Nicole Owings-Fonner: Welcome to our new webinar series entitled “Getting Reimbursed: Updates on Billing and Documentation for Psychological and Neuropsychological Testing”. My name is Nicole Owings-Fonner and I'm in the Communications department here at APA. This webinar is a little bit different than some of our other webinars in that we're not airing it live and we are dividing the content into sections that will be more manageable for you to view, watch, and find exactly what you're looking for. This series will present... be presented by Dr. Jared Skillings and additional APA staff, Dr. Antonio Puente, Dr. Neil Pliskin, Dr. Steven Gillaspy, and Dr. Michael Westerveld.

Our objectives for this series are to provide you with an update on APA Services, Inc.’s advocacy efforts related to testing codes, to briefly review the testing codes and definitions, to address major billing and documentation developments. We'll also discuss how to document your work and demonstrate how to apply the new codes using expanded practical examples. Lastly, our experts will provide responses to the most frequently asked questions that you've submitted.

And now we have Meghann Dugan-Haas, who is a coding and payment policy officer here at APA; she's going to provide us with updates and guidance on billing and coding issues. Go ahead, Meghann.

Meghann Dugan-Haas: Thank you, Nicole, and hello, everyone – thank you for joining us. Today, we will be providing an update on billing and coding issues affecting the new testing codes that we have frequently... frequently received questions about from members since January 1. Two of those issues include the new base / add-on code structure and how to utilize them properly to report the services you provide. Depicted here is a base code for testing evaluation services and, as you can see, it is comprised of three individual parts. The first part is the pre-service work: these are activities that you perform prior to the patient arriving such as preliminary test selection, reviewing your records, or contacting the referring physician to ascertain their questions that you will be addressing during the evaluation. The second part is the intra-service work: this includes the majority of the work involved in providing the overall service. It is here where you spend the most amount of your time and effort, which is why this part is much larger than those on either other side. And finally, the third part is the post-service work, which are the activities that you perform after the service is complete and the patient has left. This includes transcription, report distribution to the referring physician, and arrangement for any additional referrals. Next slide...

So, first we will cover the base and add-on code structure – which is an entirely new structure for the profession – and then we will discuss and utilize those codes properly to report the services you provide. Depicted here is a base code for testing evaluation services and, as you can see, it is comprised of three individual parts. The first part is the pre-service work: these are activities that you perform prior to the patient arriving such as preliminary test selection, reviewing your records, or contacting the referring physician to ascertain their questions that you will be addressing during the evaluation. The second part is the intra-service work: this includes the majority of the work involved in providing the overall service. It is here where you spend the most amount of your time and effort, which is why this part is much larger than those on either other side. And finally, the third part is the post-service work, which are the activities that you perform after the service is complete and the patient has left. This includes transcription, report distribution to the referring physician, and arrangement for any additional referrals. Next slide...

One question that we frequently receive is, “Why am I being paid less for my subsequent 30 minutes or hour of work if I'm doing the same amount of work for the entirety of the service?” Let me begin by saying that it does not have anything to do with your time being any less valuable. It is inherent in all base and add on code pairs across all specialties that the base code will have a higher RVU value than its corresponding add-on code. Going back to how each CPT code is made up of three parts, the activities included in the pre- and post-service work are allocated there because they are activities that you will always only perform once. Further, if you think of it in terms of the total RVU value for a service being broken up into three parts, the value of the intra-service part is much higher than that of the pre- and intra-service; therefore when the value of the pre- and post- is removed – as it is with the add-on codes – the overall value of the code is decreased. In the case of the testing codes, the intra-service activities can be performed multiple times, therefore can be billed multiple times using an add-on code. Next slide...

Next, we're going to discuss how to bill for testing code services that occur over multiple dates of service. It is typical for psychologists and neuropsychologists to provide testing evaluation services or test administration and scoring services
over multiple days. This could include multiple test sessions with scoring, non-face-to-face time engaged in professional services, and interactive feedback. When a service is spread out over multiple visits, the total cumulative time spent performing each service and the evaluation process—which includes the clinical and diagnostic interview, the testing evaluation services, and the test administration and scoring services—should all be reported at the completion of the entire episode of care. At that time, a single bill should list both base and add-on codes with the different dates of service linked to the entire episode. A single base code should only be submitted for the first unit of each type of service for the evaluation and only add-on codes should be used to capture subsequent units of service on same or different days. The episode of care concludes when the evaluation report is complete; later in the presentation, our presenters will provide expanded case examples as well as provide examples of what a completed CMS 1500 claim form should look like at the end of each episode of care. Next slide...

So, I’m going to provide a quick overview on the National Correct Coding Initiative or NCCI program. This program is overseen by the Centers for Medicaid and Medicare Services for the purposes of promoting national correct coding methodologies, controlling improper coding that can lead to improper payment of claims. There are three types of NCCI edits, all of which are incorporated directly into the claims processing system for federal and some commercial plans. The first are Procedure to Procedure or P2P edits and those prevents improper payments when there are code pairs or code combinations that should not be reported together; they are also referred to as Column 1 / Column 2 Edits. MUEs or Medically Unlikely Edits help to prevent improper payments when services are reported with incorrect units of service. And then there are Add-On Codes; these prevent add-on codes from being billed without their primary base code service. Next slide...

With the implementation of the new testing codes on January 1, psychologists and neuropsychologists started to encounter billing issues and problems related to NCCI edits. The first one was an edit that did not allow the provider and the technician to provide test administration and scoring services to the same patient on the same date of service. The second involved add-on code edits that prohibited the ability for providers to bill for evaluations that took place over multiple dates of service. With the test administration and scoring services, as you know, they are now broken up to allow for the professional or the psychologist or neuropsychologist to bill for the services as well as the technician to have their own codes to bill for those. If professional and technician services are billed on the same date of service and CPT codes nine six one three six (96136) and nine six one three eight (96138) are billed on the same day of service, NCCI edits were in place that did not allow for those services or those claims to be paid. APA has successfully resolved this issue and now, moving forward, you will have to bill the services using one of the following modifiers: either modifier 59 or modifier XE. Now, it's dependent upon the specific situation of your patient as to whether you... you will use the modifier 59 or the XE. In circumstances where the patient stays in the office and there is a hand-off between the provider starting the testing and test administration services and then immediately handing off the testing to the technician, then you would bill the services using a modifier 59, which would be appended to the nine six one three eight (96138) or the technician code. However, if there is a case where the patient comes in and the physician begins the testing services and then the patient leaves the office and comes back and the technician then picks up with the test administration and scoring, then in that case you would have to bill nine six one three eight (96138) with the XE modifier appended. And again, later in the presentation our presenters will go through a case example in which both of these scenarios take place and then they will show you a claim form that has the appropriate modifiers appended in each situation.

Next is our issue of the add-on code edits. As I discussed earlier, it is typical for psychologists and neuropsychologists to provide testing evaluation services or test administration and scoring services over multiple dates of service. This could include multiple testing sessions, non-face-to-face time engaged in professional services, and interactive feedback. Upon implementation of the new testing code set on January 1, there were several add-on code edits that were also implemented and prohibited the ability for psychologists and neuropsychologists to bill for assessments that took place over multiple dates of service. The codes affected are the four base / add-on code pairs that are listed here on the slide. In general, add-on codes describe a service that are always billed in conjunction with their primary service or base code. Therefore, if an add-on code is billed with a different date of service, then the edit that is in place causes the claim to automatically deny. Next slide...
Through APA’s advocacy efforts on behalf of the profession, we worked with NCCI to provide them with numerous resources to show that, although the structure of the codes changed on January 1, there was no change to the typical practice patterns for how these services are provided over multiple dates of service. Depicted here on the screen is the April 1st NCCI change report listing the codes that were previously affected, but as of April 1st have been suspended and are retroactive to January 1. It is important to note that each payer handles NCCI different edits differently. It is APA’s recommendation that providers resubmit claims for the services that took place during the first three months of the year between January 1st and March 31st for reprocessing if desired.