8am
  - 99054 – Service provided on Sun/holidays
  - 0074T – Online service
  - 90825 – Review of records
  - 99148-99150 - Addition of a second provider
  - 99075 – Testimony
  - 99080 - Completion of forms
  - 99078 - Educational services rendered to patients in group setting
G & Related Codes: Health Behavior Screening

(psychologists are urged to use H & B codes)

• Tobacco Cessation
  – 99406 - 3-10 minutes
  – 99407 - greater than 10 minutes

• G0137
  – Training and educational services related to the care and treatment of patient’s disabling mental health problem, per session (45 or more minutes)

• G0396 (99408)
  – Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, DAST) and brief intervention, 15-30 minutes

• G0397 (99409)
  – Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, DAST) and brief intervention, greater than 30 minutes

  – (NOTE: H & B codes should not be reported on the same day of service as these codes)
Telephone Consultation

(AMA CPT Assistant, Vol. 18, #3, pages 6-7, 2008)

Conditions

- Initiated by an established patient, family member, guardian, etc.
- Not included if an emergency visit occurs within 24 hours or next available
- No service provided for prior 7 days

- Codes
  - 5-10 minutes - 99441
  - 11-20 minutes – 99442
  - 21-30 minutes - 99443
Telephone Code

- **98966**  *Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of discussion*
Telephone Codes

• Revision of codes
• Inclusion of online service
New Codes: Preventative Health (Healthier Life Steps)\textsuperscript{tm} \\
\textit{(CPT Assistant, Vol. 19, #2, 2009)}

- Preventative Medicine (group or individual counseling): 99401-404, 99411-12
- Behavior Change Interventions (individual): 99406-09 (tobacco & alcohol)
Modifier 33 and Prevention

(CPT Assistant, December 2010, pgs. 3-6, 19)

- Can Use Modifier 33 for:
  - Depression Screening - adolescents or adults
  - Health diet Counseling
  - Obesity counseling
  - Tobacco Cessation counseling
  - STI (sexually transmitted infection) counseling
  - No co-pay in some preventive care and screenings - Bright Futures (children/women)
Modifier 33 Examples for Preventative Care

(CPT Assistant, 12.10, 20, #12)

- Alcohol Misuse Counseling (04.04)
- Depression Screening: Adolescents (03.09)
- Depression Screening: Adults (12.09)
- Health Diet Counseling (01.03)
- Obesity Screening/Counseling: Adults 12.03)
- Obesity Screening/Counseling: Children (01.10)
- STI Counseling (10.08)
- Tobacco Counseling/Prevention: Non-pregnant Adults (04.09)
- Tobacco Counseling/Prevention: Pregnant Women (04.09)
Evaluation & Management

- Created in 1982
- Non-specialty
- Non-diagnostic
- Cognitive Work
- Problem Focus
- Based on Hr. Rate

- Documentation Driven
- Clinical Decision Making Point System
- Typical Patient
- Clinically Useful
Evaluation & Management

• Rationale
  – Follow-up

• Levels
  – History
  – Examination
  – Medial decision making
E & M: Exam- New Patient

- 99201 Problem Focused (10 mins)
- 99202 Expanded Problem Focused (20 mins)
- 99203 Detailed, Low Complex (30 mins)
- 99204 Comprehensive, Moderate Complex (45 mins)
- 99205 Comprehensive, High Complex (60 mins)
E & M: Exam- Established Patient

- 99024  Post-Op/Follow-up (5 mins)
- 99211  Office/Outpatient (10 mins)
- 99212  Office/Outpatient (15 mins)
- 99213  Expanded, Problem Focused (15 mins)
- 99214  Expanded, Moderate Complex (25 mins)
- 99215  Comprehensive, High Complex (40 mins)
E & M: Office Consults

- 99241 Problem Focused (15 mins)
- 99242 Expanded, Problem Focused (30 mins)
- 99243 Detailed, Low Complex (40 mins)
- 99244 Comprehensive, Moderate Complex (60 mins)
- 99245 Comprehensive, High Complex (80 mins)
CPT: Model System

• General Areas
  – Psychiatric
  – Neurological
  – Health

• Specific Approaches
  – Individual (standard) Vs. Team (emerging)
  – Face-to-Face Vs. Telehealth
## A Coding Model

<table>
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<tr>
<th>Psychiatric</th>
<th>Neuropsych</th>
<th>Health Psych</th>
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<td>ICD</td>
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<td>Interview</td>
<td>Interview</td>
</tr>
<tr>
<td>90801</td>
<td>96116</td>
<td>96150</td>
</tr>
<tr>
<td>Testing</td>
<td>Testing</td>
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</tr>
<tr>
<td>96101</td>
<td>96118</td>
<td>96150</td>
</tr>
<tr>
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<td>Rehab</td>
<td>Rehab</td>
</tr>
<tr>
<td>e.g., 90806</td>
<td>e.g., 96152</td>
<td>e.g., 96152</td>
</tr>
</tbody>
</table>
CPT: Model Rationale

• Rationale for a Specific CPT Code:
  – Choose Code that Best Describes the Service
  – Match the Interview with the Testing with the Intervention Code with the Diagnosis
  – It is Possible, Maybe Desirable, to Mix Codes (e.g., 90801 with 96118 if the purpose & procedure of the activities in question changes due to the information obtained in the process of the evaluation)
  – Goal = Parsimony, Uniformity and Fluency
CPT: Psychiatric Model (Children & Adult)

- **Interview**
  - 90801- adult
  - 90802- child

- **Testing**
  - 96101-03
  - Also, 96111 for children

- **Intervention**
  - e.g., 90806- adult
  - e.g., 90820- child
CPT: Neurological Model
(Children & Adult)

- Interview
  - 96116
- Testing
  - 96118/19/20
- Intervention
  - 97532
CPT: Non-Neurological Medical Model (Children & Adult)

- Interview & Assessment
  - 96150 (initial)
  - 96151 (re-evaluation)

- Intervention
  - 96152 (individual)
  - 96153 (group)
  - 96154 (family with patient)
CPT: Modifiers
(from Appendix A in CPT book; see OIG reports)

• Examples
  – 22 = unusual service
  – 25 = additional payment for an E & M code as a specific procedure code (problematic)
  – 51 = multiple procedures
  – 52 = reduced services
  – 59 = when two procedures occur on same day
    CANNOT USE ANOTHER MODIFIER WITH # 59
    - 76 = repeated service by same provider
    - 77 = repeated service by other provider
    – GN, GO, AH, etc. = local carrier specific

• Problems
  – Incomplete support for modifier from 15 to 35% of documentation results in paybacks
Codes Typically Not Being Reimbursed Regularly

- Telephone Calls
- Team Conferences
- Patient Education
- Prevention (to change in 2014)
Challenges to CPT

- SNOMED
- LOINC
- RxNorm

- These systems are more clinical and granular
- Performance measures not well developed
C. Diagnosing

- Limited Formulary Often Offered by Third Parties
- Multiple Diagnoses May be of Value
- Psychiatric
  - DSM
    - The problem with DSM and neuropsych testing of developmentally-related neurological problems
- Neurological & Non-Neurological Medical
  - ICD – 9 CM (physical diagnosis coding)
    - [www.cdc.gov/nchs/about/otheract/icd9](http://www.cdc.gov/nchs/about/otheract/icd9)
    - [www.eicd.com/eicd.main.htm](http://www.eicd.com/eicd.main.htm)

(Note: Always consult LCD information to determine formulary)
Diagnosing (cont.)

• **Billing Diagnosis**
  – Based on the referral question
  – What was pursued as a function of the evaluation

• **Clinical Diagnosis**
  – What was concluded based on the results of the evaluation
  – May not be the same as the billing or original working diagnosis
International Classification of Diseases

• Present
  – ICD-9-CM (Clinical Modification)
  – Since 1978

• Future
  – ICD-10-CM (Clinical Modification)
  – ICD-10-PCS (Inpatient Procedures)
  – Start date – October 1, 2013 (DELAYED to 2014)
International Classification of Diseases

• Comparison
  – Diagnosis; 382.9 – B01.2
  – Procedure; 39.5 – 0DN90ZZ

• Timeline & Endorsements
  – World Health Organization
  – Developed 1989; released 1994

• Effective on 10.01.13

• Further Information
ICD’s Seven Levels

- 1-3- category
- 4-6 etiology, site, severity, etc.
- 7- extension
ICD 10 System

• System
  – Level 1 = alpha
  – Level 2 = numeric
  – Level 3-7 = alpha or numeric (all letters apply except u; decimal after 3 characters)
  – E.g., = 0db588zx
Uniform Editing Systems

• Some systems, like Ingenix, place neuropsychological codes with mental health diagnoses
• Working with the company to attempt to resolve this problem
D. Medical Necessity

• Scientific & Clinical Necessity
• Local Medical Determinations of Necessity May Not Reflect Standard Clinical Practice
• Necessity = CPT x DX formulary
• Necessity Dictates Type and Level of Service
• Will New Information or Outcome Be Obtained as a Function of the Activity?
• Typically Not Meeting Criteria for Necessity;
  – Screening
  – Regularly scheduled/interval based evaluations
  – Repeated evaluations without documented and valid specific purpose
Medically Reasonable and Necessary

Section 1862 (a)(1) 1963
42, C.F.R., 411.15 (k)

“Services which are reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member”

Re-evaluation should only occur when there is a potential change in;
- Diagnosis
- Symptoms
Simple Explanation of Medical Necessity and Eventual Coverage

Existence of Evidence for Therapeutic Decision Making

*(will it make a difference?)*
National Coverage Policy
Exclusions

• Services That Are Not Reasonable and Necessary for the Diagnosing and Treatment of an Illness or Injury

• Screening Services, in the Absence of Symptoms or History of Disease are Denied
E. Documentation

• History
• General Principles
• Assessment
• Intervention
Electronic Health Records

- Lifetime and Portable Health Record
- Available 24/7 to All
- Performance Measurement
- Reduction of Duplicative Services
- Population/Disease Management
- Source for Research & Public Health
Promotion of EHR

- Enhanced Billing/Revenue Collection
- Closer Relationships with Health Systems
- Increased Productivity
- Increased Coordination of Care
- Will be Required Relatively Soon (2013-2016?)
Documentation: History

(Began with in February, 1988 with development of Evaluation and Management codes (published in 1992))

(Formalized with the 1995 & 1997 Medicare Documentation Guidelines)
Documentation: General
Purpose

- Medical Necessity
- Evaluate and Plan for Treatment
- Communication and Continuity of Care
- Claims Review and Payment
- Research and Education
Documentation: Basic Components

(AMA CPT Assistant, November, 2008, 18, #11, 3-4)

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time
Documentation: General Principles

- Rationale for Service
- Procedure
- Results/Progress
- Impression and/or Diagnosis
- Plan for Care/Disposition
- If Applicable, Time
- Date and Identity of Observer
Decision Tree for New Vs. Established Patients

(AAMA CPT Assistant, August, 2009, Vol. 19, #8, pg. 10)

Service Within 3 Years?
yes  no
same specialty  new?
yes  no
same specialty  new?
yes  no
established  new?
yes  no
Documentation: Basic Information

- Identifying Information
- Date
- Time, if applicable (total time Vs. actual time)
- Identity of Observer (technician ?)
- Reason for Service
- Status
- Procedure
- Results/Findings
- Impression/Diagnosis
- Plan for Care/Disposition
Documentation: Chief Complaint

- Concise Statement Describing the Symptom, Problem, Condition, & Diagnosis
- Foundation for Medical Necessity
- Must be Free-Standing, Complete & Exhaustive (i.e., other information is not needed to understand the situation)
Documentation: Present Illness

- Symptoms
  - Location, Quality, Severity, Duration, timing, Context, Modifying Factors Associated Signs

- Follow-up
  - Changes in Condition
  - Compliance
Documentation: Assessment

• Identifying Information
• Reason for Service
• Dates
• Time (amount of service time; total Vs. actual)
• Identity of Tester (technician?)
• Tests and Protocols (included editions)
• Narrative of Results
• Impression(s) or Diagnosis(es)
• Disposition
Documentation: “Assessment” Based on New Interpretation of Codes

• Technical Component
  – Label
    • Testing by Technician
  – Information
    • Individual Tests
    • Numerical
    • Basic Qualitative

• Professional Component
  – Label
    • Examples; Integration of Findings, Testing by Professional
  – Interpretation
    • Integration of findings which may include history, prior records, interview(s), and compilation of tests
Documentation: Intervention

- Identifying Information
- Reason for Service
- Date
- Time (face-to-face time; actual)
- Status of Patient
- Intervention Performed
- Results Obtained
- Impression(s) or Diagnosis(es)
- Disposition
Documentation: Therapy

• Reason
  – Acute = Improvement of health status
  – Chronic = Stabilization of health status

• Treatment
  – Method
  – Target Symptoms
  – Results
  – Time Start/Stop
  – Capacity to Participate

• Other
  – Time
  – Observer
  – Name of Patient
  – Date
Documentation: H & B Codes

• Must show evidence of coordination of care with the patient’s primary medical care providers or medical provider for the medical management of the physical illness that the H & B activity was meant to address.
Documentation: H & B Assessment

- Onset and history of initial diagnosis of physical illness
- Clear rationale why the assessment is required
- Assessment outcome including mental status and ability to understand or respond meaningfully
- Measurable goals and expected duration of specific interventions
Documentation: H & B Intervention

- Evidence that the patient has capacity to understand or to respond meaningfully
- Clearly defined psychological intervention
- Measurable goals of the intervention stated clearly
- Documentation that the intervention is expected to improve compliance
- Response to intervention must be indicated
- Rationale for frequency and duration of service
Documentation: E & M Codes

• Initial guidelines for any form of documentation dating back to 1988
• Revised in 1995 and 1997
• Primary focus is to determine level of care
• There are five levels depending on intensity, charted similarly to a bell curve
• Focus on medical concerns and may not appropriate for psychologists
Documentation: CPT X Report

• Each CPT Code Should Generate a Separate Report (or at least a separate section)

• If Separate Sections Within One Report, Clearly Label/Title Sections of the Report to Match Code Used (e.g., Neuropsychological Testing by Technician)
Documentation: Suggestions

• Consider Having a Multi-level System of Documentation;
  – Raw data (e.g., test protocols)
  – Internal routing sheets documenting such information as start/stop time, technician name, dates, etc. (a master sheet could track technician as well as professional time)
  – Final report
Records Retention

- General Ledger: Permanent
- Deeds & Agreements: Permanent
- Year End Financials: Permanent
- Personnel Records: Permanent
- Clinical Records: 8 Years+
- Payroll Records: 5 Years
- W-4s and similar: 5 Years
- Income Tax Records: 4 Years
Red Flag Rule

- Federal Trade Commission
- Attempts to Reduce Identity Theft
- Applies if Professional is a “Creditor” (i.e., outstanding balance at any point in time)
- Requires Clinician to “Verify” Identity of Patient
F. Time

- Time is Broadly Defined as What the Professional Does
- For Intervention – Time is face-to-face
- For Assessment - Time could be either face-to-face (i.e., H & B) or professional time (e.g., Psych & Neuropsych)
Time: Conceptual

• Defining
• Professional (not patient) Time Including:
  – pre, intra & post-clinical service activities
• Interview & Assessment Codes
  – Use 15 or 60 minute increments, as applicable
• Intervention Codes
  – Use 15, 30, 60 or 90 minute increments, as applicable
Time (continued)

- Communicating Further With Others
- Follow-up With Patient, Family, and/or Others
- Arranging for Ancillary and/or Other Services
Recent Interpretations of Time

• Non face-to-face time (pre and post) sometimes is not included in the measurement of billed time but it has been included in calculating total work of the service during the survey process.

• A unit of time is obtained when the midpoint has passed.

• When a time service is reported along with a non-timed service, the two are not added.
Time Interpreted

(AMA CPT Assistant, October, 2011, Vol. 21, Issue 10, pgs. 3-4, 11).

- Time refers to “face-to-face” unless otherwise stated.
- Unit of time = “when the midpoint has been passed”
- Do not count time twice
- When multiple days are involved, time is not reset with each and create a new hour.
Time Across Days

• “If a continuous service was provided, report all units as performed on the date that the service was started”

• However, a disruption in service creates a new initial service.
“Missed” Time
Section 20.3.1.

- Billing for Services That Were Not Provided” is Fraud
- The Patient Possibly Could be Billed for Missed Appointment (not for missed service), Assuming a Contractual Relationship and Understanding Has Been Previously Established
Time: Definition
(CPT Assistant, 08.05, 15, #8, pg. 12)
(www.cms.hhs.gov/providers/therapy)

- For Timed Codes in Physical Medicine: Beginning and Ending Time Should be Documented
- Time Should be Documented Along with the Treatment Description
Time: Defining Non-Face-to-Face Time

- communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care.
- communication with home health agencies and other community services utilized by the patient.
- medication management.
- patient and/or family/caretaker education to support self-management, independent living, and activities of daily living.
- assessment and support for treatment regimen adherence.
- identification of available community and health resources.
- facilitating access to care and services needed by the patient and/or family.
- advocating for services to meet patient’s needs, and/or
- development and maintenance of a comprehensive care plan.
### Time: Defining 15 Minutes

(from CPT Assistant, 08.05, 11-12)

(www.cms.hhs.gov/manuals/104_claims/clm104c05.pdf)

- 15 Minute Increments/ The 8 Minute Rule
  - Units | Amount of Minutes
  - --- | ---
  - 1 | >08; <23
  - 2 | >22; <38
  - 3 | >38; <53
  - 4 | >53; <68
  - 5 | >68; <83
  - 6 | >83; <98
  - 7 | >98; <113
  - 8 | >113; <128
  - Over 2 hours | similar pattern as above
“Time: Defining 60 Minutes”

“The Rounding Rule”

• 1 unit > or equal to 31 minutes to < 91 minutes
• 2 units > or equal to 91 minutes to < 151 minutes
• 3 units > or equal to 151 minutes to < 211 minutes
• 4 units > or equal to 271 minutes to < 331 minutes
• And so on…”
Location of Time

- Intraservice times are defined as face-to-face time for office and other outpatient visits and as unit/floor time for hospital and other inpatient visits. This distinction is necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit.
E & M Time

- When counseling and/or coordination of care dominates (more than 50%) the encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time is the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family or significant others. The extent of counseling and/or coordination of care must be documented in the record.
Time: Quantifying for Testing

• Quantifying Time
  – Round up or down to nearest increment
  – **Actual time** not elapsed time (i.e., start/stop times)

• Time Does Not Include
  – Patient completing tests, scales, forms, etc.
  – Waiting time by patient
  – Typing of reports
  – Non-Professional (e.g., clerical) time
  – Literature searches, learning new techniques, etc.
Time: Suggestions for Documentation

- Therapy
  - Minimum: Date(s) Total Time Elapsed
  - Maximum: Date(s) Start and Stop Times

- Testing
  - Minimum: Date(s) & Total Time Elapsed
  - Maximum: Date(s) Start and Stop Times

- Backup
  - Scheduling System (e.g., schedule book; agenda, etc.)
  - Testing Sheet with Lists of Tests with Start/Stop Times
  - Keep Time Information as Long as Records Are Kept
Time: Potential Limitations

**Therapy**
- Individual = 1
- Group = 8

Interview: 4 units (if timed)

**Testing**
- Professional = 10
- Technical = 8
- Computerized = 1

**H & B**
- 4
# G. Place of Service

<table>
<thead>
<tr>
<th>#</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Doctor’s Office</td>
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<tr>
<td>12</td>
<td>Patient’s Home</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
</tr>
<tr>
<td>22</td>
<td>Outpatient Hospital</td>
</tr>
</tbody>
</table>
H. Technicians

• What is the Minimum Level of Training Required for a Technician?
  – National Association of Psychometrists/Board of Certified Psychometrists
    • www.napnet.org/www.psychometriciancertification.org
  – 40 & NAN Position Paper
    • Level of Education- Minimum of Bachelors
    • Level of Training
    • Level of Supervision
Technician: Definition

Federal Register, Vol. 66, #149, page 40382

• Requirement
  – Employee (e.g., 1099); “employees, leased employees, or independent contractor”
  – Most common is independent contractor
  – “We do not believe that the nature of the employment relationship is critical for purposes of payment to the services of physician...as long as...(the personnel) is under the required level of supervision.”

• Common Practice
  – Independent Contractor
  – In Institutional Settings – institutional contract (source- NAP)
Technician: 1500 Forms

- HCFA/CMS Line 25
  - This is the line that identifies in a common insurance form who is the “qualified health provider” that is responsible for and completing the service
  - That individual is the person with whom the contractual relationship is established
  - Anybody else, from high school graduate to post-doctoral fellow to independently licensed psychologist (but not contractually related professional), is, for all practical purposes, a technician
  - That technician is not a new class of provider and cannot bill independently of a doctoral level provider
Technician: Federal Government’s Definition

- DM & S Supplement, MP-5, Part I
  - Authority: 38 U.S.C. 4105
  - Appendix 17A Change 43
  - Psychology Technician GS-181-5/7/9

- Definition
  - Bachelor’s degree from accredited college/university with a major in appropriate social or biological sciences (+ 12 psy. hours)
Technician: NAN’s Definition

- Approved by NAN Board of Directors
  - 08.2006
- Archives of Clinical Neuropsychology
  - 2006 (e.g., Puente, et al)
Technician: NAN’s Definition Explained

• Function- administration & scoring of tests
• Responsibility- supervisor
• Education- minimum, bachelor’s level
• Training- include ethics, neuropsy, psychopath, testing
• Confidentiality- APA ethics, HIPAA…
• Emergencies- contingencies must be in place
• Cultural Sensitivity- must be considered
• Supervision- general (Medicare) level
• Contract- must be in place
• Liability Insurance- must be in place
Technicians: Application

• Practice Expense & Practice Implications
  – Each tech code has .51 work value
  – This means that the professional is engaged in the work, namely, supervision (and interpretation)
  – That supervision would include:
    • Selection of tests
    • Determination of testing protocol
    • Supervision of testing
    • Interpretation of individual tests
    • Reporting on individual tests
    • Assisting with concerns raised by the patient
Technicians: Interfacing with Professionals

• The Qualified Health Provider must;
  – See the patient first
  – Supervise the activity
  – Interpret and write the note/report
  – Engaged in an ongoing capacity

NOTE: Pattern similar to medical and other health providers
Technicians: Facility

• Technicians in a “Facility”
  – A “facility” in essentially an inpatient setting
  – If a technician is an employee of a private provider but the service is provided in an inpatient setting, the inpatient fee would be used
  – If a technician is an employee of a facility, there is some question as to whether they could be supervised by a provider who is not an employee of the facility
Technicians: Next Steps

• Development of a National, Widely Accepted System for Identifying and Credentialing Technicians in Conjunction (unlikely to happen)

• With:
  – NAN
  – Division 40
  – National Association of Psychometrists & Board of Certified Psychometrists
    • http://psychometristcertification.org
Students as Technicians

• Medicare Interpretation
  – Medicare has never reimbursed for student training for any health disciplines
  – The assumption is that GME pays training programs and double dipping would occur if the Medicare and the CPT reimbursed for student activity
  – Two caveats:
    • This limitation probably applies to Medicare only
    • Students can perform as technicians as long as they are not being trained and their activity is not part of their educational requirements (e.g., a neuropsychologist in the community employees the student as a technician in their practice)
Students as Technicians

- This is from the Medicare Benefit Policy Manual, Chapter 15, Section 80.2:

- Payment and Billing Guidelines for Psychological and Neuropsychological Tests

- The technician and computer CPT codes for psychological and neuropsychological tests include practice expense, malpractice expense and professional work relative value units. Accordingly, CPT psychological test code 96101 should not be paid when billed for the same tests or services performed under psychological test codes 96102 or 96103. CPT neuropsychological test code 96118 should not be paid when billed for the same tests or services performed under neuropsychological test codes 96119 or 96120. However, CPT codes 96101 and 96118 can be paid separately on the rare occasion when billed on the same date of service for different and separate tests from 96102, 96103, 96119 and 96120.
Students as Techs (cont.)

• Under the physician fee schedule, there is no payment for services performed by students or trainees. Accordingly, Medicare does not pay for services represented by CPT codes 96102 and 96119 when performed by a student or a trainee. However, the presence of a student or a trainee while the test is being administered does not prevent a physician, CP, IPP, NP, CNS or PA from performing and being paid for the psychological test under 96102 or the neuropsychological test under 96119.
I. Supervision

(Federal Register, 69, #150, August 5, 2004, page 47553)

• Hold Doctoral Degree in Psychology
• Licensed or Certified as a Psychologist
• Applicable Only to “clinical psychologists” (and not “independent” psychologists as defined by Medicare)
• Rationale
  – Allows for higher level of expertise to supervise
  – Could relieve burden on physicians and facilities
  – May increase services in rural areas
Supervision
Program Memorandum Carriers
Department of Health and Human Services- HCFA
Transmittal b-01-28; April 19, 2001

• Levels of Supervision
  – General
    • Furnished under overall direction and control, presence is not required
  – Direct
    • Must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure
  – Personal
    • Must be in attendance in the room during the performance of the procedure
Supervision: Levels
42 CFR 410.32

• According to Medicare published guidelines as of July, 2006;
  – General- activity is directed and supervised by the doctoral level provider but the provider does not need to be in office suite
Supervision: Supervision Vs. Incident to

- **Supervision - Clinical Concept**
  - Behavior of a “qualified health professional” and a “technician”

- **Incident to - Economic Concept**
  - The concept of a contractual relationship (e.g., 1099) between a “qualified health professional” and a “technician”
Supervision: Malpractice Issues

• Adding a Psychometrist to Malpractice Insurance, as a Independent Contractors, Makes Good Sense
• However, This Protects the Doctoral Level Provider From Illegal and/or Ethical Acts by the Psychometrist but Not the Reverse
• Hence, the Psychometrist May Want to Obtain Insurance on Their Own
J. Correct Coding Initiative

• Purpose
  – Used to evaluate submissions when provider bills more than one service for the same beneficiary and same date of service
  – Example; psychotherapy and testing

• Activation
  – Automatic edits
  – 99477 is mutually exclusive with the series of psychotherapy codes (e.g., 90806)
Physician Referral

• Most Medicare carriers do not require physician referral
• It is not a federal guideline but a carrier one
• Most carriers do not require it
• If so, the NPI # for physician must be on the claim form – 17b on claim form

(from National Uniform Claims Committee’s CMS-1500 instructions)
Part II: Economics

• A. Reimbursement
• B. Coverage and Payment
• C. Fraud and Abuse
A. Reimbursement: History

- Cost Plus
- Prospective Payment System (PPS)
- Diagnostic Related Groups (DRGs)
- Customary, Prevailing & Reasonable (CPR)
- *Resource Based Relative Value System (RBRVS)*

Note: On average, insurance companies will pay approximate 75% of its income)
Reimbursement: Relative Value Units

- Components
- Units
- Values
Relative Value System Information

• System was started on 01.1992
• Over 4,000 codes have been valued since then.
• It is a payment system based on costs associated with the delivery of that service
RVU: Acceptance

- Medicare (100% since 01.01.92)
- Medicaid = 100%
- Private Payers = 74% and increasing to 95%
  - Blue Cross/Blue Shield = 87%
  - Managed Care = 69%
- Other = 44%
- New Trends:
  - RVUs as a Model for All Health Practice Economics
  - RVUs as a Basis for Compensation Formulas, especially in for-profit institutions
CMS Acceptance of RVU
(CPT Assistant, January, 2009, 19, 8-9).

• In 2008, CMS accepted 97% of the RUC recommendations
• In 2009, CMS accepted 98% of the RUC recommendations

• NOTE: carrier pricing and policy decisions is left to each intermediary
RVU: Components

- **Physician Work Resource Value**
- **Practice Expense Resource Value**
- Malpractice
- Geographic (sometimes referred as the GPCI); urban higher than rural)
- Conversion Factor ($36.0666 down from $37.8975)
Sustainable Growth Rate

• Sustainable Growth Rate
• Based on percentage changes;
  – Fees
  – Beneficiaries
  – Gross Domestic Product
  – Laws and regulations
• Ranges;
  --.3% to 5.5% per year
SGR: Current Status

- The scheduled 26.5% Sustainable Growth Rate (SGR) cut, was averted on New Year’s Day when the Senate passed the one-year delay through 2013 as part of the “American Taxpayer Relief Act” (HR 8) by a vote of 89-8. The House then passed the measure by a 257-167. [Link](http://clerk.house.gov/evs/2012/roll659.xml).

- ADDITIONAL OF REDUCTION OF 2-3% ALSO IN 03.01.13

- $300+ BILLION TO GET RID OF SGR AT THIS POINT
Conversion Factor

• To be re-addressed around 03.2013
• Alternatives-
  – Brief period of suspension (e.g., 2 months)
  – Longer period of suspension (e.g., 5 years)
  – Permanent (cost = $300 billion)
• Conversion Factor = shifted from $33.8729 to $34.0230
RVU: Components Percentages

- Physician Work = 52%
- Practice Expense = 44%
- Liability = 4%

- NOTE: Within 5-10 years, another major component will be performance; in other words, not only the work must be performed but some results should occur as a function of the service
Concept of Costs

• Direct Costs (based on 2005 data)
  – Supplies
  – Equipment
  – Clinical Staff Time

• Indirect Costs (based on mean hrs. billed)
  – Rent
  – Utilities
  – Administrative Staff Time

Both affected by Conversion and Budget Neutrality Factors
Medicare RVU Breakdown

(Federal Register, Vol. 72, #133, July 12, 2007, page 38190; Table 14)

- Physician Compensation 52.466
  - Wages and Salaries 42.730
  - Benefits 9.735

- Practice Expense 47.534
  - Non-Physician Wages 13.808
    - Technical Wages 5.887
    - Manager Wages 3.333
    - Clerical 3.892
    - Employee Benefits 4.845
  - Other Practice Expenses 18.129
    - Office Expenses 12.209
    - Liability Insurance 3.865
  - Drugs and Supplies 4.319
  - Other Expenses 6.433

- Effective decline by 2010 is approximately -7% (table 24)
- Budget Neutrality and Increase for E & M is Based on a reduction of .88994 to work values
RVUs Through 12.31.12

- 96020 C Functional brain mapping 0.00 0.00 0.00 NA NA 0.00 XXX
- 96020 TC C Functional brain mapping 0.00 0.00 0.00 NA NA 0.00 XXX
- 96020 26 A Functional brain mapping 3.43 1.03 1.27 1.03 1.27 0.23 XXX
- 96040 B Genetic counseling, 30 min 0.00 1.05 1.11 NA NA 0.01 XXX
- 96101 A Psycho testing by psych/phys 1.86 0.24 0.39 0.23 0.38 0.05 XXX
- 96102 A Psycho testing by technician 0.50 0.98 0.94 0.10 0.12 0.03 XXX
- 96103 A Psycho testing admin by comp 0.51 1.10 0.85 0.15 0.14 0.02 XXX
- 96105 A Assessment of aphasia 0.00 2.46 2.04 NA NA 0.03 XXX
- 96110 A Developmental test, lim 0.00 0.20 0.19 NA NA 0.01 XXX
- 96111 A Developmental test, extend 2.60 1.00 0.89 0.79 0.12 XXX
- 96116 A Neurobehavioral status exam 1.86 0.58 0.61 0.45 0.47 0.07 XXX
- 96118 A Neuropsych tst by psych/phys 1.86 0.57 0.88 0.21 0.37 0.05 XXX
- 96119 A Neuropsych testing by tec 0.55 1.17 1.31 0.07 0.12 0.02 XXX
- 96120 A Neuropsych tst admin w/comp 0.51 1.77 1.49 0.14 0.13 0.02 XXX
- 96125 A Cognitive test by hc pro 1.70 1.03 0.85 0.61 0.45 0.05 XXX
- 96150 A Assess hlth/behave, init 0.50 0.06 0.11 0.05 0.10 0.01 XXX
- 96151 A Assess hlth/behave, subseq 0.48 0.06 0.11 0.05 0.10 0.01 XXX
- 96152 A Intervene hlth/behave, indiv 0.46 0.06 0.10 0.05 0.09 0.01 XXX
- 96153 A Intervene hlth/behave, group 0.10 0.02 0.03 0.01 0.02 0.01 XXX
- 96154 A Interv hlth/behav, fam w/pt 0.45 0.05 0.10 0.05 0.09 0.01 XXX
- 96155 N Interv hlth/behav fam no pt 0.44 0.16 0.16 0.16 0.16 0.02 XXX

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Mental Health Reduction

• The Mental Health Limitation should not be applied to diagnostic service that are performed to establish a diagnosis. Further, this limitation only applies to diagnostic codes ranging from 290 to 319 (or DSM codes).

RVU: Defining Physician Work

• Clinical Work
  – Mental Effort and Judgment
  – Technical Skill/Physical Effort
  – Psychological Stress
RVU: Defining Practice Expense

- Constitutes 43% of Medicare Payments
- Based on 50% of previous expense and new PPI Survey data.
- Components of Practice Expense
  - Clinical non-physician labor (43 categories)
    - RN/LPN/MTA = $.37/minute ( $37,440/year)
  - Medical disposable supplies (842 items)
  - Equipment (553 items)
RVU vs. UCR

- Many commercial carriers prefer to set rates, or UCR (usual and customary rates), are based on regional market analyses instead of RVUs.
RVU: Values

- Psychotherapy:
  - Prior Value = 1.86
  - New Value = 2.65

- Psych/NP Testing:
  - Work value until 2005 = 0
  - Hsiao study recommendation = 2.2
  - New Value = varied (see upcoming slide)

- Health & Behavior
  - .25 (per 15 minutes increments)
RVU: 2006 Changes
(CPT Assistant, January, 2006, 16, 1)

• 283 RVU Changes Submitted, Including the Testing Codes
• Medicare Accepted 97%
• Professional Liability to Change to 1.00
• Geographic Index is Revised Every 3 yrs.
  – For Montana, Wyoming, Nevada, North and South Dakota (permanent 1.0 floor)
  – For Alaska 1.50 floor
2008 Average Payments

- 90801 = $146.85
- 90806 = $87.14
- 96112 = $83.33
- 96118 = $111.52
- 96152 = $22.48
- 96154 = $20.76
# Change in Code Payment: 2005-2013

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTOR</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2013</th>
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<tbody>
<tr>
<td>96117</td>
<td>NP Testing</td>
<td>$73.52</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
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<td>NP Profess.</td>
<td>NA</td>
<td>$129.99</td>
<td>$117.21</td>
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<td>NP Technician</td>
<td>NA</td>
<td>$66.3</td>
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2/10/2013
<table>
<thead>
<tr>
<th>CODE</th>
<th>RVU</th>
<th>Facility Fee</th>
<th>Non-Facility Fee</th>
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<td>2.80</td>
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<td>96116</td>
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<td>88.49</td>
<td>93.66</td>
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<td>25.07</td>
<td>68.95</td>
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<td>90806</td>
<td>1.86</td>
<td>87.89</td>
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</table>
### 2009-10 Average Medicare Fees

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>INFO</th>
<th>2009 Fee</th>
<th>2010 Fee</th>
<th>% Change</th>
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</thead>
<tbody>
<tr>
<td>90801</td>
<td>Psych Inter.</td>
<td>$152.92</td>
<td>$153.64</td>
<td>0.47%</td>
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<tr>
<td>90806</td>
<td>45-50 Therap.</td>
<td>$ 89.08</td>
<td>$ 88.00</td>
<td>-1.21%</td>
</tr>
<tr>
<td>96101</td>
<td>Psy Test-prof.</td>
<td>$ 84.40</td>
<td>$ 82.95</td>
<td>0.84%</td>
</tr>
<tr>
<td>96102</td>
<td>Psy Test-tech.</td>
<td>$ 51.21</td>
<td>$ 53.02</td>
<td>-1.71%</td>
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<tr>
<td>96103</td>
<td>Psy Test-com.</td>
<td>$ 46.17</td>
<td>$ 49.77</td>
<td>3.53%</td>
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<td>7.80%</td>
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<td>NP Test-tech.</td>
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<td>-7.00%</td>
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<td>NP Test-com.</td>
<td>$ 68.50</td>
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<td>6.33%</td>
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<tr>
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<td>96152</td>
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2/10/2013 psychologycoding.com
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<tr>
<th>Service</th>
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<td>Work</td>
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<tr>
<td>Total</td>
<td>0.86</td>
<td>2.06</td>
</tr>
</tbody>
</table>

2/10/2013  psychologycoding.com
Misvalued Services

- Medicare Payment Advisory Commission (MedPac)
- Each code will be undergo a Five Year review Identification Workgroup analysis
Ambulatory Payment Classification (APC): 96118

- Relative Weight: 2.4340
- Payment Rate: $161.38
- Minimum Unadjusted Coinsurance: $32.28
Outpatient Treatment Limitation

- Outpatient treatment limitation, which results in copays of up to 50%, does not apply to assessment codes.
- Hence, testing is reimbursed at the standard 80/s0 split used for physical health benefits.
Practice Expense

- Based on the Balanced Budget Refinement Act of 1999
- Designed to make expense values directly associated with actual expense
- From 2006 through 2009, practice expense was reduced approximately 2%
- In 2007-08, a multi-specialty survey was initiated
Payment Problem: Practice Expense

- Effective 01.01.10
- Reduction of 17% in neuropsychological testing services
- Spread out over 4 years
- Due to the heavy equipment expense in testing
- Affects ALL of technically heavy CPT codes such as cardiology and radiology
Practice Expense Cuts

• For 96118, the 17% cut will transition in between this coming January and 2013.

• For total payments for other psychological services (e.g., psychotherapy), the cut is 8% transitioned over 4 years.
Practice Expense

• Survey in Psychology based on:
  – Initial list of all APA members who had paid dues assessment
  – A total of 56 usable surveys were completed
  – These 56 surveys served as the foundation of a reduction of indirect costs
  – Prior to 2009, psychology’s indirect costs were approximately 29% and linked to psychiatry
  – As a function of the new survey, costs reduced to approximately 20%
Practice Expense

- APA PD provided list of potential participants
- DMR Kynetic administered the survey
- Analysis completed by The Lewin Group
# Practice Survey Numbers

<table>
<thead>
<tr>
<th>Field</th>
<th>Cardiology</th>
<th>Gen Practic</th>
<th>Neuro</th>
<th>Radio</th>
<th>Fam Medic</th>
<th>Psychiatry</th>
<th>Psychology</th>
</tr>
</thead>
<tbody>
<tr>
<td># Surveys</td>
<td>55</td>
<td>30</td>
<td>73</td>
<td>56</td>
<td>98</td>
<td>86</td>
<td>56</td>
</tr>
</tbody>
</table>
Reason for Drop in Reimbursement

• Practice Expense
• Provider Requested Practice Expense Survey (2008 APA Assessment Members)
• Psychologists used psychiatry’s costs = $29.07
• CMS required individual discipline surveys
• Results: Social Workers $17.80
• Psychologists $20.07
• Psychiatrists $30.10
• Neurologists $110.39 (from $66)
Other Reasons for Drop in Reimbursement

- For codes such as 90806, Psychotherapy, Practice Expense is approximately 30%
- For codes such as 96118, Neuropsychological Testing by Professional, Practice Expense is approximately 50% of the total payments
- Net Results: Disproportionate greater cuts to all testing codes
Phase In Rate of Drops

- FY 2010: 75% old (existing) Practice Expense Relative Value Unit (PERVU) and 25% of the (PERVU) one based on CMS’ revised calculations.
- FY 2011: 50% old and 50% new
- FY 2012: 25% old and 75% new
- FY 2013: 100% new
Comparison to Others

- Procedure Based Specialties All Decreased Substantially
- Specialties with Expensive Equipment Costs Experienced the Largest Decreases
- Examples: Cardiologists & Radiologists
  - Up to 40% cuts

- THESE ARE NOT DISCIPLINE SPECIFIC CUTS
- THESE ARE AREAS THAT LITTLE EDUCATION OR LOBBYING CAN PREVENT; CONSIDER IT A CORRECTION
- THESE CHANGES HAVE TO DO WITH BUDGET NEUTRALITY DUE TO E & M ALTERATIONS
## Cut Comparison Across Disciplines

<table>
<thead>
<tr>
<th>Discipline</th>
<th>% Cuts</th>
<th>Total $ Allowable (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiologist</td>
<td>23%</td>
<td>36</td>
</tr>
<tr>
<td>Social Worker</td>
<td>7%</td>
<td>362</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>8%</td>
<td>544</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>3%</td>
<td>1,095</td>
</tr>
<tr>
<td>Neurology</td>
<td>1%</td>
<td>1,414</td>
</tr>
</tbody>
</table>

2/10/2013 psychologycoding.com
# RVU Changes By Discipline

## CMS-1413-FC pg 1170-71

## TABLE 49: CY 2010 Total Allowed Charge Impact for Work, Practice Expense, and Malpractice Changes*

<table>
<thead>
<tr>
<th>(A)</th>
<th>(B)</th>
<th>(C) Impact of Work RVU Changes</th>
<th>(D) Impact of PE RVU Changes**</th>
<th>(E) Impact of MP RVU Changes</th>
<th>(F) Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Allowed Charges (mill $)</td>
<td>Fall</td>
<td>Tran</td>
<td>Fall</td>
<td>Tran</td>
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<tr>
<td>1</td>
<td>TOTAL</td>
<td>77,795</td>
<td>0%</td>
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<tr>
<td>2</td>
<td>ALLERGY/IMMUNOLOGY</td>
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<td>3</td>
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<td>6</td>
<td>COLON AND RECTAL SURGERY</td>
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<td>-1%</td>
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<tr>
<td>7</td>
<td>CRITICAL CARE</td>
<td>223</td>
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<td>8</td>
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<td>10</td>
<td>ENDOCRINOLOGY</td>
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<tr>
<td>11</td>
<td>FAMILY PRACTICE</td>
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<td>15</td>
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<tr>
<td>17</td>
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<td>-1%</td>
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<td>18</td>
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<td>24</td>
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<td>25</td>
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<tr>
<td>26</td>
<td>OBSTETRICS/GYNECOLOGY</td>
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<td>27</td>
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<td>32</td>
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<td>6%</td>
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</tr>
</tbody>
</table>

* RVU Changes By Discipline (CMS-1413-FC pg 1170-71) 2/10/2013 psychologycoding.com
### Practice RVU Changes (cont.)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (mil $)</th>
<th>Impact of Work RVU Changes</th>
<th>Impact of PE RVU Changes**</th>
<th>Impact of MP RVU Changes</th>
<th>Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
<td>(D)</td>
<td>(E)</td>
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<td>PLASTIC SURGERY</td>
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<tr>
<td>PSYCHIATRY</td>
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<tr>
<td>PULMONARY DISEASE</td>
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<td>1%</td>
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<td>RADIATION ONCOLOGY</td>
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<td>RADIology</td>
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<td>RHEUMATOLOGY</td>
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<tr>
<td>THORACIC SURGERY</td>
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<td>0%</td>
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<td>UROLOGY</td>
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<td>-8%</td>
<td>-3%</td>
<td>0%</td>
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<tr>
<td>VASCULAR SURGERY</td>
<td>656</td>
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<tr>
<td>AUDIOLOGIST</td>
<td>36</td>
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<td>-9%</td>
<td>-7%</td>
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<td>CHIROPRACTOR</td>
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<td>CLINICAL SOCIAL WORKER</td>
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<td>NURSE ANESTHETIST</td>
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<td>1%</td>
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<tr>
<td>OPTOMETRY</td>
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<td>10%</td>
<td>3%</td>
<td>1%</td>
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<tr>
<td>ORAL/MAXILLOFACIAL SURGERY</td>
<td>36</td>
<td>-1%</td>
<td>4%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>PHYSICAL/OCCUPATIONAL THERAPY</td>
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<td>9%</td>
<td>3%</td>
<td>-1%</td>
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<tr>
<td>PHYSICIAN ASSISTANT</td>
<td>757</td>
<td>0%</td>
<td>4%</td>
<td>1%</td>
<td>0%</td>
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<tr>
<td>PODIATRY</td>
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<td>1%</td>
<td>6%</td>
<td>2%</td>
<td>-1%</td>
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<tr>
<td>DIAGNOSTIC TESTING FACILITY</td>
<td>923</td>
<td>-1%</td>
<td>-29%</td>
<td>-7%</td>
<td>-4%</td>
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<tr>
<td>INDEPENDENT LABORATORY</td>
<td>970</td>
<td>0%</td>
<td>-5%</td>
<td>0%</td>
<td>-1%</td>
</tr>
<tr>
<td>PORTABLE X-RAY SUPPLIER</td>
<td>87</td>
<td>0%</td>
<td>8%</td>
<td>3%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

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Continued Advantages Despite Reimbursement Cuts

- 2005 Reimbursement = $73.52
- 2006 Reimbursement = $129.99
- Percentage Loss Currently Experiencing Would Have Been Devastating at 2005 Levels
- Technical Codes Now Exist
- There Codes Are Within 2005 Overall Rates
  - $73.52 then Vs. $74.30 today
Developing a Fee Schedule

• Medicare
  – Conversion Factor in 2008 = $34.1350

• Standard Method of Developing Fee Schedule
  – Obtain Medicare RVU values for selected CPT codes
  – Multiply by 150%
  – Revise fee schedule as RVUs change
Pricing of Codes

• Carrier Based
• CMS
• AMA RUV (most widely accepted)
Alternative Payment Models

- Quality Metrics
- Outcome Metrics
- Bundled Payment/Episode Care System
- Population Based Systems (e.g., Accountable Care System)

- CPT is excellent for single episode of care
B. Coverage & Payment

• Origins of the Problem
  – Balanced Budget Act of 1997
  – Employer’s Cost for Health Care in 2002 = $5,000 per employee

• What Should Your Code Be Payed at?
  – www.webstore.ama-assn.org-

• State Legislation
  – www.insure.com/health/lawtool.cfm
CMS Determination of Coverage

- **Coverage Types**
  - Coverage with Conditions (specific DX, facility or provider)
  - Coverage without Conditions

- **Data Reviewed**
  - Benefit
  - Risks Vs. Benefits
  - Available Clinical Studies
    - Databases
    - Longitudinal or cohort studies
    - Prospective studies
    - Randomized clinical trials
Coverage of Category 1 and 3 Codes

• Category 1 vs. Category 3 (Carriers)
  – Until otherwise reviewed and rejected, Category 1 codes are typically covered
  – Until otherwise reviewed and accepted, Category 3 codes are typically non-covered
Evolution of Payment Practices

- Evolution of Compensation
  - Gross Charges
  - Adjusted Charges
  - RVUs
  - Receivables
Compensation: Psychiatry

- Mean pay: approximately $200,000
- Mean collection: approximately 3/4
Medicare: Payment Questions

• Cannot Impose a Limitation on a Medicare Patient That is Not Imposed on Other Pts.
• Non-Covered Services Can Be Charged if Patient Knows and Agrees Ahead of Time
• Records Should be Retained, state law or;
  – Adult- 5 years post service
  – Children- until 21
Medicare Payment: Testing Services

- Payment for testing are reimbursed under the following section of the Social Security law:
  - 1842(b)(2)(A)
  - Chapter 15, section 160
Medicare: Billing Suggestions

- When to Bill
  - Overall = after documentation is in place
  - Mental Health Reduction should not be applied when diagnostic services are used to establish a diagnosis.
  - Diagnostic Services
    - After the interview
    - After all testing is completed and a report with integration has been completed
    - Billing should occur only once after testing is complete
    - Some question regarding that all billing is not only done after all testing is complete and documented but that such billing reflect only one date of service
  - Therapeutic Services
    - Could occur after each session
    - Should occur at least by the end of the month
Recent Billing Problems

- Professional Contact
  - Professional must do some of the testing
- Incorrect Bundling
  - Billing interview under testing codes
- Incorrect Use of Modifier
  - Lack of or inclusion of, depending on carrier
- Incorrect Use of Procedural Codes
  - Mixing Psychiatric and Neuropsychological codes
- Incorrect Day of Service
  - Bill the last day that service is provided for testing
  - Reflect in the CMS form the specific date of service
Billing Concerns
(AMA CPT Assistant Bulletin, Vol. 18, #1, pages 1-2, 2008)

• Electronic Vs. Manual
  – Electronic verification of benefits = $0.74
  – Manual verification of benefits = $3.70
  – Electronic submission of benefits = $6.63
  – Manual submission of benefits = $2.90
Billing Solutions

- Become knowledgeable of LCD criteria
- Bill in house or have billing clerk responsible for tracking information (billing systems charge 8-15% of gross)
- Bill/collect patient portion at time of service
- If possible, collect within 15 days with a window not to exist 60-90 days
- If possible, bill electronically
- If payment not provided by 30 days, follow up
- Establish criteria for obtaining payment (e.g., 90% of allowable rates)
Payment: Patient Denial Rates
(coverage denial frequency)

- Blue Cross-Blue Shield = 1.0%
- Commercial = 1.0%
- Medicare = 0.5%
- Medicaid = 5.0%

Psychologists’ Experience with Specific Carriers

(APA Good Practice, Summer, 2010, pgs. 10=14)

• Problem Areas (in order of importance)
  – Health and Behavior Codes
  – Psychotherapy and Testing Codes
  – Speed and Accuracy of Reimbursement
  – Authorization and Billing Procedures
  – Transparency of Company Procedures and Policies
  – (average satisfaction of approximately 50%)
Payment: Zero Pays
Delinsky, Physicians Practice, June, 2006

- 3.5 to 4% of Claims are “Zero-Pays”
  - Appear as contractual arrangement
  - Often seen in specialists practice
  - Approximately 50% are typically appeasable
  - But due to:
    • Approximately 60% = unclear
    • Approximately 20% = 0 RVU work value
    • Approximately 10% = billed under global period

- 5 to 7% of Claims are “Underpaid”
  - Often seen in special contracts
Payment Problems

- Mental Health or Medical Health
  - Contract directs payment
  - Training/Degree directs type of contract
  - CPT is secondary to all of the preceding

- Mental Health and Medical Health
  - CPT may describe the procedure
  - Payment may come from medical side
  - Rate would be from contract (i.e., mental health)
Payment: Ranking Payers
(from Moore, Physicians Practice, June, 2006)

- Humana
- Medicare
- United Health Group
- Aetna
- Cigna
- Champus
- Wellpoint
Payment: An Example

- 90806 – $116.83 (45 minutes increments)
- 90849 - $ 42.33 (multiple entries; group)
- 90801 - $195.03 (untimed)
- 96101 - $112.18 (60 minutes increments)
- 96102 - $ 64.70 
- 96116 - $126.60 
- 96118 - $146.62 
- 96119 - $ 93.09 
- 96150 - $ 30.26 (15 minutes increments)
- 96151 - $ 29.33
An Example of A Private Payers’ Payment Policy

- May not reflect national guidelines and/or practice standards
Payment: Billing Model

- **Components**
  - Procedure Completed
  - Number of Units of that Procedure
  - Location or Site Where the Service was Provided
  - Date of Service

- **CPT**

  
  \[
  \text{CPT} \times \text{# of Units} \times \text{Dx} \times \text{Site of Service} \times \text{Date}
  \]
Payment to Practice

• Economics (e.g., GDP) Shapes Payment Policy
• Payment Policy Shapes Practice
• Payment Shapes Documentation
• Documentation Shapes Cognitive Processes
• Cognitive Processes Shapes Practice Patterns
Current Payment Problems

• Continued challenges with compliance officers relative to the use of professional and technical testing codes on the same day

• Confusion on how to bill feedback activity
C. Fraud: Definition

• Fraud
  – Intentional
  – Pattern

• Error
  – Clerical
  – Dates
Safeguarding Program Integrity

(CPT Assistant, 11.10, 20, #11, 7-10)

• 11.09- President Obama signed Executive Order calling for reduction of improper payments

• 03.10, President Obama announced expansion of recovery audits & broadens authority of federal agencies for audits

• CMS refocuses efforts (Peter Budetti)

• PPACA contains program integrity provisions
Fraud: Medicare’s Interpretation of Physician Liability

- Overpayment From Incorrect Charge
- Mathematical or Clerical Error
- Billing for Items Known Not to be Covered
- Services Provided by Non-qualified Practitioner
- Inappropriate Documentation
Federal Definition of Fraud
(AMA CPT Assistant, 2010, 20, 2)

- Billing Unnecessary Services
- Failure to Produce Documentation
- Billing for Ineligible Patients
- Billing for ineligible Providers
Fraud: Types

- 26 Different Kinds of Fraud Types
- Psychological Services Have Been Identified as Problematic
Fraud: Potential Recovery by Federal Government

• Projections
  – Current
    • 14%
  – By 2011;
    • 17% ($2.8 trillion)
Fraud: Office of Inspector General 2005 Orange Book

- Identify Nursing Home Residents with Serious Mental Illness (OEI-05-99-00701)
- Improve Assessments of Mental Illness (OEI-05-99-00700)
- Eliminate Inappropriate Payments for Mental Health Services
Fraud: Office of Inspector General

- Primary Problems
  - Medical Necessity (approximately $5 billion)
  - Documentation

- Psychotherapy
  (oig.hhs.gov/reports/region5/50100068)
  - Individual
  - Group
  - # of Hours
  - Who Does the Therapy

- Psychological Testing
  - # of Hours
  - Documentation
Fraud (continued)

- Nursing Homes
  - Identification
  - Overuse of Services
- Children
Fraud: OIG’s May 2001 Study Involving Psychology
OEI-03-99-00130

- Overall Payments in 1998 = $1.2 billion
  (62% outpatient = $718 million)

Currently, 7-14% of all reimbursements
- Inappropriate Outpatient Mental Health
- “Particularly Problematic” due to
  - Medically unnecessary
  - Billed incorrectly
  - Rendered by unqualified providers
  - Undocumented or poorly documented
**OIG Report (continued)**

- Provider Not Qualified = 11%
- Medically Unnecessary = 23%
- Billed Incorrectly = 41%
- Insufficient Documentation = 65%
Fraud: Review History (10 years)

• Initial Review (14 points of submitted claims)
  – Legibility
  – Coverage
  – Matching dates
  – Signature

• Subsequent Review (occurs if over 5-6 items are failed in initial review)
  – Does the service affect a potential change in medical condition?
Fraud: CERT Program

www.oig.hhs.gov

- Comprehensive Error Rate Testing Program
  - National
  - Contractor-specific
  - Service-specific
  - Reviews both denied and accepted claims
  - An initial written request is followed by 4 letters and 3 phone calls followed by an overpayment demand letter and interpreted as services non-rendered
Fraud: New Information

- The Good Enough or Common Sense Approach
- If Medicare Audit Occurs then an Increased Likelihood of Medicaid Audit
- Practice Situations That Increase Potential Audits;
  - Skilled Nursing Facilities
  - Statistical Outliers
  - Testing
- States with Increased Audit Activity;
  - TX, CA, FL, PR

(Note: In August 27, 2007, Report on Medicare Compliance stated that “Federal Court Orders Government to Pay Doctor’s Legal Fees for Frivolous Prosecution”
Fraud: New Information (cont.)

- Private companies involved in auditing
- Financial incentive to discover fraud
- Initial states: MA, FL, CT
- Next states include but not limited to:
  - MA, NH, NY, VT, SC, FL, CO, NM, UT, CA, MT, WY, MN, ND, SD
Fraud: 2006 Red Book

• Section 1862(a)(1)(A) of the Social Security Practice Act requires all services to be reasonable and necessary for the diagnosis or treatment of an illness or injury.

• Claim errors have exceed 34%
Problem Areas
- Acute Hospital outpatient Services ($224)
- Partial Hospitalization ($180)
- Psychiatric Hospital outpatient ($57)
- Nursing Home ($30)
- General Mental Health ($185)
  - Beneficiaries who are unable to benefit from psychotherapy services
- Note: in millions (total for 2005 - $676,000,000)
Audit: 2007

CMS 2007

• 47% Mental health did not meet payment requirements
• 26% were miscoded
• 19% were undocumented
From 1996, 2001 to 2007

- 1996 and 2001 – 33% incorrect
- 2001 – 47% incorrect

Total Estimates = $718 million
RAC: Audit Review
(no reviews prior to 10.01.07)

• Estimated Profit to RAC: 9 to 12.4%
• Automated
  – No records involved
• Complex
  – Records requested
  – 45 days turn around time
  – Expect accusatory and vague letter

(in place by 2010 based on Section 302 of the Tax Relief and Health Care Act of 2006)
Economic Audits
RAC Vs. CERT

- CERT
  - Contract performance

- RAC
  - Past payment review (may be peer review)
Recovery Audit Contractor

- 2003- Demonstration Project
- 2005- CA, FL, NY
- 2007- AZ, MA, SC

- Adjusted $1.03 billion
- 85% inpatient hospital providers
- 6% inpatient rehabilitation facilities

- Cost- 20 cents for each dollar recovered
RAC: continued

• Automatic - DRG validation, coding errors and medical necessity
• Focus starting 2010 - Medical necessity
• 2011 -
  – Diagnosis Related Group
  – Coding Errors
  – DME medical necessity
Project HEAT

- 270 convictions
- $240 million in fines, etc.
RAC Appeals

- Appeals possible
- 22.5% were appealed
- 34% in favor of providers
RAC
(The National Psychologist, 02.11, pg. 7)

- Percentage Paid to Auditors
  - Between 9 and 12%
- Protection Advise
  - Review records regularly
  - Compliance is a must, especially for government programs
  - Keep abreast of changes (e.g., attend workshops)
RAC
(CPT Assistant, November 2010, pgs. 10-11)

• Purpose
  – “Identify overpayments and underpayments:

• Current Focus
  – Diagnosis related groups (DRGs)
  – Coding errors
  – Medical Necessity

• Prevention
  – Internal assessment
  – Proper justification and documentation
  – Codes should match procedure
Private Payer Audits

- 70% (and increasing #) of Private Payers are Auditing
- Private, Incentive Driven Companies
- Incentive Driven “whistle-blowers”
Potential Overpayment Law

- 11.2009 signed Executive Order for a reduction in improper payments and decrease in waste
- 03.2010, President Obama announced expansion of payment recovery audits; law to re-capture lost funds signed
- Patient Protection and Affordable Care Act contain integrity provisions
Privacy Audits: HIPAA Compliance

- **Effective Date**
  - July, 2012

- **Company**
  - $9 million to KPMG

- **Method**
  - 20 protocols
  - 10 business days to respond
Fraud: Voluntary Compliance
D. Raisin-Waters, APA, 2005 & 2008

• Address Risk or Problematic Areas (e.g., denied claims)
• Develop a Compliance Program (with designated individual, written plan, etc.)
Fraud: Voluntary Compliance
D. Raisin-Waters, APA, 2005

• Address Risk or Problematic Areas (e.g., denied claims)
• Develop a Compliance Program (with designated individual, written plan, etc.)
Individual and Small Group Practice Compliance Guidance
(Raisin-Waters, 2008)

Seven Elements OIG determined fundamental:

1. Conducting internal monitoring and auditing
2. Implementing compliance and practice standards
3. Designating a compliance officer or contact
(continued)

4. Conducting appropriate training and education
5. Responding appropriately to detected offenses and developing corrective action
6. Developing open lines of communication
7. Enforcing disciplinary standards through well-publicized guidelines
Self-Auditing and Monitoring

(Raisin-Waters, 2008)

OIG recommendations:

• Standards and Procedures
  - develop a written manual
  - should include reviews and updates
  - can identify clinical protocol, treatment guidelines for the practice, updated documentation forms
OIG recommendations (continued)

- **Claims Submission Audit**
  - review of bills and medical records
  - can be retrospective or concurrent with claims submissions
  - look for accurate coding, complete documentation, medical necessity
  - identify the practice’s risk areas
Decreasing Audit Potential

(CPT Assistant, 11.10, 20, #11, 10)

- Internal Assessment of Billing Practices
- Match Practice to Carrier Policy
- Good Documentation
- Knowledge of Coding Guidelines and Payor Policies
- Identify and Correct Variances
- Focus Tend to be on:
  - High frequency and high cost services.

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Decreasing Audit Potentials

- Avoid Repeat Evaluations
- Avoid Multiple Similar Doctors
- Avoid Spikes in Billing Activity
- Consider Self and "Group" or Peer Auditing
- Attend Workshops and Document Such Attendance
Increasing Probability of Successful Audits

• Potential Solutions:
  – Document Everything That You Do
  – Establish Formal Internal Auditing System
  – Engage in Informal Internal Peer Review
  – Consider Periodic External Peer Review
  – Keep Abreast of Carrier Changes
  – Understanding of Medical Necessity
  – Match Procedure Codes
  – Match Diagnostic & Procedure Codes
  – Document Properly; Document Again
  – Do Change Records After Request for Audit
  – If Audited, Comply (thoroughly & quickly)
  – If Trial, Appreciate & Appraise Situation
  – Once Audit Begins, Do Not Change Existing Documentation (possibly acceptable to clarify)
If Audited…

• Possible Outcomes
  – No further questions
  – Bill for overpayment
  – Request additional records
  – Discuss records
  – Schedule administrative hearing
  – Determine compliance plan
  – Schedule criminal hearing
Audit Insurance

• Terms
  – Investigation, regulatory cyber liability, “medefense”

• Coverage
  – Will not cover over/underpayment
  – Will pay for legal fees
  – Some will pay fines and fees
Fraud: Effects on Abuse on Clinical Services and Outcomes
(Becker, Kessler & McClellan, 2004)

• Increased enforcement results in;
  – Lower billings
  – No adverse consequences
Fraud: Web Site

Malpractice Claims
(New England Journal of Medicine, 2011)

• Small fraction of mistakes actually file claims
• About 5-7.5% on average per year of MDs have had a file a malpractice claim
• Fewer than 2% of MDs had a successful claim against them
• Neurosurgeons were sued the most (19%) and psychiatrists the least (3%)
Part III: Challenges & Approaches

- A. National Provide Identification Number
- B. CMS National Directive
- C. National Correct Coding Initiative
- D. Potential Solutions to Current Problems
- E. The Future
A. National Provider Identification Number

- Required
  - For Medicare by March 1, 2008
  - For all other carriers by May 23, 2008

- General Codes
  - Psychologist
  - Neuropsychologist

- APA Advises to Choose Both

- A Committee of AMA with Little External Output

- Common NPI errors:
  - Submitting the group NPI/PIN as the provider (may require a different paper claim- 24J- or electronic loop- 2310B)
  - Submitting an NPU with an invalid PIN

• **Title**
  – Pub 100-02 Medicare Benefit Policy
  – Transmittal 55

• **Dates**
  – *Issued* September 29, 2006
  – *Effective Date*: January 1, 2006
  – *Implementation Date*: December 28, 2006
  – *Re-Interpreted and Resolved*: January 1, 2008

Statement

• 5204.1
  – “Carriers and fiscal intermediaries shall pay for medically necessary diagnostic psychological and neuropsychological tests…”

• 5204.2
  – “Contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims to 01.01.06. However, contractors shall adjust claims brought to their attention”. 
CMS National Directive: Summary of September, 2006 Statement

• “When diagnostic psychological tests are performed by a psychologists who is not practicing independently, but is on the staff of an institution, agency or clinic, that entity bills for the psychological tests.”
CMS National Directive: Summary of September, 2006 Statement

- Independent is defined as:
  - “Free of professional control…”
  - “The persons they treat are their own patients”
  - “They have the right to bill directly…”

- For those psychologists practicing in an office located in an institution:
  - The office is confined to a separately-identified part of the facility which is used solely as the psychologist’s office
  - The psychologists conducts a private practice…services are rendered to patients in and outside of the institution
CMS National Directive: Summary of September, 2006 Statement

• “CPT … test codes 96101/96118 should not be paid when billed for the same tests or services performed under the...test codes 96102/103/96119/120.”

• “Medicare does not pay for services represented by CPT codes 96102 and 96119 when performed by a student or a trainee.”
C. Correct Coding Initiative: September, 2006 Statement

- Introduced in March 30, 2006 for Comment; Effective 10.01.06
- When 96118, 96119 and/or 961120 occur together, a modifier might be of value;
  - Most appropriate code is probably 59 (possibly 51)
  - Model used is radiology (when more than one service is provided by the same provider to the same patient)
D. Solutions to Testing Code Problems: Use of Modifiers

• Routine in Medicine, Especially Radiology (since their common use of technicians)
• Describes That More Than One Procedure Was Provide to the Same Patient on the Same Day
• Should not Increase Time to Reimbursement or Audit Probability Nor Decrease Reimbursement
• Apply Modifier 59
• NOT TYPICAL FOR COMMERCIAL CARRIERS
Solutions: AMA CPT Assistant Publications

• Q & A Appeared September, 2006
• Full Length Article Last Approved 10.02.06 & Published in November, 2006
  – A Comprehensive Review of the Information Previously Presented
  – Approved by the AMA CPT Editorial Panel
  – Allows for the Use of All Codes Simultaneously or Alone
• A Follow-up Q & Appeared in December, 2006
• Again, Issue Has Been Resolved as of 01.01.08
Solutions: Alternatives

- Not Accept Medicare Patients
- Take a Conservative Approach
- Interface with Individual Carriers to Develop Specific Understanding and Procedures
- Use of Modifiers
- Administration of One Test by Professional
- Testing by Professional and Technician on Different Days
- Interpretation by Professional on Different Days as Testing

*NOTE: The final decision on how to code rests on the individual and/or their institution’s assessment of carrier contract as well as their understanding of the current policy situation*
Solutions: Summary

• Medicare
  – Resolved as of 01.01.08
  – Proceed as November, 2007 CPT Assistant and as codes were intended to be used
  – Completely resolved on June, 2008 with published Q and A’s

• All Others
  – See list of suggestions outlined in extended CPT presentation
E. The Future: Pay for Performance (P4P) Initiatives

• Premise
  – Evidence-based guidelines
  – Outcome more than procedure based

• Estimated Application in Payment Systems
  – First Set 01.01.08
  – Work Group = Merla Arnold, Jean Carter, Katherine Nordal, Craig Piso, Mirean Coleman, Paula Hartman-Stein (Gerontologist)

Information in P4P section comes primarily from Hartman-Stein (Center for Healthy Aging)
Physician Quality Reporting Initiative

- Definition - A financial incentive to improve quality of health care (approx. 2%)
- Began 2011. If not participating by 2015, a 1.5% penalty being raised to 2%
- 119 Measures
- Focus on measurement of process and documentation
PQRS Measures

- Measure #280 – Staging of Dementia
- Measure #281 – Cognitive Assessment
- Measure #282 – Functional Status Assessment
- Measure #283 – Neuropsychiatric Symptom Assessment
- Measure #284 – Management of Neuropsychiatric Symptoms
- Measure #285 – Screening for Depressive Symptoms
- Measure #286 – Counseling Regarding Safety Concerns
- Measure #287 – Counseling Regarding Risks of Driving
- Measure #288 – Caregiver Education and Support
Other PQRS Measures

- Advising Smokers to Quit (#115)
- Preventive Care and Screening: Body Mass Index Screening and Follow-Up (#128)
- Documentation of Current Medications in the Medical Record (#130)
- #173 - Preventive Care and Screening: Unhealthy Alcohol Use – Screening
- #181 - Elder Maltreatment Screen and Follow-Up Plan
- #226 - Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention
PQRI Example: Screening for Cognitive Impairment

• Instructions
• Numerator
• Denominator
• Rationale
• Recommendations
## Staging of Dementia

<table>
<thead>
<tr>
<th>Measure #280</th>
<th>Staging of Dementia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Patients whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period. Dementia severity can be assessed using one of a number of available valid and reliable instruments available from the medical literature, including formal neuropsychological assessment.</td>
</tr>
<tr>
<td>QDC</td>
<td>CPT II 1490F</td>
</tr>
<tr>
<td></td>
<td>Dementia severity classified, mild</td>
</tr>
<tr>
<td></td>
<td>CPT II 1491F</td>
</tr>
<tr>
<td></td>
<td>Dementia severity classified, moderate</td>
</tr>
<tr>
<td></td>
<td>CPT II 1493F</td>
</tr>
<tr>
<td></td>
<td>Dementia severity classified, severe</td>
</tr>
<tr>
<td></td>
<td>1490F with 8P</td>
</tr>
<tr>
<td></td>
<td>Dementia severity not classified, reason not otherwise specified</td>
</tr>
</tbody>
</table>

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## Cognitive Assessment

**Numerator**

Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period. Cognition can be assessed by direct examination of the patient using one of a number of instruments, including several originally developed and validated for screening purposes. Formal neuropsychological assessment also satisfies this requirement.

### QDC

<table>
<thead>
<tr>
<th>CPT II 1494F</th>
<th>Cognition assessed and reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1494F with 1P:</td>
<td>Documentation of medical reason(s) for not assessing and reviewing cognition</td>
</tr>
<tr>
<td>1494F with 2P</td>
<td>Documentation of patient reason(s) for not assessing and reviewing cognition</td>
</tr>
<tr>
<td>1494F with 8P:</td>
<td>Cognition not assessed and reviewed, reason not otherwise specified</td>
</tr>
</tbody>
</table>

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# Functional Assessment

## Numerator

Patients for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period. Functional status can be assessed by direct examination of the patient or knowledgeable informant. An assessment of functional status should include, at a minimum, an evaluation of the patient’s ability to perform instrumental activities of daily living (IADL) and basic activities of daily living (ADL).

## QDC

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT II 1175F</td>
<td>Functional status for dementia assessed and results reviewed</td>
</tr>
<tr>
<td>1175F with 1P</td>
<td>Documentation of medical reason(s) for not assessing and reviewing functional status for dementia</td>
</tr>
<tr>
<td>1175F with 8P</td>
<td>Functional status for dementia not assessed and results not reviewed, reason not otherwise specified</td>
</tr>
</tbody>
</table>
Neuropsychiatric Symptom Assessment

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuropsychiatric symptoms can be assessed by direct examination of the patient or knowledgeable informant.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QDC</th>
<th>CPT II 1181F</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1181F</td>
<td>Neuropsychiatric symptoms assessed and results reviewed</td>
<td></td>
</tr>
<tr>
<td>1181F with 8P</td>
<td>Neuropsychiatric symptoms not assessed and results not reviewed, reason not otherwise specified</td>
<td></td>
</tr>
</tbody>
</table>
### Neuropsychiatric Symptoms: Management

#### Numerator

Patients who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period.  
(Note: (One G-code [G8947] & one CPT II code are required on the claim form to submit this numerator option)

#### G-Code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G8947</td>
<td>One or more neuropsychiatric symptoms</td>
</tr>
<tr>
<td>G8948</td>
<td>No neuropsychiatric symptoms</td>
</tr>
</tbody>
</table>

#### QDC

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT II 4525F</td>
<td>Neuropsychiatric intervention ordered</td>
</tr>
<tr>
<td>CPT II 4526F</td>
<td>Neuropsychiatric intervention received</td>
</tr>
<tr>
<td>4525F with 8P</td>
<td>Neuropsychiatric Intervention not ordered, reason not otherwise specified</td>
</tr>
<tr>
<td>4526F with 8P</td>
<td>Neuropsychiatric Intervention not received, reason not otherwise specified</td>
</tr>
</tbody>
</table>
## Screening for Depression

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Patients who were screened for depressive symptoms within a 12 month period</th>
</tr>
</thead>
<tbody>
<tr>
<td>QDC</td>
<td></td>
</tr>
<tr>
<td>CPT II 3725F</td>
<td>Screening for depression performed</td>
</tr>
<tr>
<td>3725F with 8P</td>
<td>Screening for depression not performed, reason not otherwise specified</td>
</tr>
</tbody>
</table>
Pay for Performance Status

• Pay for Performance at Present = Pay for Reporting
• Diagnoses
  – Medication Verification
  – Pain Assessment
  – Screening for Depression
  – Treatment Planning
• Mild Cognitive Disorder
  – Specific Diagnoses
  – Specific Process (Documentation?)
  – Eventually Measure Development
• Outcome
  – Increased Accountability
  – Increased Remuneration
• Minimum of 50% (vs. 80% historically) of patients in program
• Bonus is 1% (with additional .%% per year if MOC)
• Check www.usqualitymeasures.org
How to report PQRI measures

- Example of a CMS 1500 claim form with G code reported - Note that there is no monetary value for code.
CPT Codes for psychologists that have accompanying measures:

- Psychiatric diagnostic interview examination: 90801, 90802
- Neurobehavioral status exam: 96116
- Health and behavior assessment: 96150, 96151
- Health and behavior intervention: 96152
- Individual psychotherapy: 90804, 90806, 90808
PQRI: Performance

• Five years of program
• Over 100,000 participants
• $36 million in incentives or 1.5% with similar penalties
• Major problems
  – Reporting of codes
  – Denominator mistakes
  – Dx/Rx mismatch
CMS PQRI WEBSITE

Use the following link to access the Medicare 2008 PQRI web page. On the left of the page is a button for the PQRI Tool Kit. At the bottom of the page is the link to all the PQRI measures.

http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp
Status of PQRS

- Enrollment Should Occur by 2013
- Bonus
  - .5% per year through 2014
- Penalties
  - Starting 2015
Problems With P4P

• California Medicaid System
• Five Measures of Clinical Quality Collected Between 2004-2007
• Comparisons of Counties That Used Measures Vs. Counties that Did Not Use Measures
• No Differential Effect of Health Care Was Found

(Guthrie, Bindman & Auerback, 2010)
Likely Winners in Payment Changes

- Chronic Diseases
- Care Transition
- Team & Interdisciplinary Care
- Population Management
2007 Medicare Changes

• CMS Payment Changes
  – 08.02.07
  – CMS will increase payments of $690 million or 3.3% of the Medicare Budget for Medicare Skilled Nursing Facilities
  – Decreased reimbursement for procedures and increased reimbursement for E & M activities
  – Fee Schedule Reductions
    • Anticipated 10.1% unless Congress passes a bill limiting the reduction (passed in the House, pending in the Senate)
2008 Medicare Changes

• Congressional Activity in 2008
  – Medicare Fee Schedule must be released by early November and revised with the closing of Congress (most likely an Omnibus bill in mid-December; will result in problems with billing for first quarter of 2008)
  – Requested = Between 10.1% reduction
  – Occurred =
    • 1% raise
    • Gradual reduction of mental health disparity/copay
2009-10 Medicare

• Requested 21.2% reduction in fees
  – On hold until 04.01.10 (plus 10 days)

• Medicare as a national health plan by default

• Congressional options (to be determined between August and September, 2009)
  – “Medical home”
  – “Interdisciplinary and coordinated care”
  – Cost containment through increased efficiency including electronic records & audits
General Medical Education

- $2.6 billion or 5.5% in 2002 (Office of Actuary, 2001)
- Includes Funding for Education of Residents But Does Not Include Psychology
- Post-doctoral training in hospital-based programs can apply for funds but such funds are limited economically and are controlled by the hospital and not training programs.
- This disparity needs to be addressed for the doctoral, internship and post-doctoral training programs and their viability.
APA and GME

- Medicare Funding for Psychology Internship Training
- Legislative History
  - July 30, 1997 – Conference report language accompanying the “Balanced Budget Act of 1997” (BBA ’97) urges the Secretary of Health and Human Services to fund psychologist training under the allied health funding provisions.
  - November 18, 1999 – Conference report language, regarding the Medicare “Givebacks” bill of 1999, indicates that the conferees are pleased that the HHS Secretary, consistent with the BBA ’97 mandate, is considering a proposal to initiate graduate medical education payments to institutions involved in the training of psychologists. The conferees urge the Secretary “to issue a notice of proposed rulemaking to accomplish this modification before June 1, 2000.”
  - May 12, 2000 – Senate Committee on Appropriations report language, as part of the Departments of Labor, Health and Human Services, and Education 2001 appropriations bill and as accepted in the final Conference report, notes that HCFA has failed to issue the necessary rule for psychology internship training. The committee indicates that it “expects the agency to release the rule immediately.”
  - October 5, 2000 – Senate includes as Medicare psychology training funding provision in the Senate Medicare “Givebacks” bill of 2000 (S.3165). House Ways and Means Committee is assured by CMS that rulemaking is imminent and therefore does not include the psychology training provision. The final Medicare “Givebacks” bill is enacted without the psychology provision on December 21, 2000, as part of the Consolidated Appropriations Act of 2001.
- 2002 – Practice works with CMS to finalize the proposed rule and attempts to have to a legislative fix included in the 2002 Medicare “givebacks” bill.
APA & GME (continued)

• Postdoctoral Fellows
  – Not automatically ruled out and therefore could fall into existing GME categories
  – Several postdoctoral programs are receiving GME funds for the training of psychologists
An Alternative to No GME

- Acquiring CMS Funding for an APA-Accredited Postdoctoral Psychology Fellowship Program
- Stucky, Buterakos, Crystal and Hanks
- Training and Education in Professional Psychology, 2008, 2, 3, 165-175
Medically Unlikely Edits (MUE)

- A list of MUEs have been posted by the National Correct Coding Initiative (NCCI) under license to Correct Coding Solutions (Change request 5402)
- Developed to reduce the paid claims error rate.
- Defined as a Unit of Service that is the maximum # of units a single provider can do per day.
- The idea is that two codes would be impossible to be used together (e.g., brain surgery and psychotherapy).
- MUEs are for a single day of service and are not applied to an episode of service.
MUEs & Testing

• It may be that testing should not exceed approximately 10 hours

• Example from Cigna; Section VI.5 of Cigna Government Services LCD 6224

  “Typically, the test battery will require 5-7 hours to perform, including administration, scoring and interpretation. If the testing is done over several days, the testing time should be combined and reported all on the last day of service. If the testing time exceeds 11 hours, a report must be submitted indicated the medical necessity for this extended testing”.

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psychologycoding.com 435
MUEs and H & B

- 4 Units per day (1 hour) for either assessment or re-assessment
- 4 Units total for intervention (per day?)
- Total intervention is limited to 48 units (12 hours)
MUEs and Modifiers

- Major problems arise when providers use modifiers to avoid the limits imposed, published or unpublished, on a service by using MUE.
- Might signal increased audit possibilities.
Nursing Homes

• New Initiative from CMS:
  – Minimum Data Set (MDS) – Version 3.0
  – Implementation (Fall, 2010)
  – Focus on:
    • Section C (Cognitive Patterns)
    • Section D (Mood)
    • Section E (Behavior)
Health Care Reform: What Does the American Public Want?

- Life Expectancy #1
- Expected Expenditure on Health Care will finally settle at about 1/3 of earned income
- To be Competitive (especially globally), Industry and Business will Shift Cost of Health Care to Consumers and the Government
- Government (e.g., Medicare) Will, However, Set the Standard for Health Care
Health Care Expenditures
(CMS)

• Health Care Spending & Gross Domestic Product
  – 1960 = 5.0%
  – 1970 = 7.0%
  – 1990 = 9.0%
  – 2002 = 15.4%
  – 2004 = 16.0%
  – 2005 = 16.2%
  – 2010 = 18.0%
  – 2015 = 20.0% (or 4 trillion $)
  – Final = 33.3%
Payment System Reform

• The Commonwealth Fund (Stremkis, Davis, November 2008)
• Fee for service not effective
• Payment incentives to improve efficiency
Medical/Health Home

• Overview
  – Health Affairs, 27, #5, 2008, 1235-1245

• Medical Home Defined
  – Board certified physician acts as personal physician
  – Coordinates care
  – Receives a case management fee monthly

• Role for Neuropsychology
  – Psychiatry and Neurology presently excluded
  – Maybe a new tier will develop
Integrating Demographic and Economic Pattern Analysis with Psychological Practice I

• Information Processing
  – Electronic health records
  – NPI as a foundation for future activities

• Type of Problems
  – Elderly
  – Non-Elderly: MVA, CVA, Lifestyle Diseases

• Economics
  – Increased interdisciplinary care
  – Expansion of services by lowest common denominator
Integrating Demographic and Economic Pattern Analysis with Psychological Practice II

• Demographics
  – Greatest growth in ethnic minorities
  – Hispanics comprise 50% of current population growth and will be the majority group in the US probably within 25-30 years
  – Most population growth in the south (African-Americans) and southwest (Hispanics) close to 100% in the lower 1/3 of US; where there is the lowest numbers of psychologists

(Harold Hodgkinson, 11.05.07, National Academy of Practice, Washington, DC)
Integrating Demographic and Economic Pattern Analysis with Psychological Practice III

• Training Issues
  – GME, GME, GME
  – 4,000 new doctoral level graduates per year

• Practice
  – 4 of 10 are self-employed (1 of 10 in other health care)
  – National Licensure

• Trends
  – Medical home (The Commonwealth Fund)

• Emerging Issues- Iraq & Afghanistan
  – 30-38% of regular service personnel and 49% of National Guard returning from Iraq will require psych/neuropsych assistance
    Two signature problems are PTSD and TBI
  – 117 active duty psychologists and 2,400 in the VA system

  – (Originated from Senator Inouye’s office, 11.05.07)
December 19, 2007 a 10.1% cut was changed by Congress with a .5% increase; This is a yearly activity

Medicare Parity (?)

SGR (21%) was to go into effect in the fall of 2010 but postponed;

Faced a 27.4% reduction in 2011 in Congress

In 2013, 26.2% SGR cut is scheduled…
SGR: Continued

• 26.2% cut expected on 03.01.13; probably reduced to 2%
• If a temporary repeal, then subsequent costs would be around 33%
• Costs to permanently repeal = $300 billion

(if sgr had been previously been attended the costs would have been $40 million; one alternative is to write it off as a “bad debt”)

2/10/2013 psychologycoding.com 447
Psychotherapy Cut

• Question as to its Reinstatement (pessimistic)
• Total Expected Loss of 5% (artificially obtained)
  – 3% in 2012
  – 2% in 2013
  – 1+ in 2014
Integrating Demographic and Economic Pattern Analysis with Psychological Practice V

• Participation, if available, for PQRI will result in a 1.5% increase (though 2007 incentive has yet to be paid)

• National Provider Identification (NPI) # is required for Medicare claims starting March, 2008

• NPI # is required for all other payers starting May 23, 2008
The Future of CPT

• CPT to P4P to PQRI (from doing to performing; Category II type activity)
• ICD 9 to ICD 10 (major change)
• Psychotherapy and Interviewing Codes Have Undergone Major Revision
• Focus on;
  – Correct Billing
  – Correct Documentation
  – Performance rather than activity
  – Over the next 5-10 years
New Initiatives: Insurance

• Private Payers
  – Restricted interpretation by BC/BS of testing codes
  – Working on resolving this in specific states (e.g., AL, FL, TN, …)

• CMS Interpretation of Students/Trainees
  – Presently cannot use students/trainees IN TRAINING and request reimbursement from Medicare patients using a CPT code
  – This is due to the interpretation by CMS that psychology receives General Medical Education funds (postdoc training programs may be able to pursue GME funds)
  – Next step includes either the use of GME funds or allowing student/trainees to bill using CPT codes (we are surveying training programs)
  – This only applies to Medicare
Stalled Initiatives: Registration of Psychometrists

- Collaborative Project of National Association of Psychometrists, NAN and Division 40
  - Initial proposal developed and revised
  - Presented to NAN and 40 Boards in 2007
  - Revised at INS by Presidents of NAN/40; submitted to respective Boards (not accepted by either Board)
  - Currently stalled in negotiations between NAN/40 & NAP (does not looked promising)
  - Working on New York state issues (NY Neuropsychology group); Meeting with state officials has occurred and alternatives being proposed
Ongoing Initiatives: New York Technicians

- Problem (Psychologists against Psychologists)
- Status
  - On 11.08.07 the New York Psychological Association Council voted in favor of pursuing a legislative solution that allows technicians (caveat; IQ = Masters)
  - Secretary Munoz from NY is reviewing options, ruling is forthcoming soon
- Potential Alternatives
  - Legislative solution (unlikely)
  - No prosecution as long as alternatives are being considered
  - No solution in sight
Economic Concerns

- Economics
  - National
    - Recession to deep recession occurred with long term impact
    - National health insurance
  - Health Care
    - Stable through 2009
    - Uncertain from summer of 2009 to present
    - Probable reduction in fees based on loss of practice expense & SGR
    - New health care bill will determine future
Stimulus Package

• Electronic Records
  – Starting 2011
  – Approximately $30 billion
  – Entrance into system is rewarded/punished:
    • 2011-12 = $44K
    • 2013 = $39k
    • 2014 = $24k
    • 2015 = -$1k
    • 2016- = -$2k
    • 2017 = -$3K
New Mandates

• Privacy
  – Encrypted technology necessary for electronic transmission of information (further study required)
  – Introduction - 09.09
  – Enforced - 02.10

• PQRI
  – Introduction - 2010-11
  – Penalty - 2013
Health Care Reform: Likely Outcomes & Timetable

• Change
• Introduction to Congress During Summer and Fall of 2009
• Resolution occurred in March, 2010
• Working Out Details Through 2010
• Presently, Volatile and Uncertain; House will repeal, Senate will not
The Near Future

- Last Year Suggested Stable Early 2009, Questionable Late 2009, Unstable 2010
- What Will 2012-13 Bring?
  - More opportunity
  - Less pay with traditional paradigms
  - Medicare will set the precedent for all insurance programs including the new ones being addressed by Congress
  - Based on discussions with CMS Staff & five Medicare Medical Directors
    - Greater pool of patients
    - Dementia, stroke, etc. probably over represented in this new pool of patients
    - If you are in the Medicare program, you will probably have access to the new pool of patients
    - Most likely federally funded, state regulated programs
    - Codes and payments will remain same (minus practice and SGR) except the valuing of the psychotherapy codes
The Near Future: Non-Government

• Updating of Test “Formulary”
  – Test Use Frequency
  – Test Usage (e.g., time)

• Psychotherapy
  – Re-conceptualization
  – Re-valuing

• General Medical Education
  – Current Practice
  – Potential Misalignment with Third Party Rules
The Near Future: Government

Released on October 30, to be published in the Federal Register on November 25, 2009

- **SGR or Conversion Factor**
  - Typical timetable = on the books every year
  - Proposed = 26.2%
  - Why = Putting off cuts over the years (e.g., compounding interest)
  - Fiscal cliff
  - Likely outcome for 2013, 2% drop
History of Health Care Reform
(New York Times, 08.19.09)

• 1912: Theodore Roosevelt proposes national health insurance
• 1929: First health insurance program - Baylor Hospital in Dallas, TX
• 1931: First HMO - Farmer’s Union Cooperative Health Association
• 1932: Wilbur Commission recommends health insurance prepayment
History of Health Care Reform
(New York Times, 08.19.09)

• 1945: Harry Truman proposes compulsory health coverage
• 1965: Birth of Medicare & Medicaid (LBJ)
• 1968: Beginning of spiraling of health care
• 1971: Richard Nixon requires minimum health insurance by employers
• 1976: Jimmy Carter calls for universal and mandatory coverage
• 1993: Bill (Hilary) Clinton’s managed competition
National Background

- **Total Costs**
  - Annually = $2.3Trillion (Federal = $1.26)
  - Approximately 18% of the GNP of the US; 15% of GDP
- **Insurance Plans**
  - 84% Insured/ 14% Uninsured
  - Over 700 Health Care plans (15% admin cost for private; 3% for federal)
- **Breakdown**
  - Clinical Services = $421.7
  - Hospital = $611.6
  - Other = $338.6
  - Medical Products & Drugs = $258.8
  - Nursing Homes = $169.3
- **Comparison to Other Nations**
  - US = 16.0%
  - UK = 8.3%
  - CHINA = 4.7%
## Health Statistics: 2010

*(The Economist, 12.12.09)*

<table>
<thead>
<tr>
<th>Country</th>
<th>Private Cost</th>
<th>Public Cost</th>
<th>Per Person ($'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>8%</td>
<td>7%</td>
<td>7.3</td>
</tr>
<tr>
<td>France</td>
<td>3%</td>
<td>8%</td>
<td>3.6</td>
</tr>
<tr>
<td>Germany</td>
<td>3%</td>
<td>7%</td>
<td>3.6</td>
</tr>
<tr>
<td>Canada</td>
<td>4%</td>
<td>6%</td>
<td>3.9</td>
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<tr>
<td>Britain</td>
<td>2%</td>
<td>7%</td>
<td>3.0</td>
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<tr>
<td>Japan</td>
<td>2%</td>
<td>7%</td>
<td>2.6</td>
</tr>
<tr>
<td>Turkey</td>
<td>2%</td>
<td>5%</td>
<td>0.6</td>
</tr>
</tbody>
</table>
Health Care Bill: How Health Care Will Be Revolutionized by 2018

Bill:
http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.4872:

Timetable:
http://www.commonwealthfund.org/Content/Publications/Other/2010/Timeline-for-Health-Care-Reform-Implementation.aspx#2010

(also, www.healthcare.gov)
Affordable Health Care for America Act (HR 3962)

- No Limitations on Pre-existing Conditions
- Guaranteed Renewal
- Limit Rating on Patients Based on Health
- Ban Use of Annual & Lifetime Caps
- Address Personnel Shortfall
- Medical Home Pilot Projects
- Phase Out Drug Doughnut Hole by 2019
Specifics of Health Care Bill: I
(adapted from Medscape.com 03.31.10; Commonwealth 05.10.10)

• Small Business Tax Credits
  – Tax credits of up to 35% for insurance (immediate)
  – Will go up to 50% (by 2014)

• Preventive Care (Private Plans- 10.01.10; Medicare- 01.01.11)
  – Eliminates copayments for preventive care
  – Exempts preventive care from deductibles

• Ends Rescissions (10.01.10)
  – Bans health plans from dropping coverage for being sick
Specifics of Health Care Bill: II
(adapted from Medscape.com 03.31.10; Commonwealth 05.10.10)

- **Temporary High Risk Pool** (07.01.10; NC and all but 17 states will run own program; $5,950 individuals and $11,900 families)

- **Voluntary, Public Long-term Care Insurance Program** (01.01.11)
  - Financed by voluntary payroll deductions
  - Befits to those who become functionally disabled

- **Community Health Centers** (07.01.10)
  - Increase to for doubling number of patients within 5 years with funding of over $10 billion
Specifics of Health Care Bill: III
(adapted from Medscape.com 03.31.10)

- Extending Health Insurance Programs to Children through Age 26
- Increasing Primary Care Physicians (07.01.10)
  - Increasing primary care MD and related professionals focusing on public health
Specifics of Health Care Bill: IV
(adapted from Medscape.com 03.31.10)

• Creates Temporary Insurance Program for Early Retirees (04.01.10)
  – Between ages of 55-64

• No Discrimination Against Children with Pre-existing Conditions (10.01.10)

• Bans Lifetime Limits on Coverage (10.01.10)

• Bans Restrictive Annual Limits on Coverage by Medicare (10.01.10)
  – From all health plans by 2014
Preventive Services: A New Frontier

- Annual wellness visits
- Prevention plan services
- Furnish personalized health advise to health education or prevention services
- Detect cognitive impairment

NOTE: Unclear application for psychologists
Prevention Services

• Removal of deductible and co-insurance
• Addition of annual wellness visits
• Addition of Health Risk Assessment

See ama-assn.or/go/medicare-prevention
The Affordable Care Act requires an examination of potentially misvalued codes in seven categories:

1. Codes and families of codes for which there has been the fastest growth,
2. Codes and families of codes that have experienced substantial changes in practice expenses,
3. Codes that are recently established for new technologies or services,
4. Multiple codes that are frequently billed in conjunction with furnishing a single service,
5. Codes with low relative values, esp. those that are billed multiple times for a single service,
6. Codes which have not been reviewed since the implementation of the RBRVS (the so-called “Harvard-valued codes”),
7. Other codes to be determined by the Secretary.
Integrative Health Care: Engagement of Behavioral Health

- 75% are chronic illnesses
- 50% of mental health care is done by PCP
- 600,000 behavioral health professionals of which 100,000 are psychologists
- Current coding limited for physicians more limited for psychologists
Specifics of Health Care Reform

• Reducing Fraud
  – Community Mental Health Centers
  – Prepayment Review
  – Increase funding for fraud, waste & abuse

• Medicare
  – Disproportionate payment to hospitals
  – Imaging
  – Physician ownership referral

• Medicaid
  – Disproportionate payment to hospitals
  – Primary Care Providers
## Health Care Reform: Process

<table>
<thead>
<tr>
<th>Level of Action</th>
<th>Agency Level</th>
<th>Roadblocks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congressional</td>
<td>NA</td>
<td>Republican Take-over</td>
</tr>
<tr>
<td>Federal Agency</td>
<td>CMS</td>
<td>State Lawsuits Supreme Court</td>
</tr>
<tr>
<td>State Agency</td>
<td>Medicaid/Insurance XC.</td>
<td>State Budgets</td>
</tr>
<tr>
<td>Private Companies</td>
<td>e.g., BC/BS</td>
<td>RVU minus model</td>
</tr>
<tr>
<td>Institutional</td>
<td>HR/Budget Authorities</td>
<td>Compliance Officers</td>
</tr>
</tbody>
</table>

2/10/2013

psychologycoding.com
## Origins of Health Care Reform

<table>
<thead>
<tr>
<th>Driving Force</th>
<th>Initial Focus</th>
<th>Implementation</th>
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<tbody>
<tr>
<td>Reducing Budget Deficit</td>
<td>Increase Efficiency</td>
<td>Audits</td>
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<tr>
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<td>Electronic Health Record</td>
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<td>Community Health</td>
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<td>Outcome Based</td>
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<td>Medical Home</td>
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<td></td>
<td></td>
<td>Efficient Models (e.g. VA)</td>
</tr>
<tr>
<td>Moral Attributes</td>
<td>Insuring 50 million people</td>
<td>Children to 26 yrs of age</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-exclusionary limits</td>
</tr>
<tr>
<td></td>
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<td>Health Rae Exchanges</td>
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</tbody>
</table>
# Health Care Reform Timetable

<table>
<thead>
<tr>
<th>Timetable</th>
<th>Driving Activity</th>
<th>Involved Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall 2010</td>
<td>Elections</td>
<td>Patient Advocacy Organizations (e.g., Families USA)</td>
</tr>
<tr>
<td>Winter 2011</td>
<td>Congressional Debate</td>
<td>Health Care Organizations (e.g., AMA, APA, …)</td>
</tr>
<tr>
<td>Spring 2011</td>
<td>Public Debate</td>
<td>Talk Shows, Newspapers, etc…</td>
</tr>
<tr>
<td>Summer 2011</td>
<td>Congressional Action</td>
<td>Everybody</td>
</tr>
<tr>
<td>Spring 2012 to 06.30.12</td>
<td>Supreme Court</td>
<td>Everybody</td>
</tr>
<tr>
<td>Fall 2012</td>
<td>Congress (SGR)</td>
<td>Providers</td>
</tr>
<tr>
<td>Winter 2013</td>
<td>State</td>
<td>Providers</td>
</tr>
</tbody>
</table>
Health Care Reform Bill Summary

- Costs - $940 billion over 10 years
- Savings - Reduce deficit by $130 billion over 10 years, $$1.2 trillion over next 10
- Coverage - Expand by 32 million people
- Exchanges for Uninsured and Self-employed (133-400% of poverty level)
- Exchanges for Small Businesses - 2014
Summary Continued

• Insurers Will No Longer Be Able To:
  – Deny coverage to children with pre-existing conditions
  – Place lifetime and/or annual benefit limits
  – Cancel policy without proving fraud

• Consumers Will Be Able To:
  – Access no-cost prevention services
  – Allow children access to health care coverage until 26 if enrolled student
  – Choose primary care provider, ob/gyn, pediatrician
  – Use nearest Emergency Room without penalty
Changes in Affordable Health Care Act: Positive

• Positive Aspects & Unlikely to Change (examples):
  – Coverage extension
  – Pre-existing conditions
  – Expanding to a larger pool of individuals
Changes in Affordable Health Care Act

• Changes:
  – Individual mandate
  – De-fund Innovation Center

• Questions
  – Independent Payment Advisory Board
  – Tort Reform
Rules of the Mandate
(adapted from Kaiser, 2012)

• No Penalty
  – Religion
  – Medicare or Medicaid
  – Indian Tribe
  – Not required to file tax return
  – Cannot find insurance that costs less than 8% of your income

• Penalty
  – 2014- $95
  – 2015- $325
  – 2016- $695
Health Care Bill- Executive Summary

• Expand Affordable Health Insurance to Those Without Coverage
• Increase Affordability of Insurance for Those Who Have It
• Slow the Rise of Health Care Costs and Control National Deficit
Winners

- Uninsured and Working Class Self-Employed (& Small Businesses)
- Pre-existing Conditions
- Mobile Individuals
- Some Seniors and Women
- Children & Students (till 26)
Supporters

- Investment Incomes
- Cadillac Insurance Plans
- Tanning Booths
- Large (over 50 employees) Companies
- Health Care Providers
Health Care Bill: Areas of Potential Interest

• Mental Health Parity (Section 214, pg. 100)
• Federally Qualified Behavioral Health Centers (Section 2513, pg. 1367)
Benefits Package
(Sec. 1302; Sec. 2713 of Public Health Service Act)

• Essential
  – Bronze - 60% coverage
  – Silver - 70% coverage
  – Gold - 80% coverage
  – Platinum - 90% coverage

  – Focus on children, hospitals, prevention and mental health
Health Care Benefits Exchange

• States will create exchanges (or join federal government)
• Limited to citizens/residents who do not have employer based insurance
• Will provide standardize information
• Determine eligibility
Post-Health Care Bill

• Passed Bill: Largely an insurance reform bill

• Future Direction & Impact of Bill:
  – At agency level
  – Then, at private third party level
  – May turn out to be the health care reform of what has occurred thus far
  – Revolutionary changes will occur quietly between now and 2018, largely at state levels
Example of Post Health Care Bill

- Medicare Shared Savings Program (06.24.10):
  Accountable Care Organizations (ACOs)
  - Engagement of clinical staff
  - Protection and savings for patients
  - Assessment of quality
  - Data management (e.g., EMR)

To be established no later than 01.01.12
Must include at least 5,000 beneficiaries
Accountable Care Organization

- Expand Medicaid Eligibility
- Provider Based
- Competency Based

- 15 states have ACOs; 3 partnering with federal government
Electronic Medical Record (EMR/EHR)

• EMR is broadly defined as a patient’s health record in an electronic format
• Required by Congress
• Connected to a Health Information Exchange
• Minimum amount of information
• Start date: 2012
• Required date: ?
Another Example

• Health Insurance Exchanges
  – Selection of beneficiaries
  – Large numbers and varied samples
  – Choice without complexity
  – Transparency and disclosure
  – Increased competition
  – Limit internal and external costs
  – Geographic limits (Regional/ State/National?)

(Jost, 2010)
Applications of Bill

- Development of Performance Metrics
- Increasing Transparency & Reporting
- Improving CMS Delivery

(Stremikis, Davis & Audet, The Commonwealth Fund, July, 2010)
Post-Health Care Health Bill
(Commonwealth 05.10.10)

• Defining “Medical”
• Medical Packages
  – From Bronze, 60%, to Platinum, 90%)
• Medicaid Expansion
  – Increase of 133% of the poverty level
• Independent Advisory Board
• Limit health Spending (to 6% from 6.6.%)
Paying for Health Care Bill

- Decrease Budget Deficit by $141 billion or $511 billion over 10 years
- Productivity by improvement ($160)
- Medicare Advantage ($204)
- Home Health ($40)
- Payment Advisory Board ($16)
- Other ($75)
Bipartisan Congressional Budget Committee

• Due dates
  – 11.23.11
  – Congressional vote occurred 12.23.11

• Outcomes
  – Lack of consensus = automatic spending cuts of $1.2 trillion over 10 years starting in 2013
Present Trends at Federal Level

• GOAL OF LOWER COSTS
• INCREASED EFFICIENCY (E.G., DUPLICATION OF SERVICES, INNOVATION IN DELIVERY AND PAYMENT)
• INCREASING TRANSPARENCY/ACCOUNTABILITY (E.G., PQRS)
Final Outcome

- Congressional Interface of Senate & House Bills
  - Focus is on payment and insurance reform
    - Tort and Insurance Company Reform out
    - Medicare Payment Cuts (about $400 billion/years) with a reduction in deficit of $143 billion in 10 years due to
      - Medicare Audits (RAC and CERT) and pre-service audits
      - Reduction of practice expense for procedures
      - Increase in interface with multidisciplinary focus
      - Electronic health records
      - Increase focus on prevention
  - Probable outcome
    - Delivery system- Medicare
    - Payment system- Medicaid
Supreme Court & Health Care Reform

• Three Questions
  – Tax Liability; No
  – Individual Mandate; Yes
  – Severability (survivability of other aspects)

• Impact
  – Continuation of Law/Regulations
  – Shift from Federal to State Levels
  – Was not Overturned and Unlikely to Return (or for Congress to tackle any aspect of it)
Timetable

• Now
  – Public plans to cover pre-existing conditions
  – Coverage of children through 26
  – Coverage of preventative services

• 2014
  – Health status inconsequential
  – Federal subsidies according to income
  – Higher taxes after $200,000
  – All individuals required health coverage
Timelines

- CMS
  - Cciio.cms/gov
- ACA
  - Healthcare.gov/center
- US DOL
  - Dol.gov/ebsa/faqs/faq-aca2.html
- White House
  - Whitehouse.gove/healthreform/timeline
Mega Trends

(from : P. Hollman, 10.13.11; AMA CPT meeting)

• Unsustainable Cost Trends
• Increased Audits
• Electronic Health Records
• Health Care Homes
• Tele-health
• New Diagnostic Codes
• Chronic Care Model (and elderly patients)
• Redefinition of Diseases
<table>
<thead>
<tr>
<th>Activity</th>
<th>Current</th>
<th>Future</th>
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<tbody>
<tr>
<td>Reimbursement Base</td>
<td>Service</td>
<td>Outcome</td>
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<tr>
<td>Location of Service</td>
<td>Inpatient</td>
<td>Outpatient (e.g., home)</td>
</tr>
<tr>
<td>Provider Approach</td>
<td>Silo</td>
<td>Integrated</td>
</tr>
<tr>
<td>Numbers</td>
<td>Volume</td>
<td>Limited (&amp; targeted)</td>
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<tr>
<td>Patient Approach</td>
<td>Standardized</td>
<td>Personalized</td>
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<tr>
<td>Foundation of Service</td>
<td>Experience based</td>
<td>Empirically based</td>
</tr>
<tr>
<td>Location of Patient</td>
<td>Independent</td>
<td>Health Care Home</td>
</tr>
</tbody>
</table>
Final Summary

• **Negative News**
  – Decrease in Reimbursement (about 2%)
  – Transparency & Accountability (negative?)

• **Positive News**
  – Transparency & Accountability
  – Much Wider Scope of Practice
  – Larger Number of Patients
  – Newer Paradigms (telehealth; team & coordinated care)
  – Increase in Professionalism
  – Mainstream Integrated Health Care (Vs. Silo/Isolated)
Tsunami of a Change

• **Expected to Change**
  – Reimbursement System
  – National Health Care Policy
  – Diagnostic System

• **Timetable of Change**
  – 2012-214
A Summary of Approximately 25 Years

- Expanded from approximately 3-4 codes to over several dozen codes.
- Total revision of all diagnostic, testing, and psychotherapy codes.
- Addition of prescription privilege code.
- Expanded from psychiatric only to all of medicine and health care.
- Expanded from no uniformity and lack of understanding to high levels of professionalism and recognition & collaboration with psychology and medicine/health care.
- Reimbursement increases has outpaced other health care disciplines by a significant factor.
Current Puente Activities

• Focus on the Implementation of Health Care Bill
• Conversion Factors Problems/SGR
• Continue working on Psychiatric Interviewing, Psychotherapy Practice Expense & New Psychotherapy Codes
  – 90 Minutes
  – Surveying of psychopharmacology code
• Working with Randy Phelps and new APA Office of Health Care Economics
• Working with Neil Pliskin in New Role with AMA CPT
• Continue to Serve on:
  – AMA CPT Panel (voting member; permanent seat)
  – Joint Committee for Standards for Educational and Psychological Tests (representing neuropsychology as well as non-majority groups)
  – APA Ethics Panel (Technical)
Upcoming Activities

• Surveying of Existing Codes (spring 2013)
  – Crisis
  – Interactive Complexity
  – Psychopharmacologic Management

• Development of New Codes (2013)
  – Prolonged Psychotherapy (one)
  – Testing Feedback (one); or resolve the use of 96118 for feedback for some carriers
  – Coordination of Care for Integrated Care (several)

• Revision of Existing Codes (2013)
  – Health and Behavior
    • Possibly addressing non-face-to-face
    • Definitely re-surveying the existing codes
Emerging Patterns

- Performance Based Reimbursement
- Shift from Pre to Post "Authorizations" (i.e., Audit)
- Documentation is Support for Medical Necessity
- Medical Necessity is the Basis for the Service
- Integrative (virtual and/or geographic) Health Care Delivery
- Shift of Focus from Federal to State
- Accuracy, Transparency and Utility
- Fast Moving, Major Paradigm Shifting
Economic Outlook

• Estimated
  – For 2013, generally no change
  – Subsequently, probably 5-25% decrease in psychotherapy and "90801" reimbursement plus SGR
  – Probably 2% for testing due to refinement of practice expense in codes surveyed in 2012
  – SGR of 2% + (overall)
  – Affordable Care Act = Medicaid "light"
Personal Involvement

• Professional Membership
  – Join NAN, APA/40, SPA and your state association
  – Start a local/state specialty association (e.g., North Carolina NP Society)
  – Think nationally; act locally (e.g., state wide)

• Professional Participation
  – Join a organization committee, listserv
  – Join an insurance committee
  – Track insurance patterns in your state/area
  – Keep others informed and engaged
  – Take proactive and positive perspective
  – *Note: Listserv information may be incorrect*
Final Comments

• Last Year's Theme = End of the World as We Know It (REM; Athens, Georgia)

• This Year's Theme = It is Indeed a New World
And “I feel fine”

http://www.apamonitor-digital.org/apamonitor/201212/?pg=70&pm=2&u1=friend
Part IV: Resources

- General Web Sites
  - www.apa.org (apa practice directorate tool box)
  - www.nanonline.org/paio (practice patterns & information)
  - www.cms.org (medicare/medicaid)
  - www.hhs.org (health & human services)
  - www.oig.hhs.gov (inspector general)
  - www.apa.org/practice/cpt (apa’s cpt information)
  - www.ahrq.gov (agency for healthcare research)
  - www.medpac.gov (medical payment advisory comm.)
  - www.whitehouse.gov/fsbr/health (statistics)
  - www.div40.org (clinical neuropsychology div of apa)
  - www.napnet.org (national association of psychometrists)
  - www.psychometristscertification.org (board of psychometrists)
  - www.access.gpo.gov (federal statutes and regulations)
  - www.healthcare.group.com (staff salaries)
  - www.psychometristscertification.org (certification)
Resources (continued)

• Payment/Coverage
  – [Website](http://www.myhealthscore.com/consumer/phyoutcptsearch.htm)
  – [Website](http://www.cms.hhs.gov/statistics/feeforservice/default.asp) (covered services)
  – [Website](http://www.cms.hhs.gov/mcd/viewtrackingsheet.asp?id=167) (non-covered)
  – [Website](http://www.apa.org/pi/aging/lmrp/toolkit/homepage.html) (apa lcd)
  – [Website](http://www.cms.hhs.gov/providers/mr/lmrp/asp) (medicare lmrp)
  – [Website](http://www.quickfacts.census.gov/qfd) (census x type of procedure data)
  – [Website](http://www.usqualitymeasures.org) (payment for performance)

• LMRP Reconsideration Process
  – [Website](http://www.cms.gov/manuals/pm_trans/R28PIM.pdf)

• PQRS
  – [Website](http://www.centerforhealthyaging.com)

• Compliance Web Sites
  – [Website](http://www.oig.hhs.gov) (office of inspector general)
  – [Website](http://www.cms.hhs.gov/manuals) (medicare)
  – [Website](http://www.uscode.house.gov/usc.htm) (united states codes)
  – [Website](http://www.apa.org) (psychologists & hipaa)
  – [Website](http://www.cms.hhs.gov/hipaa) (hipaa)
  – [Website](http://www.hcca-info.org) (health care compliance assoc.)
  – [Website](http://www.cms.gov/oas/cms.asp)
Resources (continued)

• ICD
  – www.who.int/icd/vol1htm2003/fr-icd.htm (who)

• PQRS
  – www.centerforhealthyaging.com

• Coding Web Sites
  – www.catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp (ama cpt)
  – www.aapcnatl.org (academy of coders)
  – www.ntis.gov/product/correct-coding (coding edits)
AMA Contact Information

• Website
  – www.amabookstore.com
  – Link to;
    • catalog.ama-assn.org/Catalog/cpt/issue_search.jsp

• Telephone
  – 312.464.5116
APA Contact Information

• American Psychological Association
  - Katherine Nordal, Ph.D.
    Practice Directorate, Director
    American Psychological Association
    750 First Street, N.W.
    Washington, D.C. 2002

• Association for the Advancement of Psychology
  – [www.aapnet.org](http://www.aapnet.org)
  – P.O.Box 38129
  – Colorado Springs, Colorado 38129
Puente Contact Information

- **Websites**
  - Coding = [www.psychologycoding.com](http://www.psychologycoding.com)
  - Univ = [www.uncw.edu/people/puente](http://www.uncw.edu/people/puente)
  - Practice = [www.clinicalneuropsychology.us](http://www.clinicalneuropsychology.us)
  - NAN = [www.nanonline.org/paic](http://www.nanonline.org/paic)
  - Div 40 = [www.div40.org](http://www.div40.org)
- **E-mail**
  - University = puente@uncw.edu
  - Practice = clinicalneuropsychology@gmail.com
- **Telephone**
  - University = 910.962.3812
  - Practice = 910.509.9371