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.

In this section, Dr. Stephen Gillaspy and Dr. Michael Westerveld will walk us through some psychological assessment expanded clinical examples. Dr. Gillaspy is first going to walk us through some introductory information.

Dr. Stephen Gillaspy: Here we lay out our five psychological assessment stages. This is really just a framework that we think is beneficial for practitioners to think about the different things that they’re doing: the different components of an assessment and it also makes it a little bit easier for us to talk about the difference between test administration, integration, and report generation. So, I'm going to walk you through that.

In stage one, it’s really more about the record review and clarifying the referral question - when you get a referral in from a provider and when you start to... start to think about what's going to be the initial test selection in order to address the referral question. So, that's... we think of that as stage 1. Stage 2 is where you would perform your psychiatric diagnostic evaluation and again, at the end of that you're going to be thinking about, based off the referral question and the results of the diagnostic interview, start thinking about how you... how you might want to modify the initial test selection based on your interview findings after stage 2. That really takes you to stage 3, which is test administration and scoring. So, the actual administration of all the different tests: psychological tests that you're going to administer, scoring that, and organizing all that information. Stage 4 gets you into the integration where you're going to be synthesizing all that information, not only from the diagnostic interview information you got from the referral source - all the information from the testing that you performed; you integrate that into your report. And then stage 5 is going to be the feedback session and again where you're going to give feedback to the patient and family as well as feedback to the referring physician or whatever the referral source might have been.

Dr. Michael Westerveld: All right, so this is one of the case examples we're going to use to show the use of the psychological testing codes. This is a five-year-old male with caregiver report of short attention span, difficulty focusing, problems following directions and listening, and he's been getting into trouble at school due to constantly being out of his seat and talking to others and talking out of turn. He was referred for a neuro... for a psychological evaluation due to concerns related to inattention, hyperactivity, and impulsive behaviors. So, there's a few things to keep in mind; there's a few important points. One, as you've probably heard, I almost slipped and said, “neuropsychological evaluation testing codes”. Many people may bill for an ADHD or for evaluating attention problems using either the psychological or the neuropsychological testing codes; it's really important to keep in mind if you're going to use the neuropsychological testing codes for an ADHD evaluation, there should be a primary medical condition that's coded first as your diagnosis with the attention symptoms and/or the ADHD diagnosis coded secondary. For the psychological testing codes, you would code the ADHD diagnosis as your primary code. Now, a few other important reminders: remember that the CPT codes are all reported based on the cumulative time spent performing each individual service, even if time occurs on the same or different dates of service. So, we'll have examples of how to bill and add it... add that up and code in some of
the following slides, but it's the cumulative time spent with each individual service. It's also important to remember that only one unit of a base code should be billed per episode of care and is based on the stated time in the CPT code descriptor, which for the base code for test administration and scoring is 30 minutes, but for the evaluation services is 60 minutes. And then last, the number of add-on code units that are billed is determined once again by the amount of time spent performing each service beyond the first unit of the base code. Next slide...

Okay, so this is an example of how you may bill or code for an ADHD evaluation. In this particular case, the evaluation or the overall psychological assessment episode of care occurred over three dates of service in this particular case. Test administration and scoring performed by the professional and the technician on the same date of service: again, that's time spent on the various activities associated with each CPT code and is cumulative, but they don't necessarily happen chronologically or on the same date of service. So, at the top you'll see that there was the initial evaluation, the... the diagnostic evaluation visit and so the CPT code for that visit is nine oh seven nine one (90791). Unlike the testing and evaluation services codes, this is not a time-based code; this is an encounter-based code, so no matter how much time or how little time you spend, if you meet the criteria for using that code with all of the components you just bill one unit. Now, in this particular case after the diagnostic evaluation, testing was planned, so the types of tests may vary significantly from individual provider to individual provider. On the example we use here is for the WPPSI 4, the BRIEF 2, and the BASC 3. So, that's what we're going to be coding and showing how they're coded. However, in many cases, a practitioner or psychologist may choose to also administer a computerized measure of attention like a continuous performance test of some... some... some... type. Important to keep in mind if you're doing that how to bill for it. If it is automated - meaning if you start the test, let the person go ahead and take the test, and you leave the room to do something else - you would not bill for the time that that patients spent taking the test nor would you bill for the computer-based testing code. The nine six one four six (96146) is for standalone computer-based testing with automated report. However, if you or the technician is... the psychologist or the technician remain in the room to monitor the child's test-taking behavior during that task, you would bill for that using the psychological testing services, either administration and scoring by the psychologist or by the technician added on to the other tasks. Either way, regardless of whether you're in the room during the entire administration to monitor test taking behaviors or whether it's done independently, you would bill for the evaluation services and time spent integrating the results of that test into the results with the WPPSI 4, the BRIEF 2, the BASC and any other tests that you've used to create that report. So, that integration time is added, even if you're not adding the actual testing time.

So, in this particular case, after the initial interview the patient came back, and the psychologist spent 44 minutes with test administration and scoring. So, if you look in the box to the right, you'll see the breakdown of what those services were. So, it's in the test administration and scoring by the psychologist, so day one spent 44 minutes: the first 30 minutes is used... using... is billed using the base code nine six one three six (96136) and the other 14 minutes did not reach the threshold of being more than 15 minutes to use an additional 30 minutes for the scoring and testing... or testing and scoring by the psychologist. So, you would only bill one unit for the testing and scoring by the psychologist. Now, in the example I gave earlier, if you're also in the room monitoring test-taking behaviors while a CPT or other computerized measure is given, you can then add that to your 14 minutes, and you may exceed that threshold, then use additional units. However, the way it's currently shown, you only can bill for that one base code unit for your own personal time testing. Now, then you handoff the patient to the technician who spends an additional two hours with test administration and scoring. So, the way that that's coded is that the base code- again is a 30-minute base code. You score one or you bill for one base code unit and then three additional add-on units using the nine six one three nine (96139).

So, on this form you can see that the 30 or the 44 minutes that the psychologist spent with the testing on the same day is billed using the nine six one three six (96136). You don't see the nine six one three seven (96137) code because we didn't meet that threshold because it was only 14 minutes. Now, the nine six one three eight (96138) and nine six one three nine (96139) are the time the technician’s spent and you'll see next to the nine six one three eight (96138) - that is the base code for the technician - the five nine (59) modifier is used. Now, there is another modifier... so that's how to use the... the five nine (59) modifier. The five nine (59) modifier is used to identify procedures and services other than evaluation and management services that are not normally reported together, but are appropriate under the circumstances and most people should be familiar with that and how to use that modifier because that was the modifier we used with the old codes when the psychologist and the technician provided services for the same episode of care. So,
this is a little bit different because it's when you do the base code on the same day, but the idea is the same; you have to
demonstrate that this is a distinct and separate service -- you gave a different task than your psychometrist did. Now,
there are certain situations where the professional may begin the test administration service and then the patient is
given a break and leaves the office - maybe to get lunch or something - and then returns on the same date of service and
the technician begins with a second encounter with the patient. In this case, a different modifier - the XE modifier -
would be appended to the technician code nine six one three eight (96138). So, the modifier XE is used to identify a
service that's distinct because it occurred during a distinct but separate encounter on the same date of service. So, if
they leave the office for any reason and come back between your services and the technician’s services, you would use
the XE code. If the technician is giving them the test and then it takes 4 hours, so you give them a break for lunch - they
leave the office - you wouldn’t use the XE modifier because that’s the same episode of care for the technician testing.

OK, and so this is a different example, and this is for a 35-year-old female who is experiencing depressive symptoms,
social withdrawal, and substantial fatigue, but also presents with a history of recent emotional trauma. Her primary care
physician refers her for psychological testing to help them with determinations about treatment. So, in this particular
one on this example... next slide?

This example table depicts the dates, times, and codes billed for the psychological evaluation that took place over three
days. All the services in this example were provided by the psychologist only, so most... many clinical psychologists will
perform their own testing and do not use psychometrist. So, if you don’t use a psychometrist, this is the way you would
bill for that type of episode of care. Once again, the nine zero seven nine one (90791) is the initial intake and diagnostic
interview, which is billed using the nine zero seven nine one (90791) code and it's not a time-based code so that's always
going to be one unit. Now, in this case the test administration - if you can look at the bottom of the slide - test
administration and scoring by the psychologist was direct face-to-face testing for two hours and then scoring for an
additional 90 minutes. So that is 180 minutes total. So that's the time spent administration and scoring of the test; you
would bill one base code unit consistent with everything else for that and then five additional add-on units - the nine six
one three seven (96137) add-on units for your personal time spent testing and scoring.

Now, if you go to the middle, you'll see the evaluation services and what the breakdown of that is: so, for nine six one
three oh (96130) and nine six one three one (96131), again the base code is for the first 60 minutes of nine six one three
oh (96130). You break it down: you spent five minutes with record review, the... the referral from the physician,
clarifying the referral question; then, during the evaluation, you're going to be making some clinical decisions based on
your observations and interactions with the patients and that takes maybe roughly five minutes, but that would be
dependent on your interaction and may vary, patient symptom management and managing the person's responses and
behaviors during the evaluation. So, if they get really upset when you're giving a personality test and have to stop and
you need to intervene, that would be how you would capture that. During the evaluation, you may have your own
decision-making alder... algorithm about when you need to explore something further by adding a different test. So,
that's the clinical decision making and battery modification within the testing episode. And the integration and report
generation may be done on a different day, but you would still use the base and add-on codes based on a single episode
of care, capturing the cumulative amount of time throughout the episode of care.

So, you may not get to start writing the report until a different day and if you spend an hour writing the report, that gets
added into your evaluation services. Then, the interactive feedback - and this is a little bit of a change than from the
previous codes where the feedback session may have been billed as a therapy session. However, the new codes
incorporate interactive feedback into the entire episode of care, so the time you spend with the patient and their family
giving feedback about the testing and making recommendations is also added into the evaluation services. So, the total
is 120 minutes or 2 hours. You bill one unit of the base code for the first 60 minutes and one unit of the add-on code for
the additional 60 minutes. And throughout all of this, the common thread for the psychological testing and
neuropsychological testing codes is that the evaluation services codes are 60 minutes and the test administration and
scoring codes are 30 minutes; that's important to keep in mind when you're billing the numbers. Next slide...

And this is an example of how you would fill out the claim form: again, you see the single unit for nine zero seven nine
one (90791) and then you see the base unit for the nine six one three zero (96130) which is the evaluation services and
then the nine six one three one (96131), the add-on code for the evaluation services, is one unit. You'll notice that that's
a different date of service, right, so the date of service is from 4/1 to 4/3 when you saw them for the feedback. That’s still billed as the add-on code. You don’t bill an additional base code unless there’s a new episode of care. And then the testing and scoring are billed using the nine six one three six (96136) base code for one 30-minute unit and nine six one three seven (96137) for five additional 30-minute units to capture the entire three hours of testing and scoring.

Dr. Stephen Gillaspy: Here, we have our third clinical example. This is our developmental case example; we have a seven-year-old patient who’s shown progressive pattern of academic and social struggles since preschool. The school refuses to do testing because they think it may be autism and referral is made to a psychologist for an assessment.

So, this brings us to our developmental testing codes code nine six one one two (96112) developmental testing... developmental test administration. This is including assessment of fine and/or gross motor, language, cognitive level, social, memory, or executive functioning using a developmental... a standardized developmental instrument. Again, the developmental testing codes follow a base and add-on structure with the base code being nine six one one two (96112) for the first hour and then CPT code nine six one one three (96113) is for each additional thirty minutes and again that is the add-on code. Of note, there’s two important things to think about as far as when you use the developmental testing CPT code versus our normal psychological testing codes. So, when to use the developmental testing codes - the nine six one one two (96112) and nine six one one three (96113)? So, we use those when standardized developmental measures are used to assess skill development in multiple areas that include receptive and expressive language, social, cognitive, gross and fine motor, and adaptive functioning. In contrast, when the primary referral question is to assess developmental skill acquisition appropriate for age or loss of previously acquired skills or failure to attain expected skills in young children. So, you can use nine six one one two (96112) and one one three (96113) for the total time spent administering, observing, scoring, and interpreting, and the clinical decision-making related to the entire test battery. That’s in contrast to when the referral question is not for developmental concerns, but a standardized developmental instrument is used to determine loss of previously acquired skills or failure to attain expected skills for age. So, in that situation, you can use nine six one one two (96112) and nine six one one three (96113) only for the time spent administering, scoring, observing, interpreting, and clinical decision-making related to the standardized developmental instrument.

On this slide, what we’ve done is we’ve taken the example of the developmental assessment and what you see is where we’ve documented at the top... we’ve documented the... the diagnostic interview or the clinical interview that... that happens on day one. And again, diagnostic interview is an untimed procedure, so you have a unit of one for that. And then in the next range there, you see developmental test administration with interpretation report and here is where we... it’s breaking down both the record review - which again, as we think about our stages that’s stage one, the record review and clarifying the referral question - that happened on day one. May... you may spend about 10 minutes on that. We move down into test administration, so again face-to-face test administration that takes... here, we have it taking 90 minutes. Then you move down into scoring; again, this is all occurring on day one; scoring may take 15 minutes. And then as you move down into the integration and the synthesis - integrating all that information. Here - we have it taking 60 minutes. And what this shows you is the base, again, the base and add-on structure: the base code being nine six one one two (96112) for the first 60 minutes, the add-on code being for the additional 30 minutes. So, all of that together equals 180 minutes.

So, that’s where you have the example of the one base unit and the four additional add-on units; again, those are all... all that work is happening on day one. And then as you go down, we have some work that also... work that is happening on day two and that’s for the interactive feedback session. Again, that’s typically going to occur on a different day, and for that, we’re going to bill... here, we have for 50 minutes; we have the interactive feedback session occurring in 50 minutes, so you would bill one unit of the nine six one three zero (96130).

This next slide shows how you complete the claim form to clearly document the developmental testing that occurred so here at the at the top over where it says number 1, this documents on the date of service that this occurred on the 29th. This is for the diagnostic interview, the nine oh seven nine one (90791). As we go down again, the nine six one one two (96112), also happening on the 29th. Again, that’s the base code for the developmental testing code and it shows as far as the... the one base code unit for that. The next line: again, having... occurring on the same day, you have the add-on unit for developmental testing code, the nine six one one three (96113). It clearly documents that happened on the...
same day of service and then the actual the units for that. And then the last row shows where on the 30th: again, a
different day of service. It's where the feedback session occurred, and we clearly document that with the nine six one
three zero (96130) with 1 unit.