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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.

Nicole Owings-Fonner: We have received the following questions that I think your expertise would help with. The first one is “Should I resubmit claims if I have learned that the insurance company has fixed problems with its processing of testing claims?”

Alan Nessman: We understand that many insurers are reprocessing claims, but you should check with your particular company on whether you need to resubmit. In some cases, the company may already be handling that; they may automatically be resubmitting claims for reprocessing. So, check if you do need to resubmit claims; find out how to do this so that they get resubmitted properly.

Nicole Owings-Fonner: Thank you. “What if APA recommends submitting claims one way, but my insurer or Medicaid payer says to do it a different way?”

Alan Nessman: In that situation, you should follow what your insurer or Medicaid payer says. APA is trying to educate payers about best practices for handling these new testing codes and we're trying to encourage uniformity, but the companies don’t... and the companies and the payers don’t have to follow our recommendations. Where the divergence between our recommendations and the company practices are creating pervasive problems, we can try to advocate with a payer to change their practices and to get them in line with what other payers are doing.

Nicole Owings-Fonner: Thank you, Dr. Pliskin and Dr. Puente. The first question is “Can we bill nine six one three two (96132) before we see the patient to review records?”

Dr. Neil Pliskin: Well, I think we've already answered that question in this segment and I'll... we can say again that there's a... there could be potentially a small amount of pre-service work that the professional engages in before seeing the patient. Patient... the patient or client is referred to you; you might have an intake sheet. You might have a post-it note; you might have medical records – all of those things are available to you and might contribute to your making some initial decisions of a... which initial test to give. So, let's say for example, the example that we've just finished: talking about our 58-year-old with suspected cognitive decline. You might look at... well, this is a 58-year-old, so I might choose to give Test A, have the technician give Test A while I go ahead and move on to stage two where I’m going to interview the patient and get more detailed information, by which then to modify. So, even those two or three minutes that you might spend reviewing that patient's file and understanding who they are, who referred them, and why they're...
being referred, and what the referral question might be – that's a uniquely professional service activity that you would provide before seeing the patient for the assessment.

Tony, “Can you please discuss the appropriate billing for feedback visits as it relates in general and as it relates to the new NCCI edits?”

Dr. Antonio Puente: Neil, one of the concerns that we have regarding the National Correct Coding Initiative is the history that the follow-up codes or the add-on codes to the base codes historically had been wedded together within a single day of service, which is not typical for neuropsychological and many psychological evaluations as well. So, after much discussion, we now have a new interpretation by a NCCI edit - which goes back to January 1 - and that is that the different add-on or follow-up codes could be added to the base code days after the base code. And more importantly - maybe I should say most importantly - that the feedback code is part of the evaluation process - and maybe more specifically than the evaluation process - just make sure that people don't hang on the word “evaluation” - for the entire neuropsychological / psychological assessment feedback is part of that activity and should be billed as that... as part of the evaluation.

Dr. Neil Pliskin: But, Tony - what happens if my... my feedback session... my interactive feedback session isn't scheduled, you know, for... for a period of weeks to months afterwards? Sometimes it takes time to get all the medical records or sometimes the... the patient or the family isn't available, or - for that matter - what happens if it's a more complicated feedback session that requires more of my professional services?

Dr. Antonio Puente: Well, under those unusual circumstances, we believe it may be appropriate to initiate a new encounter of service or a new episode of service. It could be also, Neil, that sometimes the patient decompensates during the activity and then you might end up with more of a psychotherapeutic encounter. So, each event has to be weighed on its own merits. We believe that most evaluations should be finished within eight weeks, but under the circumstances that it is not... consider alternative ways to code and bill the activity.

Dr. Neil Pliskin: So, in other words, if I... if I do an evaluation and then, for circumstances beyond my control, I don't do the feedback session for eight weeks I'm gonna have to... I mean, my memory is not that good; I'm gonna have to go back and I'm gonna have to review my file and review my report before conducting that interactive feedback... with that. Would that be considered pre-service work that would justify a new base code for providing this interactive feedback service?

Dr. Antonio Puente: I believe so, or maybe there's new information that needs to be understood or new records that should be reviewed. So, in that case then, if you will, start with a new base code and continue on.

How about “Are the minutes and units cumulative across an entire evaluation or only by day?”

Dr. Neil Pliskin: The answer is the minutes and units are cumulative across the evaluation. So, if you're on day one, if you don't achieve your threshold of 31 minutes, as an example, to bill a professional services code - let's say, you've spent 20 minutes engaged in pre-service activity; then the next day when you provide the additional professional service so that you've achieved the the minimum of 31 minutes, then you would add those minutes from day one to day two and they would be cumulative.

Dr. Antonio Puente: Now, having said that, we also are searching deeper to get a better understanding because it could well be that a code lives for only one day. This is our present interpretation of how we add up units or minutes per code but stay tuned - we will gather more information to share with you as soon as we have that available, but at present this is our understanding of the circumstance.

Dr. Neil Pliskin: Next slide...
Dr. Antonio Puente: Neil, “Can nine six one three oh (96130), three six (96136)/three seven (96137) be used together in one day? I've actually been denied when I use one three oh (96130) in conjunction with the other two. What's going on here?”

Dr. Neil Pliskin: And, Tony, for that matter the second FAQ really addresses the same concern; in this case, “How can I bill for I admin... my administration of a Wechsler Adult Intelligence Scale and my technician scoring of it on the same day? I had it rejected.” So, in both of these scenarios, you have combinations of codes that have been rejected and, at this time, we understand that we've gone from a system where we've gone from three codes up to twelve and sometimes thirteen codes to describe these services. It has taken time for not only the professional community, but also the the commercial carriers and CMS, to appreciate the nuances of these differences. So, of course, if you're doing psychological testing using test administration, using nine six one three six (96136) and nine six one three seven (96137) for your psychological test administration done by you, the professional, then of course you're going to include nine six one three oh (96130) - your professional services by which to provide the integration and the report generation and all the other professional activities that would be captured: that... that the testing data would be used for and would be captured under nine six one three oh (96130). So, clearly the fact that that combination of codes has been denied indicates that additional education and advocacy is required and most definitely is ongoing. Likewise, if you're billing for the administration of a... of an IQ test like the WAIS and your technician is scoring it the same day – now you're getting into activities that are on the same day with the same patient but are separate, distinct, and non-overlapping services; at which point then the rejection here could have occurred because of the lack of the addition of the modifier 59 indicating that distinct profession... procedural services were provided. So, in the first question, the... the education and advocacy needs to be more at the level of the commercial insurance carrier and CMS, which we know is ongoing, and the second FAQ really relates more to the need to educate our colleagues who do this work to understand that when you and... when you, as the professional, and the technician are providing unique services on the same day with the same patient, then you're going to use the modifier 59 for... to indicate the distinct procedural service and that should deal with the rejection.

Dr. Antonio Puente: Neil, let’s emphasize one more time that the information we’re sharing with our colleagues in this presentation is the best knowledge that we have at this particular time. However, we're continuing to pursue, refine, understand; as we get that, we'll share with others. It's also important to note two other things: that AM... APA staff and our volunteers that work on this are working very diligently with multiple carriers and multiple circumstances to understand and ameliorate all the problems that are surfacing, and finally we cannot guarantee that what we're sharing is understood by the carriers who are paying you because many carriers have different interpretations. This is our best understanding of the federal guidelines for the codes as we have developed them over the several years in collaboration with the AMA staff as well as CMS.

Dr. Neil Pliskin: Well, thank you very much!

Nicole Owings-Fonner: And thank you both; we really appreciate your expertise.

And here we have Dr. Gillaspy with us who's going to ask... answer some questions that we've received from the audience who registered. First, “Under what circumstances would I use the developmental testing codes nine six one one two (96112) and nine six one one three (96113) in conjunction with or instead of the psychological testing codes nine six one three six (96136) and nine six one three seven (96137)?”

Dr. Stephen Gillaspy: So, just as a review - 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. So, when the primary referral question is to assess developmental skill acquisition appropriate for age or loss of previously acquired skills, failure to attain the expected skills in children, then you can use the nine six one one two (96112), the base code, and nine six one one three (96113) for the total time spent administering, scoring, observing, interpreting, and clinical decision-making related to the entire test battery, which must include the use of a standardized developmental instrument. So again, when the focus of the referral question is specifically on development, you can use the developmental testing codes for the entire test administration as well as the synthesis
and generation of the report. You still would use... for the feedback session, you would use the nine six one three zero (96130).

Now, when the referral question is not specifically for development, but a standardized developmental instrument is used to determine the loss of previously acquired skills or failure to attain expected skills for age, you can use the nine six one two (96112) and nine six one three (96113) only for the time spent administering, scoring, observing, interpreting, any clinical decision-making related to the standardized developmental instrument. For the rest of the assessment, then you would use... or for the rest of the test administration for things that are not developmental, you would use the nine six one three six (96136) and the nine six one three seven (96137). And again, for the integration of the report, you would use the nine six one three zero (96130) and the add-on code to capture all that additional work.

Nicole Owings-Fonner: Thank you. We have one additional question: “Can the test administration using the developmental testing codes be performed by a technician?”

Dr. Stephen Gillaspy: So, the technician can not use the developmental testing codes; the developmental testing codes are only to be used by the qualified health care professional or, in our case, the psychologist. The only codes the technicians can use for test administration are those specific for the technician. They cannot use the developmental testing codes.

Nicole Owings-Fonner: “Can you bill clients for units not covered by insurance? For example: if covered for seven units, but it takes you nine -- who pays, if anyone?”

Dr. Michael Westerveld: The short answer is yes, you can; however, there may be a contractual issue between the provider and the insurance company. So, for example, if you're credentialed with a company, they may have a policy that prohibits you from balance billing or billing over what their limitation is. However, there is an alternative and that is to have the patient sign an advanced beneficiary notice waiver. This is similar to the process that CMS uses for Medicare when you suspect a service may not be covered by Medicare. You have the... the patient sign the notice beforehand acknowledging that if it's not covered that you will be... that they will be responsible for the overage.

Nicole Owings-Fonner: Thank you, Doctor Westerveld. I have another question for you: “How do i bill for psycho-educational testing -- for example, ADHD testing or dyslexia testing?”

Dr. Michael Westerveld: When the primary referral question for young children or older children who are delayed is to assess the developmental skill acquisition appropriate for their age or loss of previously acquired skills or failure to obtain expected skills, you should use developmental codes for the total time; however, in the case of ADHD, it's common to use both neuropsychological and/or psychological tests as well as rating scales for teachers, parents, and other relatives. The psychologist performing the evaluation would bill the appropriate code depending on the primary underlying or suspected cause. So, for example, if it's developmental ADHD and there are no known risk factors, many insurance companies cover that under their behavioral or mental health policies. However, in the case of attention problems or learning problems that are suspected to be related to an underlying medical or neurological condition, you would use the neuropsychological testing codes including the evaluation services codes.

Nicole Owings-Fonner: Thank you. Another question for you: “How do i bill for a rating scale completed by a teacher that's scored online as part of a comprehensive assessment where I'm doing two or more tests?”

Dr. Michael Westerveld: The rating scale completed by a teacher and scored online requires no face-to-face test administration or scoring time, so you would not be able to bill for that. However, if you use that information and integrate it into the other information that you've had when preparing the report, you would spend that... or you would bill that time using the professional evaluation services nine six one three oh (96130) for psychological testing or nine six one three three (96133) or nine six one three two (96132) for neuropsychological testing with the add-on codes, if necessary.
Nicole Owings-Fonner: Thank you. One more question for you: “Can developmental codes nine six one one two (96112) etc., be billed with neuropsychological codes?”

Dr. Michael Westerveld: Yes, there are a number of instances where that might be appropriate. When the primary referral question is not for developmental concerns, but a standardized developmental instrument - for example, the ADOS - is used to determine loss of previously acquired skills or failure to obtain expected skills for age in the context of a neuropsychological and/or psychological evaluation, the qualified health professional should use the nine six one one two (96112) and nine six one one three (96113) codes only for the time spent administering, scoring, observing, interpreting, and clinical decision-making related to that developmental instrument. Additional neuropsychological or psychological tests would be billed using the appropriate neuropsychological or psychological testing codes.

Nicole Owings-Fonner: Thank you.