AUDITING NEUROPSYCHOLOGICAL SERVICES:

Understanding the Complexities of the CPT System

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Acknowledgments: Organizations

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

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Support Provided

- **AMA = AMA pays travel and lodging for AMA CPT activities 2009-present (*no salary, stipend and/or honorarium; stringent conflict of interest and confidentiality guidelines*)**
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- **NAN = (from PAIO budget) Supported UNCW activities (*no salary/ honorarium obtained from stipend/paid to the university directly; conflict of interest guidelines adhered to) from 2002-2009***
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- **Stipends = 100% goes to the UNCW Department of Psychology to fund training of students in neuropsychology**

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

Personal Background (1988 – present)

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

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

Standards & Guidelines for the Practice of Psychology

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

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

CPT: Copyright

- CPT is Copyrighted by the American Medical Association
- CPT Manuals May be Ordered from the AMA at 1.800.621.8335
- www.ama-assn.org/go/cpt

Three Types of Codes

- Psychiatric/Mental Health (1970s?)
- Neuropsychological (added in 1990s)
- Health and Behavior (2000s)
- Miscellaneous
  - Preventative
  - Evaluation & Management (E & M)
  - Telehealth

Psychiatric Codes

- Neuropsychological
- Health and Behavior

Psychotherapy: History (cont.)

- Last Major Revision
  - 27 New Codes
  - 9 Code Revisions
  - 8 Code Deletions Total = 44
- Current Revision
  - 11 New Codes
  - 4 Code Revisions
  - 27 Code Deletions Total = 42

Brief Summary of Changes in Psychotherapy Codes

- Psychiatric Diagnostic Interviewing Changed
- Most Frequently Used Psychotherapy Codes Changed
- Two Major Changes
  - Time
  - Intensity

(documentation suggestions in the psychiatric interviewing and psychotherapy codes are in italics)

Time & Intensity in Psychotherapy

- Time
  - 30 Minutes
  - 45 Minutes
  - 60 Minutes
  - TBD- 90 Minutes
- Intensity
  - Standard
  - Interactive
  - Crisis

Psychiatric Diagnostic Interviewing Paradigm

Intensity
Standard Complexity
Interactive Complexity

Psychiatric Interviewing I

- Use ***90791*** to report psychiatric diagnostic evaluation, an integrated biopsychosocial assessment, including history, mental status, and recommendations. The evaluation may include communication with family or other sources, and review and ordering of diagnostic studies.
- Replaces 90801.

Psychiatric Interviewing II

90791

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

90792

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

Psychiatric Interviewing III

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

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

Psychiatric Interviewing: IV

- Includes examination of patient, exchange of information with (or in lieu of the patient other informants such as nurses or family members and preparation of report
- Re-assessments are permitted (on different days)
- Report more than once when separate interviews are conducted with the patient and informant(s)

Psychiatric Interviewing: VI

- History obtained includes;
  - Past psychiatric history
  - Chemical dependency history
  - Family history
  - Social history
  - Treatment history
  - Medical history

Psychiatric Interviewing: VII

- Additional Information Obtained;
  - Review of systems
  - Safety
  - Lethality
  - Aggression
  - Competency

Psychiatric Interviewing: VIII

- Specialty Specific Examination
  - Mental status (see prior slides from pre-2013)
- Diagnosi(e)s;
  - Psychiatric diagnosi(e)s
  - Personality considerations
  - Contributing medical factors
  - Psychosocial stressors
  - Current level of functioning

Psychiatric Interviewing: IX

- Treatment Plan
  - Consideration of medications
  - Psychotherapy
  - Tests
  - Level of Care/Supervision
- Informed Consent for Treatment Plan
- Disposition of Patient (e.g., testing)

Psychiatric Interviewing: Basic Summary

Code Number	Code Descriptor
90791	Psychiatric interviewing
90792	Psychiatric interviewing with medication management

Psychotherapy Paradigm

TYPE of PSYCHOTHERAPY		TIME of PSYCHOTHERAPY	
	Brief	*Regular*	*Extended*
Standard	30’	45’	60’
Interactive	30’	45’	60’
Crisis	30-74’	add for every additional 30’	undefined

Psychotherapy: I

- “Psychotherapy is the treatment of mental illness and behavioral disturbances in which the physician or other qualified health professional, though definitive communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavioral and encourage personality growth and development.

Psychotherapy: II

- The new psychotherapy codes is used in all settings
  - There will no longer be separate inpatient and outpatient codes
- There will no longer be codes for interactive psychotherapy
  - Instead there is a new add-on code for interactive complexity ***90785***

Psychotherapy: III

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

Psychotherapy Codes: IV

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

Psychotherapy- V

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

Psychotherapy: VI

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

Psychotherapy: VII

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

(tip = current prolonged services codes are E & M and thus not *typically* reimbursable for non-physicians)

Psychotherapy: Basic Summary

Code Number	Code Descriptor
90832	Psychotherapy, 30’ with patient and/or family member (other)
90833	Psychotherapy, 30’ with patient and/or family member (other) with E & M
90834	Psychotherapy, 45’ with patient and/or family member (other)
90836	Psychotherapy, 45’ with patient and/or family member (other) with E & M
90837	Psychotherapy, 60’ with patient and/or family member (other)
90838	Psychotherapy, 60’ with patient and/or family member (other) with E & M

Psychotherapy: Interactive Complexity I

- Interactive complexity, reported with add-on code ***90785***, refers to specific communication factors that complicate the delivery of certain psychiatric procedures (***90791, 90792, 90832 - 90838, 90853***).

(tip= significant complicating factor)

Psychotherapy: Interactive Complexity II

- "Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure. Common factors include more difficult with communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients. Typical patients are those who have third parties such as parents, guardians, other family members, interpreters language translators, agencies court officers, schools…" (AMA CPT)

Psychotherapy: Interactive Complexity III

- To report ***90785*** at least one of the following factors must be present:
  1. The need to manage maladaptive maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates the delivery of care.
  2. Caregiver emotions or behavior that interferes with the caregiver's understanding and ability to assist in the implementation of the treatment plan
  3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient or other visit participants
  4. Use of play equipment, other physical devices, interpreter or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a patient who;
     1. Is not fluent in the same language as the physician or other qualified health care professional, or
     2. Has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment or receptive skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication

  (tip = time is determined by original base code)

Psychotherapy: Interactive Complexity IV

- May involve family, guardians or significant others instead of pt.
- May be reported more than once if more than one diagnostic evaluation is conducted.
- The service is reported only once per day.

Psychotherapy: Crisis (I)

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

Psychotherapy: Crisis (II)

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

Psychotherapy: Crisis (III)

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

Psychotherapy: Crisis (IV)

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

Psychotherapy: Non-Patient

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

(See Chapter 1, section 70.1 of the *Medicare National Coverage Determinations Manual*, Pub. 100-03 for discussion on caregivers; K. Bryant, CMS, undated)

Other Psychotherapy: Basic Summary

Code Number	Code Descriptor
90839	Psychotherapy for crisis, first 60’
90840	…crisis for each additional 30’
90845	Psychoanalysis
90846	Family psychotherapy (without patient)
90847	Family psychotherapy (with patient)
90849	Multiple family psychotherapy
90853	Group psychotherapy
90863	Pharmacologic management when performed with psychotherapy

Psychotherapy: Payment I

- page 69090 of the CY 2013 Medicare Physician Fee Schedule Final Rule with Comment Period (77 Fed. Reg. 68892 (Nov. 16, 2012)). http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf

Psychotherapy: Payment II

- Individual Therapy
  - Estimated 1-5% reduction
- Group/Family
  - 10-20+ % reduction

Psychotherapy: Summary

Interview
90791/90792

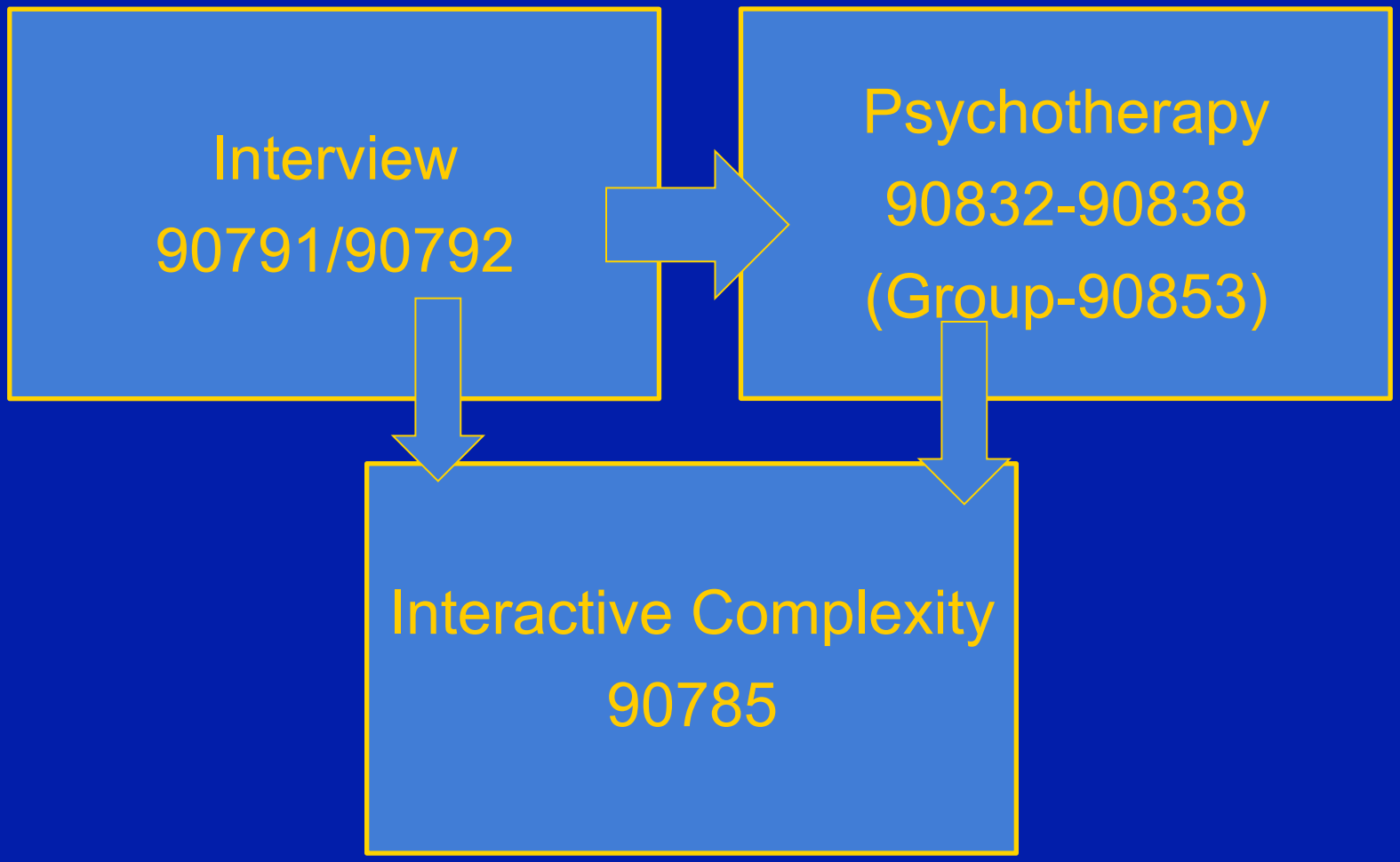
Psychotherapy
90832-90838

Crisis Therapy
90839-90840

Interactive Complexity
90785

Psychopharm Management

Dx X Rx x Complexity



New Interventions

Crisis Therapy
90839-90840

Psychopharm
Management

Psychotherapy: Reporting I

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

Psychotherapy: Reporting II

Service	*Psychotherapy for Crisis*	*Family Psychotherapy*	*Group Psychotherapy*	*Pharmacologic Management (same day psychotherapy)*	*Other Psychiatric Services*
Codes	90839, 90840	90846, 90847	90853	90863	90845, 90849, 90865-90899
Explanation		With or without patient present	Does not include a multiple-family group	Add-on code in conjunction with psychotherapy service; may report ONLY by physicians or other qualified healthcare professionals who may NOT report E/M	Psychoanalysis, multiple-family group psychotherapy, narcosynthesis, TMS, ECT, biofeedback with psychotherapy, hypnotherapy, environmental intervention, evaluation of records, interpretation or results, preparation of report, unlisted psychiatric procedure
Reportable same day			90785	Primary procedure: 90832, 90834, or 90837	
NOT reportable on same day	90832, 90834, 90837, 90785, 90791, 90792				

Psychotherapy- Incident to

- Incident to may be feasible assuming the psychologist provides direction and is regularly (undefined) 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).

Emerging Issues with New Psychotherapy Codes

- 60 Minutes
  - Pre-authorization required by some companies
  - Does not equal previous 45’ code
- 90 Minutes
  - In E & M section, hence CMS is not covering
  - Examination of a 90’ code
  - Other carriers may

Neuropsychological (and psychological testing)

- Psychiatric
- Health and Behavior

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

Reporting Testing Codes

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

(CPT Changes: An insider's view, 2011)

Neurobehavioral Status Exam

(01.01.06; Revised 02.09.07; Implemented 01.01.08)

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

96116 Explained

(*AMA CPT Assistant*, November, 2006)

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

Neuropsychological Testing: By Professional

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

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

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

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

96118 Explained

(*AMA CPT Assistant*, November, 2006)

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

96118 Applications

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

(not to be used as a treatment basedcode)

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."

Computerized Testing

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

Computerized Testing: Use by Physicians

- 96103
  - Neurologists = 27%
  - Family Physicians/Internal Medicine = 22%
- 96120
  - Neurologists = 47 %

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 thee 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."

Tests Performed by Technicians & Computers

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

ID 9176, Created 06/17/2008, 11:21 am; Last updated 06/09/2009 01:41PM

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>
  - MLN Matters: MM5204 Revised, Effective December 28, 2006
  - Most conservative; modifier 59 and one test by professional

Psychological & Neuropsychological Testing Codes:

Use of Professional and Technical/Computer Codes

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

Simultaneous Use of Testing Codes

1. When the provider administers at least one of the tests, then pre-existing problems with the simultaneous use of two testing codes do not apply (Niles Rosen, M.D., NCCI, Personal Communication, November, 2009)
2. When the professional and the technical services are not provided on the same date.

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)

Information of The Use of Two Testing Codes: I

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

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

Two Testing Codes: II

- Our answer ID #9180 is yes. If several different, clinically appropriate tests are administered on the same date to the same patient (whether by a physician/ psychologist, technician or by computer), then the appropriate testing codes for psychological testing or neuropsychological testing can be billed together. More than one code can also be billed when several distinct tests are administered to the same patient on the same date of service via technician (96102/96119) or computer (96103/96120), and the physician/psychologist needs to integrate the separate interpretations and written reports for each of these tests into a comprehensive report.

Two Testing Codes: III

- Additionally, the American Medical Association (AMA) provides further guidance for billing CPT codes in the code descriptors. Accordingly, the descriptors for CPT codes 96101 and 96118 and, the parentheticals that follow these codes provide further instruction as to how to use these codes when additional time is necessary for the physician/psychologist to integrate separate interpretations into a comprehensive report.

Two Testing Codes: IV

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

- CMS Response: Yes, CPT code 96101 and 96118 can be billed for the integration of separate reports of tests administered by the technician. But, the CPT code descriptor advises that the interpretation of these reports/ results should have already been completed and the time used by the psychologist/physician to interpret the tests administered by the technician may not also be billed under CPT codes 96101 and 96118. Specifically, the parentheticals under CPT codes 96101 and 96118 provide AMA guidance that these codes can be used in those circumstances where additional time is necessary to integrate other sources of clinical data, including previously reported technician- and computer-administered tests

Two Testing Codes: V

•2. When the technician administers test and bills the amount of time it took to do so with 96119, may the time spent by physician / psychologist interpreting and writing the report on those technician-administered tests be added to the time billed as technician time?

•CMS Response: No. The time spent for interpreting and writing the report cannot be added and billed as technician time. The AMA guidance under the descriptors for CPT codes 96102 and 96119 both state that the technician-administered testing includes the qualified health care professional's interpretation and report.

Take Away Message on the Use of Two or More Testing Codes

- Bill for techs what techs do, period.
- Bill for professionals what professionals do, period (this includes “integrate separate interpretations into a comprehensive report”)
- You CAN bill for both sets of codes together.

96111 & 96119 and Medicaid

- Polling of allowing the use of technician code with state Medicaid systems indicated;
  - Npsych listserv informal survey
  - September, 2013
  - Approximately 2/3rds of states were represented
  - Approximately 1/3rd accepted technician code

Simultaneous Use of 90801 and 96116

- Under No Circumstances are the Psychiatric (90801) and Neurobehavioral Status Examination (96116) are to be Used Simultaneously

G & Related Codes: Health Behavior Screening

(psychologists are urged to use H & B codes)

- Tobacco Cessation
  - 99406 - 3-10 minutes
  - 99407 - greater than 10 minutes
- G0137
  - Training and educational services related to the care and treatment of patient's disabling mental health problem, per session (45 or more minutes)
- G0396 (99408)
  - Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, DAST) and brief intervention, 15-30 minutes
- G0397 (99409)
  - Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, DAST) and brief intervention, greater than 30 minutes
  - (NOTE: H & B codes should not be reported on the same day of service as these codes)

Shifting Codes

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

A Sample Coding Model

Psychiatric	**Neuropsych**	**Health Psych**
Diagnosis DSM	*Diagnosis* ICD	*Diagnosis* ICD
Interview 90837	*Interview* 96116	*Interview* 96150
Testing 96101	*Testing* 96118	*Testing* 96150
Therapy 90837	*Rehab* 96152	*Rehab* 96152

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

Diagnosing

- Billing Diagnosis
  - Based on the referral question
  - What was pursued as a function of the evaluation
- Clinical Diagnosis
  - What was concluded based on the results of the evaluation
  - May not be the same as the billing or original working diagnosis

International Classification of Diseases

- Present
  - ICD-9-CM (Clinical Modification)
  - Since 1978
- Future
  - ICD-10-CM (Clinical Modification)
  - ICD-10-PCS (Inpatient Procedures)
  - Start date – October 1, 2013 (DELAYED to 10.01.2014)
  - Except auto insurance & disability cases

Medical Necessity

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

Medically Reasonable and Necessary

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

- "Services which are reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member"
- Re-evaluation should only occur when there is a potential change in;
  - Diagnosis
  - Symptoms

Simple Explanation of Medical Necessity and Eventual Coverage

Existence of Evidence
for
Therapeutic Decision Making

(*will it make a difference?*)

Documentation

- History
- General Principles
- Assessment
- Intervention

Electronic Health Records

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

Promotion of EHR

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

Documentation: History (www.cms.hhs.gov/medlearn/emdoc.asp)

- Began with in February, 1988 with development of Evaluation and Management codes (published in 1992)
- Formalized with the 1995 & 1997 Medicare Documentation Guidelines

Documentation: General Purpose

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

Documentation: Basic Components

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

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time

Documentation: General Principles

- Rationale for Service
- Procedure
- Results/Progress
- Impression and/or Diagnosis
- Plan for Care/Disposition
- If Applicable, Time
- Date and Identity of Observer

Documentation: Basic Information

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

Documentation: Chief Complaint

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

Documentation: Present Illness

- Symptoms
  - Location, Quality, Severity, Duration, timing, Context, Modifying Factors Associated Signs
- Follow-up
  - Changes in Condition
  - Compliance

Documentation: Assessment

- Identifying Information
- Reason for Service
- Dates
- Time (amount of service time; total Vs. actual)
- Identity of Tester (technician?)
- Tests and Protocols (included editions)
- Narrative of Results
- Impression(s) or Diagnosis(es)
- Disposition

Documentation: "Assessment" Based on New Interpretation of Codes

- Technical Component
  - Label
    - Testing by Technician
  - Information
    - Individual Tests
    - Numerical
    - Basic Qualitative
- Professional Component
  - Label
    - Examples; Integration of Findings, Testing by Professional
  - Interpretation
    - Integration of findings which may include history, prior records, interview(s), and compilation of tests

Documentation: Intervention

- Identifying Information
- Reason for Service
- Date
- Time (face-to-face time; actual)
- Status of Patient
- Intervention Performed
- Results Obtained
- Impression(s) or Diagnosi(e)s
- Disposition

Documentation: Therapy

- Reason
  - Acute = Improvement of health status
  - Chronic = Stabilization of health status
- Treatment
  - Method
  - Target Symptoms
  - Results
  - Time Start/Stop
  - Capacity to Participate
- Other
  - Time
  - Observer
  - Name of Patient
  - Date

Documentation: H & B Codes

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

Documentation: H & B Assessment

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

Documentation: H & B Intervention

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

Documentation: E & M Codes

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

Documentation: CPT X Report

- Each CPT Code Should Generate a Separate Report (or at least a separate section)
- If Separate Sections Within One Report, Clearly Label/Title Sections of the Report to Match Code Used (e.g., Neuropsychological Testing by Technician)

Documentation: Suggestions

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

Records Retention

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

Red Flag Rule

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

Time

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

Time: Conceptual

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

Time (continued)

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

Recent Interpretations of Time

- Non face-to-face time (pre and post) sometimes is not included in the measurement of billed time but it has been included in calculating total work of the service during the survey process.
- A unit of time is obtained when the mid-point has passed.
- When a time service is reported along with a non-timed service, the two are not added.

Time Interpreted

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

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

Time Across Days

- “If a continuous service was provided, report all units as performed on the date that the service was started”
- However, a disruption in service creates a new initial service.

"Missed" Time Section 20.3.1.

- Billing for Services That Were Not Provided" is Fraud
- The Patient Possibly Could be Billed for Missed Appointment (not for missed service), Assuming a Contractual Relationship and Understanding Has Been Previously Established

Time: Definition

(CPT Assistant, 08.05, 15, #8, pg. 12)
(www.cms.hhs.gov/providers/therapy)

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

Time: Defining Non-Face-to-Face Time

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

- development and maintenance of a comprehensive care plan.

Time: Defining 60 Minutes

"The Rounding Rule"

- 1 unit > or equal to 31 minutes to < 91 minutes
- 2 units > or equal to 91 minutes to < 151 mns.
- 3 units > or equal to 151 minutes to < 211s mns.
- 4 units > or equal to 271 minutes to < 331 mns.
- And so on…

Location of Time

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

Time: Quantifying for Testing

- Quantifying Time
  - Round up or down to nearest increment
  - **Actual time** not elapsed time (I.e., start/stop times)
- Time Does Not Include
  - Patient completing tests, scales, forms, etc.
  - Waiting time by patient
  - Typing of reports
  - Non-Professional (e.g., clerical) time
  - Literature searches, learning new techniques, etc.

Time: Suggestions for Documentation

- Therapy
  - Minimum: Date(s) Total Time Elapsed
  - Maximum: Date(s) Start and Stop Times
- Testing
  - Minimum: Date(s) & Total Time Elapsed
  - Maximum: Date(s) Start and Stop Times
- Backup
  - Scheduling System (e.g., schedule book; agenda, etc.)
  - Testing Sheet with Lists of Tests with Start/Stop Times
  - Keep Time Information as Long as Records Are Kept

Time: Potential Limitations

Therapy

- Individual = 1
- Group = 8

Interview: 4 units (if timed)

Testing

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

H & B

- 4

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: Federal Government's Definition

- DM & S Supplement, MP-5, Part I
  - Authority: 38 U.S.C. 4105
  - Appendix 17A Change 43
  - Psychology Technician GS-181-5/7/9
- Definition
  - Bachelor's degree from accredited college/ university with a major in appropriate social or biological sciences (+ 12 psy. hours)

Technician: NAN's Definition

- Approved by NAN Board of Directors
  - 08.2006
- Archives of Clinical Neuropsychology-
  - 2006 (e.g., Puente, et al)

Technician: NAN's Definition Explained

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

Technicians: Application

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

Technicians: Interfacing with Professionals

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

NOTE: Pattern similar to medical and other health providers

Students as Technicians

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

Students as Technicians

- This is from the Medicare Benefit Policy Manual, Chapter 15, Section 80.2 :
- Payment and Billing Guidelines for Psychological and Neuropsychological Tests
- The technician and computer CPT codes for psychological and neuropsychological tests include practice expense, malpractice expense and professional work relative value units. Accordingly, CPT psychological test code 96101 should not be paid when billed for the same tests or services performed under psychological test codes 96102 or 96103. CPT neuropsychological test code 96118 should not be paid when billed for the same tests or services performed under neuropsychological test codes 96119 or 96120. However, CPT codes 96101 and 96118 can be paid separately on the rare occasion when billed on the same date of service for different and separate tests from 96102, 96103, 96119 and 96120.

Students as Techs (cont.)

- Under the physician fee schedule, there is no payment for services performed by students or trainees. Accordingly, Medicare does not pay for services represented by CPT codes96102 and 96119 when performed by a student or a trainee. However, the presence of a student or a trainee while the test is being administered does not prevent a physician, CP, IPP, NP, CNS or PA from performing and being paid for the psychological test under 96102 or the neuropsychological test under 96119.

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: 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"

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

A Coding Model

Psychiatric	Neuropsych	Health Psych
DSM	ICD	ICD
Interview 90801	Interview 96116	Interview 96150
Testing 96101	Testing 96118	Testing 96150
Therapy e.g., 90806	Rehab e.g., 96152	Rehab e.g., 96152

Current Payment Problems

- Continued challenges with compliance officers relative to the use of professional and technical testing codes on the same day
- Confusion on how to bill feedback activity

Fraud: Definition

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

Safeguarding Program Integrity
(*CPT Assistant*, 11.10, *20*, #11, 7-10)

- 11.09- President Obama signed Executive Order calling for reduction of improper payments
- 03.10, President Obama announced expansion of recovery audits & broadens authority of federal agencies for audits
- CMS refocuses efforts (Peter Budetti)
- PPACA contains program integrity provisions

Fraud: Medicare's Interpretation of Physician Liability

- Overpayment From Incorrect Charge
- Mathematical or Clerical Error
- Billing for Items Known Not to be Covered
- Services Provided by Non-qualified Practitioner
- Inappropriate Documentation

Federal Definition of Fraud (*AMA CPT Assistant*, 2010, *20*, 2)

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

Fraud: Types

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

Fraud: Potential Recovery by Federal Government

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

Fraud: Office of Inspector General 2005 Orange Book

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

Fraud: Office of Inspector General

- Primary Problems
  - Medical Necessity (approximately $5 billion)
  - Documentation
- Psychotherapy (oig.hhs/gov/reports/region5/50100068)
  - Individual
  - Group
  - # of Hours
  - Who Does the Therapy
- Psychological Testing
  - # of Hours
  - Documentation

Fraud (continued)

- Nursing Homes
  - Identification
  - Overuse of Services
- Children

Fraud: OIG's May 2001 Study Involving Psychology

OEI-03-99-00130

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

Currently, 7-14% of all reimbursements

- Inappropriate Outpatient Mental Health
- "Particularly Problematic" due to
  - Medically unnecessary
  - Billed incorrectly
  - Rendered by unqualified providers
  - Undocumented or poorly documented

OIG Report (continued)

- Provider Not Qualified = 11%
- Medically Unnecessary = 23%
- Billed Incorrectly = 41%
- Insufficient Documentation = 65%

Fraud: Review History (10 years)

- Initial Review (14 points of submitted claims)
  - Legibility
  - Coverage
  - Matching dates
  - Signature
- Subsequent Review (occurs if over 5-6 items are failed in initial review)
  - Does the service affect a potential change in medical condition?

Fraud: CERT Program

www.oig.hhs.gov

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

Fraud: New Information

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

(Note: In August 27, 2007, Report on Medicare Compliance stated that "Federal Court Orders Government to Pay Doctor's Legal Fees for Frivolous Prosecution"

Fraud: New Information (cont.)

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

Fraud: 2006 Red Book

- Section 1862(a)(1)(A) of the Social Security Practice Act requires all services to be reasonable and necessary for the diagnosis or treatment of an illness or injury.
- Claim errors have exceed 34%

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)

From 1996, 2001 to 2007

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

Total Estimates = $718 million

RAC: Audit Review

(no reviews prior to 10.01.07)

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

(in place by 2010 based on Section 302 of the Tax Relief and Health Care Act of 2006)

Economic Audits
RAC Vs. CERT

- CERT
  - Contract performance
- RAC
  - Past payment review (may be peer review)

Recovery Audit Contractor

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

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

- Cost- 20 cents for each dollar recovered

RAC: continued

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

RAC Appeals

- Appeals possible
- 22.5% were appealed
- 34% in favor of providers

RAC

(*The National Psychologist*, 02.11, pg. 7)

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

RAC

(*CPT Assistant*, November 2010, pgs. 10-11)

- Purpose
  - "Identify overpayments and underpayments:
- Current Focus
  - Diagnosis related groups (DRGs)
  - Coding errors
  - Medical Necessity
- Prevention
  - Internal assessment
  - Proper justification and documentation
  - Codes should match procedure

Private Payer Audits

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

Potential Overpayment Law

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

Privacy Audits: HIPAA Compliance

- Effective Date
  - July, 2012
- Company
  - $9 million to KPMG
- Method
  - 20 protocols
  - 10 business days to respond

Fraud: Voluntary Compliance

D. Raisin-Waters, APA, 2005 & 2008

- Address Risk or Problematic Areas (e.g., denied claims)
- Develop a Compliance Program (with designated individual, written plan, etc.)

Fraud: Voluntary Compliance

D. Raisin-Waters, APA, 2005

- Address Risk or Problematic Areas (e.g., denied claims)
- Develop a Compliance Program (with designated individual, written plan, etc.)

Common Billing Mistakes

* Billing Medicare for trainees' work
* Billing tech non-face-to-face time
* Billing units on expected/anticipated time rather that based actual time
* Billing units of testing that include testing AND interview
* Billing for an interview code but not differential documenting the service
* Billing units of testing that include time that patient was not in office

Individual and Small Group Practice Compliance Guidance

(Raisin-Waters, 2008)

Seven Elements OIG determined fundamental:

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

(continued)

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

Self-Auditing and Monitoring

(Raisin-Waters, 2008)

OIG recommendations:

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

OIG recommendations (continued)

- Claims Submission Audit

  -review of bills and medical records

  -can be retrospective or concurrent with claims submissions

  -look for accurate coding, complete documentation, medical necessity

  -identify the practice's risk areas

Decreasing Audit Potential
(*CPT Assistant*, 11.10, *20*, #11, 10)

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

Decreasing Audit Potentials

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

Increasing Probability of Successful Audits

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

If Audited…

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

Audit Insurance

- Terms
  - Investigation, regulatory cyber liability, "medefense"
- Coverage
  - Will not cover over/underpayment
  - Will pay for legal fees
  - Some will pay fines and fees

Fraud: Effects on Abuse on Clinical Services and Outcomes

(Becker, Kessler & McClellan, 2004)

- Increased enforcement results in;
  - Lower billings
  - No adverse consequences

Fraud: Web Site

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

Malpractice Claims
(*New England Journal of Medicine*, 2011)

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

HIPAA Compliance

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

www.aasn.org.go/5010

Physician Quality Reporting Initiative

- Definition- A financial incentive to improve quality of health care (approx. 2%)
- Began 2011. Need to register by 10.18.13
- If not participating by 2015, a 1.5% penalty being raised to 2%
- 166 Measures
- Focus on measurement of process and documentation

PQRS Measures

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

PQRI Example: Screening for Cognitive Impairment

- Instructions
- Numerator
- Denominator
- Rationale
- Recommendations

Staging of Dementia

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

Cognitive Assessment

Numerator	**Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period. Cognition can be assessed by direct examination of the patient using one of a number of instruments, including several originally developed and validated for screening purposes. Formal neuropsychological assessment also satisfies this requirement.**	
QDC	CPT II 1494F	**Cognition assessed and reviewed**
	1494F with 1P:	**Documentation of medical reason(s) for not assessing and reviewing cognition**
	1494F with 2P	**Documentation of patient reason(s) for not assessing and reviewing cognition**
	1494F with 8P:	**Cognition not assessed and reviewed, reason not otherwise specified**

Functional Assessment

Numerator	**Patients for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period. Functional status can be assessed by direct examination of the patient or knowledgeable informant. An assessment of functional status should include, at a minimum, an evaluation of the patient's ability to perform instrumental activities of daily living (IADL) and basic activities of daily living (ADL).**	
QDC	CPT II 1175F	**Functional status for dementia assessed and results reviewed**
	1175F with 1P	**Documentation of medical reason(s) for not assessing and reviewing functional status for dementia**
	1175F with 8P	**Functional status for dementia not assessed and results not reviewed, reason not otherwise specified**

Neuropsychiatric Symptom Assessment

Numerator	Neuropsychiatric symptoms can be assessed by direct examination of the patient or knowledgeable informant.	
QDC	CPT II 1181F	Neuropsychiatric symptoms assessed and results reviewed
	1181F with 8P	Neuropsychiatric symptoms not assessed and results not reviewed, reason not otherwise specified

Neuropsychiatric Symptoms: Management

Numerator	Patients who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period. (Note: (One G-code [G8947] & one CPT II code are required on the claim form to submit this numerator option)	
G-Code	G8947	One or more neuropsychiatric symptoms
	G8948	No neuropsychiatric symptoms
QDC	CPT II 4525F	Neuropsychiatric intervention ordered
	CPT II 4526F	Neuropsychiatric intervention received
	4525F with 8P	Neuropsychiatric Intervention not ordered, reason not otherwise specified
	4526F with 8P	Neuropsychiatric Intervention not received, reason not otherwise specified

Screening for Depression

Numerator	Patients who were screened for depressive symptoms within a 12 month period	
QDC	CPT II 3725F	Screening for depression performed
	3725F with 8P	Screening for depression not performed, reason not otherwise specified

Pay for Performance Status

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

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_MeasuresCodes.asp

Status of PQRS

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

Health Care Bill:

How Health Care Will Be Revolutionized by 2018

Bill:

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

Timetable:

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

(also, www.healthcare.gov)

Specifics of Health Care Reform

- Reducing Fraud
  - Community Mental Health Centers
  - Prepayment Review
  - Increase funding for fraud, waste & abuse
- Medicare
  - Disproportionate payment to hospitals
  - Imaging
  - Physician ownership referral
- Medicaid
  - Disproportionate payment to hospitals
  - Primary Care Providers

Past & Future

Activity	Current	Future
Reimbursement Base	Service	Outcome
Reimbursement Direction	Singular	Bundled
Location of Service	Inpatient	Outpatient (e.g., home)
Provider Approach	Silo	Integrated
Numbers	Volume	Limited (& targeted)
Patient Approach	Standardized	Personalized
Foundation of Service	Experience based	Empirically based
Location of Patient	Independent	**Health Care Home/ Neighborhood**

Final Summary

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

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

Ongoing & Upcoming Activities

- Surveying of Existing Codes (spring 2013)
  - Crisis
  - Interactive Complexity
  - Psychopharmacologic Management
- Reviewing of New Codes by CMS (fall 2013)
- Development of New Codes (2014)
  - Prolonged Psychotherapy (one)
  - Testing Feedback (one); or resolve the use of 96118 for feedback for some carriers
  - Coordination of Care for Integrated Care (several)
- Revision of Existing Codes (2014)
  - G or Prevention Codes
  - Health and Behavior
    - Possibly addressing non-face-to-face
    - Definitely re-surveying the existing codes

Tsunami of Change

- Expected to Change
  - Reimbursement System
  - National Heath Care Policy
  - Diagnostic System
- Timetable of Change
  - New Codes next 5 years
  - New System thereafter

Tsunami Explained: Present Paradigms

- Comprehensive
- Uniformity
- Transparency
- Documentation
- Integrative
- Performance

Tsunami Explained: Emerging Patterns

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

Tsunami Explained: Future Paradigms

- Traditional Paradigms
  - Yearly reduction of 1-5% for foreseeable future
  - Traditional practice will be unsustainable by 2020
- New Paradigms
  - Boutique and niche services (24/7) vs. high volume
  - Prevention
  - Interface with other industries (e.g., legal, industrial, sports)
  - Encounter based care will be disappear
  - Integrative & multi-disciplinary (geographic or virtual); from medical homes to health neighborhoods

Puente Contact Information

- Websites
  - Coding= www.psychologycoding.com
  - Univ = www.uncw.edu/people/puente
  - PDFs, etc. = www.antonioepuente.com
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