

# **Coding, Documenting & Billing Mental Health & Related Services**

**Antonio E. Puente**  
**University of North Carolina Wilmington**

**(revised & extended version)**

November 15, 2008

# Disclaimer

The information contained in this extended presentation is not intended to reflect NAN, APA, Division 40, NCPA (or any state psychological association), AMA, CMS (Medicare), state Medicaid and/or any private third party carrier policy. Further, this presentation is intended to be informative and does not supersede APA or state/provincial licensing boards' ethical guidelines and/or local, state, provincial or national regulations and/or laws. Further, Local Coverage Determination and specific health care contracts supersede the information presented. The information contained herein is meant to provide practitioners as well as health care institutions (e.g., insurance companies) involved in psychological services with the latest information available to the author regarding the issues addressed. This is a living document that can and will be revised as additional information becomes available. The ultimate responsibility of the validity, utility and application of the information contained herein lies with the individual and/or institution using this information and not with any supporting organization and/or the author of this presentation. Suggestions or changes should be directly addressed to the author. Thank you...

# Acknowledgments

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

Special thanks to the APA Practice Directorate and the AMA CPT Staff, Department of Psychology @ UNC-Wilmington, James Georgoulakis, Neil Pliskin, Pat Pimental, and AEP's Clinical and Research Staff

# Financial Support Provided

- **APA** = All expenses paid for travel (airfare & lodging) associated with CPT activities (*no salary, stipend and/or honorarium*)
- **NAN** = (from PAIO budget) applied to UNCW activities
  - 2002-2004 = \$10,000 per year – one course for two semesters teaching reduction
  - 2005 = \$5,000 per year – one course for one semester teaching reduction
  - 2006, 2007 & 2008 = \$25,000 per year – used for year round teaching reduction and partial support of university activities (e.g., work assistant graduate student)/*no salary/honorarium obtained from stipend/paid to the university directly*
  - 2009 = \$12,500 – same as above
- **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
- **AMA** = Effective 10.20.08, AMA will pay all future travel and lodging for CPT activities (*no salary, stipend and/or honorarium*)

# 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)
- ❑ *American Medical Association's Current Procedural Terminology – Editorial Panel (e)*

November 15, 2008

legend; a = appointment, fa = federal appointment, e = election; *italics implies current appointment/elected position*

# National Background

- Total Costs
  - Annually = \$2.3 Trillion (Federal = \$1.26)
  - Approximately 18% of the GNP of the US
  - 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%

# Primary Goals & General Outcomes

- **Goal (20 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 single national payor system

# 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
  - B. *Current Procedural Terminology*
  - 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

# 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
  - Daniel K. Inouye, *American Psychologist*, 1983

# 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

# **B. Current Procedural Terminology (CPT): Overview**

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

# Noridian

- Medical Director  
Dick Whitten, M.D.

- LCD Web Site

[https://www.noridianmedicare.com/p-medb/train/presentations/mental\\_health.pdf](https://www.noridianmedicare.com/p-medb/train/presentations/mental_health.pdf)  
05/01/08

# 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**

# 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: Background

- American Medical Association
  - Developed by Surgeons (& Physicians) in 1966 for Billing Purposes
  - 7,500+ 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

# 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
  - D = Add-on Codes
  - H = Performance Measures by Clinical Condition or Topic

# 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 Appointed/Voted on by HCPAC

# CPT: Applicable Codes

- Total Possible Codes = Approximately 7,500
- Possible Codes for Psychology = Approximately 40 to 60
- Sections = Five Primary Separate Sections
  - Psychiatry (e.g., mental health)
  - Biofeedback
  - Central Nervous System Assessment (testing)
  - Physical Medicine & Rehabilitation
  - Health & Behavior Assessment & Management
  - Team Conference
  - Evaluation and Management

# 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

# CPT:

## CNS Assessment Codes Timetable

- Activity x Date
  - Codes Without Cognitive Work Obtained, 1994
  - Ongoing Discussions with CMS About Lack of Work Value, 1995-2000
  - 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

# Psychiatry: Interviewing

- Psychiatry Interviewing
  - **90801**
  - One time per illness incident or bout
  - Un-timed (est. @ approximately 1.5 hours)
  - 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: 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

# Psychiatry: Intervention Information

AMA CPT Workbook, 2007

- “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 e personality growth an 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**

# 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).

# Additional Related Interventions

- Psychophysiological Therapy  
Incorporating Biofeedback **90875-76**

# 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

# 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.

# 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 interpretation 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

# 96102 Explained

*(AMA CPT Assistant, November, 2006)*

- 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 an interview. On the basis of the information gathered from the interview, the professional has selected test instruments that may be administered by a computer. The qualified health professional installs the computer program/test and instructs 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 installs the next instrument and continues as before until all tests are completed. The qualified health professional meets again with the patient in order to answer any last question about the procedures and to inform him or her about the 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 involve 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

# 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.”

# 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 gather 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 monitors 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 grater 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.”

# 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 these 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.”

# Code Usage

*(AMA CPT Assistant, November, 2006)*

- “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)

# Simultaneous Use of Professional and Technical Codes

- Currently Allowed by Medicare
  - [https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/print\\_alp.php?faq\\_array=9177,9179,9176,9180,9181,9182,9183,9178](https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/print_alp.php?faq_array=9177,9179,9176,9180,9181,9182,9183,9178)>
  - MLN Matters: MM5204 Revised, Effective December 28, 2006
  - Most conservative; modifier 59 and one test by professional

# Simultaneous Use of Testing Codes

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.

# 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)

# 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

# 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)

# Official Q & As from CMS Regarding Testing Codes

- ([https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/print\\_alp.php?faq\\_array=9177,9179,9176,9180,9181,9182,9183,9178](https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/print_alp.php?faq_array=9177,9179,9176,9180,9181,9182,9183,9178))
- Probably will not be further revised and additional concerns will be handled at the local carrier level

# 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 Qualified Health 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)

# Other Testing Codes: Developmental Testing

- Developmental 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)

# 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)

# Other Testing Codes: 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 neoplasmas
  - 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

([http://www.cms.hhs.gov/manuals/102\\_policy/bp102index.asp](http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp))

- Effective 01.01.08 96116 Will Be Available as a TeleMedicine/Telehealth Code
- 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)

# Telehealth Services

- Individual Psychotherapy
- Psychiatric Diagnostic Interviewing
- 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)

# **CPT: Health & Behavior Assessment & Management**

**(CPT Assistant, 03.04)**

**(CPT Assistant, 08.05, 15, #6, 10)**

- 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)
- **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

# H & B: CORF

[www.cms.hhs.gov/manuals/downloads/bp102c12.pdf](http://www.cms.hhs.gov/manuals/downloads/bp102c12.pdf)

- 96152 is the only psychological code for both assessment and intervention (except 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 = 8 units
- Re-assessment = 6 units
- Group = 8 units
- Intervention = 24 units

per day

# 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)**

- 99050 – Office, outside regular office hrs.
- 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
  
- *Evaluation and management codes*

# G & Related Codes

(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

# 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

# CPT: Model System

- General Areas
  - Psychiatric
  - Neurological
  - Health
- Specific Approaches
  - Individual (standard) Vs. Team (emerging)
  - Face-to-Face Vs. Telehealth

# 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*
- GN, GO, AH, etc. = local carrier specific

- Problems

- Incomplete support for modifier from 15 to 35% of documentation results in paybacks

# 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

# **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

# 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**

- General Principles
- Assessment
- Intervention

# **Documentation: General Purpose**

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

# **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

# 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; total Vs. 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: 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

# 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

# **“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](http://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 15 Minutes

(from CPT Assistant, 08.05, 11-12)

([www.cms.hhs.gov/manuals/104\\_claims/clm104c05.pdf](http://www.cms.hhs.gov/manuals/104_claims/clm104c05.pdf))

- Defining 15 Minute Increments

– 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: Quantifying for Testing

- Quantifying Time
  - Round up or down to nearest increment
  - Actual time vs. Elapsed time?
- 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

# G. Place of Service

#	Location
11	Doctor's Office
12	Patient's Home
21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
56	Psychiatric Residential
61	Inpatient Rehabilitation

# 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](http://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, neuropsych, 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
  - 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” is 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 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)

# 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)

# 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

# RVU: Acceptance

- Medicare (100% since 01.01.92)
- Medicaid = 100%
- Private Payors = 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

# RVU: Components

- *Physician Work Resource Value*
- *Practice Expense Resource Value*
- Malpractice
- Geographic (sometimes referred as the GPCI); urban higher than rural)
- Conversion Factor (approx. \$37.8975); experienced a 1% increase in July, 2008

# 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

# 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		

# 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
- 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

# Estimate of Psychologists' Value

- Psychologist .82
- Speech Pathologist .55
- Audiologist .52
- Dietician .43
- RN .42

– Goal for psychology = 1.0

# 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.

# National Work RVU/Estimated \$ 2006 Values

op=outpatient, ip=inpatient, est.=estimate rvu = work

<i>Code #</i>	<i>OP RVU</i>	<i>IP RVU</i>	<i>OP \$ est</i>	<i>IN \$est</i>
96101	2.56	2.54	97.02	96.26
96102	1.17	0.68	44.34	25.77
96103	0.74	0.70	28.04	26.53
96116	2.87	2.68	108.77	101.57
96118	3.43	2.67	129.99	101.19
96119	1.75	0.92	66.32	34.87
96120	1.27	0.70	48.13	26.53

November 15, 2008

160

# CIGNA Medicare Part B

## 2006 Fee Schedule for North Carolina (participating provider)

<b>Code #</b>	<b>OP \$</b>	<b>IP \$</b>
96101	90.08	89.42
96102	40.29	23.09
96103	25.90	24.57
96116	99.08	92.76
96118	117.72	92.42
96119	58.01	30.39
96120	43.54	24.57

November 15, 2008

161

# 2008 Average Payments

- 90801 = \$146.85
- 90806 = \$ 87.14
- 96112 = \$ 83.33
- 96118 = \$111.52
- 96152 = \$ 22.48
- 96154 = \$ 20.76

# 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

# 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](http://www.webstore.ama-assn.org)
- State Legislation
  - [www.insure.com/health/lawtool.cfm](http://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

# Evolution of Payment Practices

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

# 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 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

# Billing Problems

- 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)

# 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 verification of benefits = \$2.90

# Payment: Patient Denial Rates

(coverage denial frequency)

- Blue Cross-Blue Shield = 1.0%
- Commercial = 1.0%
- Medicare = 0.5%
- Medicaid = 5.0%
  
- Martirossov, J. (2006). *Physicians' Practice*, April 2006, page 49-52.

# Payment: Zero Pays

Delinsky, Physicians Practice, June, 2006

- 3.5 to 4% of Claims are “Zero-Pays”
  - Appear as contractual arrangement
  - Often see in specialists practice
  - Approximately 50% are typically appealable
  - 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 ,,

# Payment: Billing Model

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

# C. Fraud: Definition

- Fraud
  - Intentional
  - Pattern
- Error
  - Clerical
  - Dates

# Fraud: Types

- 26 Different Kinds of Fraud Types
- Psychological Services Have Been Identified as Problematic

# 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: Potential Recovery by Federal Government**

- Projections
  - Current
    - 14%
  - By 2011;
    - 17% (\$2.8 trillion)

# **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

# Fraud: Office of Inspector General

- Primary Problems
  - Medical Necessity (approximately \$5 billion)
  - Documentation
- Psychotherapy  
([oig.hhs.gov/reports/region5/50100068](http://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](http://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 exceeded 34%

# Fraud: Red Book (continued)

- 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)

# Private Payer Audits

- 70% of Private Payers are Auditing
- Private, Incentive Driven Companies
- Incentive Driven “whistle-blowers”

# 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

# 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)

November 15, 2008

# If Audited...

- Possible Outcomes
  - No further questions
  - Bill for overpayment
  - Request additional records
  - Discuss records
  - Schedule administrative hearing
  - Determine compliance plan
  - Schedule criminal hearing

# 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

- <http://oig.hhs.gov/publications/docs/mfcu/MFCU%202004-5.pdf>

# Part III: Challenges & Approaches

- A. National Provider 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

# B. CMS National Directive: Summary of September, 2006 Statement

- 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*

# CMS National Directive: Summary of September, 2006 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 psychologist 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: 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**

November 15, 2008

# 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

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: Ongoing Activities

- **NAN**
  - PAIC monitoring and variety of activities
  - Conference calls
  - E-mail blasts
- **CMS**
  - Vignettes Submitted to CMS in June, 2007
  - Verbal solution indicated October, 2007
  - Follow-up letters sent (e.g., May, 2007)
  - Q & A published online (CMS Medline on June, 2008)
  - Direct Interfacing with Director of Medical Director's Workgroup (Dick Whitten, M.D.) as well as CMS Medical Policy Staff Including
    - Face to face meetings
    - Conference calls
    - Development and submission of vignettes
    - Continuation of discussion about the application of testing codes
- **AMA**
  - CPT Assistant Article (November, 2006)
  - CPT Assistant Q & A (December, 2006)
  - CPT Manual- Parenthetical, preamble, and/or footnote
  - Presentation at February, 2007 AMA CPT Meeting in San Diego
- **APA**
  - Bi-Monthly Conference Calls with Psychological Test Work Group
  - Submission of Case Vignettes Along with All Possible Clinical Permutations
  - Presentation at the State Leadership Conference, APA annual conference

# 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
- Initial Application
  - Dartmouth, Duke & Michigan
  - AMA and APA Practice forming work groups
- 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 primarily comes from Hartman-Stein (APA, 2008) November 15, 2008

# Physician Quality Reporting Initiative

- Definition- A financial incentive to improve quality of health care (approx. 2%)
- 119 Measures
- Focus on measurement of process and documentation
- Application existing

# PQRI Measures

- Patients Who Have Major Depression Disorder (#106)
- Patients Who Have Major Depression Disorder Who Are Assessed for Suicide Risk (#107)
- Inquiry Regarding Tobacco Use (#114)
- Advising Smokers to Quit (#115)
- Pain Assessment Prior to Initiation of Treatment (#131)
- Screening for Cognitive Impairment (#133)
- Screening for Clinical Depression (#134)

# PQRI Example: Screening for Cognitive Impairment

- Instructions
- Numerator
- Denominator
- Rationale
- Recommendations

# 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
- Check [www.usqualitymeasures.org](http://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.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.							
1. 2.50 0.00																			
2. 3.										23. PRIOR AUTHORIZATION NUMBER									
24. A. DATE(S) OF SERVICE										F. \$ CHARGES		G. DAYS OF UNITS		H. ICD-9-CM CODE		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
From To																			
B. PLACE OF SERVICE																			
C. EMTG																			
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)																			
E. DIAGNOSIS POINTER																			
1. 07 01 08 07 01 08 11 99213 1 50 00 NPI 0123456789																			
2. 07 01 08 07 01 08 11 3048F 1 0 NPI 0123456789																			
3. 07 01 08 07 01 08 11 G8485 1 0 NPI 0123456789																			
4.																			
5.																			
6.																			
25. FEDERAL TAX I.D. NUMBER					SSN EIN		26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back)			28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE		
XX-01234567							987 54321			<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			\$ 50 00		\$		\$ 50 00		

Measure #2 November 15, 2008

## 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

# 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\\_MeasuresCode\\_s.asp](http://www.cms.hhs.gov/PQRI/15_MeasuresCode_s.asp)

# The Future: 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
  - <http://www.cms.hhs.gov/SNFPPS/downloads/cms-1545-f-display.pdf>
  - Fee Schedule Reductions
    - Anticipated 10.1% unless Congress passes a bill limiting the reduction (passed in the House, pending in the Senate)

# The Future: Medicare Changes

- Congressional Activity
  - 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 = 10.1% reduction
  - Occurred =
    - 1% raise
    - Gradual reduction of mental health disparity/copay

# The Future: 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.
- December 4, 2001 – House Energy & Commerce committee includes report language in the Medicare Regulatory, Appeals, Contracting and Education Reform 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.
- November 2003 – Practice nearly gets legislative language included in the Medicare prescription drug bill. Conference report language for the bill “directs” implementation of the January 2001 proposed rule.

# 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

# 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 provide can do per day.
- APA is contesting the pairs and the time associated.
- The idea is that two codes would be impossible to be used together (e.g., brain surgery and psychotherapy).

# MUEs & Testing

- NCCI has indicated that testing should not exceed 8 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”.

# The Future:

## 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

# The Future: 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%

# The Future: 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

# The Future: 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)

# The Future: 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
  - 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
  - (Senator Inouye's office, 11.05.07)

# The Future: Integrating Demographic and Economic Pattern Analysis with Psychological Practice IV

- December 19, 2007 a 10.1% cut was changed by Congress with a .5% increase
- Medicare Parity (?)
- Expected Cuts of Up to 20%

# The Future: 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
- 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

# New 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
  - Currently stalled in negotiations between NAN/40 & NAP
  - Working on New York state issues (NY Neuropsychology group); Meeting with state officials anticipated

# New Initiatives: New York Technicians

- Problem
- Current Status
  - As of Friday, 11.08.07 the New York Psychological Association Council voted in favor of pursuing a legislative solution that allows technicians (caveat; IQ = Masters)
- Potential Alternatives
  - National Labor Relations Law Complaint?

# Your 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

# *Final Summary*

- **Negative News**
  - Probable Minimal Increase in Reimbursement (across all health care professions)
  - Greater Transparency & Accountability (is this really negative?)
- **Positive News**
  - Much Wider Scope of Practice Reflective of Present and Emerging Practice Patterns
  - Newer Paradigms (telehealth & team)
  - Much Better Reimbursement
  - Much More Uniformity

# Economic Concerns

- Economics
  - National
    - Recession to deep recession likely
    - Depression less likely
  - Health Care
    - Stable for 6 or so months
    - Uncertain for second half of 2009
    - Probable reduction in fees based on Congressional action of 5-10% reduction

# A Summary of Approximately 20 Years: Is the End Really Near?

- Expanded from a Approximately 3-4 Codes to Over Several Dozen Codes
- 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 Both Psychology and Other Health Care Disciplines by a Significant Factor

The Future of Health Care Parity  
Has Arrived...

It is Simply Not in the Form of  
Mental Health Parity.

It Is Time for Change and Evolution  
of Psychology

# Part IV: Resources

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

# Resources (continued)

- **Payment/Coverage**
  - [www.myhealthscore.com/consumer/phyoutcptsearch.htm](http://www.myhealthscore.com/consumer/phyoutcptsearch.htm)
  - [www.cms.hhs.gov/statistics/feeforservice/default.asp](http://www.cms.hhs.gov/statistics/feeforservice/default.asp) (covered services)
  - [www.cms.hhs.gov/mcd/viewtrackingsheet.asp?id=167](http://www.cms.hhs.gov/mcd/viewtrackingsheet.asp?id=167) (non-covered)
  - [www.apa.org/pi/aging/lmrp/toolkit/homepage.html](http://www.apa.org/pi/aging/lmrp/toolkit/homepage.html) (apa lmrp)
  - [www.cms.hhs.gov/providers/mr/lmrp/asp](http://www.cms.hhs.gov/providers/mr/lmrp/asp) (medicare lmrp)
  - [www.quickfacts.census.gov/qfd](http://www.quickfacts.census.gov/qfd) (census x type of procedure data)
  - [www.usqualitymeasures.org](http://www.usqualitymeasures.org) (payment for performance)
- **LMRP Reconsideration Process**
  - [www.cms.gov/manuals/pm\\_trans/R28PIM.pdf](http://www.cms.gov/manuals/pm_trans/R28PIM.pdf)
- **Compliance Web Sites**
  - [www.oig.hhs.gov](http://www.oig.hhs.gov) (office of inspector general)
  - [www.cms.hhs.gov/manuals](http://www.cms.hhs.gov/manuals) (medicare)
  - [www.uscode.house.gov/usc.htm](http://www.uscode.house.gov/usc.htm) (united states codes)
  - [www.apa.org](http://www.apa.org) (psychologists & hipaa)
  - [www.cms.hhs.gov/hipaa](http://www.cms.hhs.gov/hipaa) (hipaa)
  - [www.hcca-info.org](http://www.hcca-info.org) (health care compliance assoc.)

# Resources (continued)

- ICD
  - [www.who.int/icd/vol1htm2003/fr-icd.htm](http://www.who.int/icd/vol1htm2003/fr-icd.htm) (who)
  - [www.cdc.gov/nchas/about/otheract/icd9/abtcd9.htm](http://www.cdc.gov/nchas/about/otheract/icd9/abtcd9.htm) (ccd)
- Coding Web Sites
  - [www.catalog.ama-assn.org/Catalog/cpt/cpt\\_search.jsp](http://www.catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp) (ama cpt)
  - [www.aapcnatl.org](http://www.aapcnatl.org) (academy of coders)
  - [www.ntis.gov/product/correct-coding](http://www.ntis.gov/product/correct-coding) (coding edits)

# AMA Contact Information

- Website
  - [www.amabookstore.com](http://www.amabookstore.com)
  - Link to;
    - [catalog.ama-assn.org/Catalog/cpt/issue\\_search.jsp](http://catalog.ama-assn.org/Catalog/cpt/issue_search.jsp)
- Telephone
  - Matt Menning
  - 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

- Univ = [www.uncw.edu/people/puente](http://www.uncw.edu/people/puente)
- Practice = [www.clinicalneuropsychology.us](http://www.clinicalneuropsychology.us)
- NAN = [www.nanonline.org/paio](http://www.nanonline.org/paio)

- E-mail

- University = puente@uncw.edu
- Practice = clinicalneuropsychology@gmail.com

- Telephone

- University = 910.962.3812
- Practice = 910.509.9371