

Webinar: Getting Reimbursed: Continued Preparation for January's Testing Code Changes
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Participants:

- **Nicole Owings-Fonner, moderator, APA**
- **Dr. Antonio Puente, PhD**
- **Dr. Neil Pliskin, PhD**

Nicole Owings-Fonner: Good afternoon or good morning, depending upon where you are. Welcome to today's webinar. Getting Reimbursed: Continued Preparation for January's Testing Code Changes. This webinar is hosted by the APA Practice Organization. My name is Nicole Owings-Fonner, and I'm a communications project manager at APA. I will be moderating today's webinar.

This webinar is being recorded. A copy will be emailed within 24 hours to all participants, and those who registered, but could not join the live presentation. A copy of the slides used during today's presentation can be found in the handout section. You can also find PDFs of the code definitions, and all the crosswalks that the presenters will be referencing today.

Prior to the webinar we received over 400 questions. Given the amount of material to cover, and the sheer volume of inquiries, the presenters will first respond to the most frequently asked questions that have been submitted, and then we'll turn to the audience for live questions during the question, and answer session at the end. Please use your questions box to submit questions at any time during the presentation.

Our presenters today are Doctors Antonio Puente, and Neil Pliskin. Diane Pedulla will be joining them at the end of the session for the question and answer portion. Doctor Puente and Doctor Pliskin, please go ahead and get us started.

Dr. Antonio Puente: Again, welcome to our latest webinar on this very important topic. We appreciate you being here, and on behalf of the APA Board of Directors, as well as our president, we welcome you, and look forward to having a productive webinar. As you can see on this first slide involving objectives, our goal today is to very quickly review the new testing codes and definitions. Doctor Pliskin will do that over the next 15 or 20 minutes and then we'll walk through the old codes to the new ones.

An important portion will be going over the RVUs, and the payment structure and applying the new codes using very practical examples. Probably one of the most important things that we'll do today - and this is critical that we all focus on this particular segment - is how do we document your work. In other words, what is cognitive work? How do you do clinical decision making? And then most importantly, how do you document it in a way that survives an audit? Finally, we'll address some of the most frequently asked questions.

So, at this juncture, let me turn it over to my colleague and good friend, Neil Pliskin.

Dr. Neil Pliskin: Thank you, Doctor Puente. This will be ... we can go to the next slide, thank you. This will be the fourth time approximately that we've been talking about the new testing code structure. So, I'm big on repetition, and familiarity, so we're going to go through it again but we're going to go through it at a little bit quicker pace, with the understanding that, for most of you this is not the first time that you've been exposed to this information.

As a reminder, there's an entirely new testing code structure. There is not a one-to-one crosswalk between the current codes that are about to be deleted, and the new codes that come online January 1. The new testing code structure will involve a base code and an add-on code, and depicted here, as many of you have seen before is what goes into the base code: the pre-service work, the actual intra-service work, and then the post-service work. Next slide.

The structure involved a base code that's used one time that incorporates pre-service, and post-service work. Then for additional time spent beyond the base code time, we'll be using a new add-on code, which captures just the intra-service work. Next slide.

Here's the overview that we'll go through again. These are all the codes that are relevant for neuropsychological assessment, and most of the codes that are relevant for psychological assessment, minus the initial clinical interview using the psychiatric diagnostic code, which we'll go back to in a few minutes. But as a reminder, in the new code structure, there is a clear distinction between test evaluation services and test administration and scoring. Test evaluation services, whether it's psychological or neuropsychological testing, is the service that's provided uniquely by the qualified healthcare professional. And test administration and scoring services, which includes both face to face and non-face to face time spent scoring. There are separate codes for when the psychologist, or other qualified healthcare professional does their own testing versus when the qualified healthcare professional supervises the work of a technician doing the data gathering, the test administration and scoring. To highlight again that some of the key changes, the test evaluation services are in hourly units. The test administration and scoring services are in 30-minute units. In order to use the test administration and scoring codes, one needs to administer two or more tests and use the test evaluation services in conjunction with that. Now we'll just quickly go through, and review the actual codes themselves, and the crosswalks. Next slide.

Let's start with psychological testing services. This was just what I was alluding to that wasn't present on that overview slide, and that is ... If you're doing a psychological evaluation, and you're incorporating a clinical interview into that psychological evaluation, you would use as before the 90791 psychiatric diagnostic evaluation code. There have been no changes to this code, and this service includes the comprehensive diagnostic evaluation that goes along with psychological testing. Next slide.

Here's the overview. If you're looking at the left-hand side of this busy figure, what you see is that you're in ... In the current year you're using 90791 psychiatric diagnostic interview for your capture your clinical interview portion of the evaluation, and you will do that again in 2019. But the old codes, or soon to be old codes of 96101 and 96102 will be deleted, and in their place will be separate codes if the testing, and scoring is done by the qualified healthcare professional, psychologist, or if it's done by a technician. If you look at 96101, and you look down there, then in the yellow squares are 96136 the base, and 96137 the add-on for if the psychologist, or other qualified healthcare professional does their own testing, and scoring, or if you look to the right-hand side of that figure in the red boxes, you have the 96138, and 96139, the base, and the add-on. Note 30 minutes for test administration, data gathering, and scoring done by the technician. Whether you're doing psychological testing, or you're doing neuropsychological testing, these are the test administration and scoring codes that you would use.

If you're doing a psychological evaluation, the professional services provided by the psychologist, or other QHP, qualified healthcare professional, now it's coded separately with the base code 96130 for the first hour, and the add-on code 96131 for each additional hour. Again, the clear distinction between

what are test administration and scoring services, and what are the professional services provided by the qualifying healthcare professional. Next slide.

We'll just quickly go through these definitions. Again, in your code description for your psychological testing evaluation services, and you'll note based on this description these are the services that are uniquely provided by the professional. I'll just go through these one time. That's your integration of patient data. That's your interpretation of standardized test results, and clinical data. That's your clinical decision making, which is going to be a central point of discussion in this webinar. Your treatment planning, and report, and your interactive feedback to the patient, family member, or caregiver when that is performed. Base code 96130, each additional hour add-on code 96131. Note, finally, that this code involves both face to face, and non-face to face activities. Next slide.

If the psychologist, or other QHP, is doing their own test administration and scoring: the base code 96136, the add-on code 96137. Again, please note this is a significant change for everybody: first 30 minutes, two or more tests, and note any method. Unlike currently where there's a separate code for computerized test administration and scoring, that is no longer the case. These codes will apply for test administration and scoring gathered by any method. Next slide.

Here's the crosswalk with 96101 now being bifurcated into 96130 and 131, the professional services, and 96136 and 137 when the psychologist, or other QHP, does their own testing 30 minutes. Next slide.

Just to round this out. 96138, the base code for when the technician is providing the test administration and scoring, and 96139 the additional 30-minute add-on code. Again, two or more tests to use these codes, any method, and in 30-minute chunks. Next slide.

Here's the crosswalk for when the testing is done by a technician under the supervision of a QHP. So, 96101 is to be deleted. Professional service now 96130 based, 96131 add-on. Test administration and scoring by technician. 96138, first 30 minutes. 96139 each additional 30 minutes. **[brief audio glitch]** Next slide.

The story will be the same with just some minor differences with neuropsychological testing services. When the clinical interview is conducted in the context, clinical interview, and clinical assessment is done in the context of a neuropsychological evaluation, you would use as you are currently using 96116 neuro behavioral status exam. But there's a difference, as we know for this coming year, and that is there's now a base, and add-on structure to this neuro behavioral status exam code series as well. If the neuro behavioral status exam extends beyond the first hour, then you would use the add-on code which is new 96121 for each additional hour. Next.

Here's the crosswalk for that. 96116 remains 96116 for the first hour, and 96121 for each additional hour. Next.

Here's the overview. We've just finished talking about the left-hand column 96116, when we look at the code 96118, which is about to be deleted. Again, we're seeing the split between what are professional service, and what are test administration and scoring services. Test administration and scoring by psychologist in the yellow box. 96136, 96137 -- base and add-on like we've been discussing. First 30 minutes, and then each additional 30 minutes. If the testing is done by a technician under the supervision of the qualified health care professional. Looking to the right side of the diagram, 96119 is to

be deleted, and will be replaced by 96138 the base, 96139 the add-on. Each 30 minutes, first 30 minutes, and then each additional 30 minutes. The other new element is the separation of the professional services from the test administration and scoring, whether that's done by the professional or by the technician, and the professional services for test evaluation is now coded 96132 for the first hour, 96133 for each additional hour. Next.

These are the code descriptors. I won't go back over these except just to point out that there are face to face and non-face to face activities that are... are... these services are captured by these codes. Next slide.

When the testing, and scoring is done by the professional, 96136 the base, 96137 the add-on. Note the switch -- 30 minutes. You have to give two, or more tests to use these codes, any method, and you would use these with the testing evaluation services codes. Next slide.

Here's the crosswalk for that. Next slide.

Once again, these are the testing administration and scoring when it's done by the technician. Same parameters, two or more tests. Any method, it can be computer, it can be paper, and pencil. It can be tablet -- it doesn't matter. First 30 minutes, and then 96139, each additional 30 minutes as the add-on. Next slide.

Here's the crosswalk for that. Next.

Okay. When we're talking about the unit of time -- 30 minutes, 60 minutes -- there is the CPT time rule for time-based codes. These are the standards that apply. When you're talking about a 30-minute code, a unit of time is attained when the midpoint has passed. A 30-minute code, it would be a minimum of 16 minutes, and a maximum of 30 minutes that have to be provided to use the 30-minute code. Two 30-minute units can be billed when 46 to 60 minutes of service is provided. Similarly, a unit of time is obtained when the midpoint has passed for a 60-minute code. That means a minimum of 31 minutes, and a maximum of 60 minutes must be provided to use the 60-minute code. When it extends beyond 60 minutes, two 60-minute codes, units can be billed when 91 minutes to 120 minutes of service is provided. Next.

Here's an example. When performing a neurobehavioral status examination, the first hour of service is billed with the code 96116. However, if the service isn't completed in that first hour, then the first unit of add-on, 96121 would be used if the neuropsychologist, psychologist, or other qualified healthcare professional performs at least an additional 31 minutes of work that gets beyond the midpoint. Next slide.

Finally, to round out the code set, we have single psychological, or neuropsychological automated testing, and result. As we've discussed already, there's no longer a distinction between testing administered by computer. This code actually represents when a psychological or neuropsychological test is administered with a single automated result only. Single test, automated result. Next slide.

The code reads psychological or neuropsychological test administration with single automated instrument via electronic platform, with automated result only. This is a very specific code describing a very specific type of service. Next.

Here's the crosswalk which we've already discussed. The new code will be 96146. It's not a time-based code. It's a single automated instrument via electronic platform, with automated result only. Next.

Now let's turn our attention to clinical decision making. Next slide.

Clinical decision making for psychologists involves the time that is spent engaged in the cognitive portion, the thinking portion of the work. This is a concept, medical decision making, clinical decision making that physicians are highly attuned to, and are very used to capturing and quantifying their work that goes into their medical and clinical decision making. Psychologists -- to use us as an example -- also engage in clinical decision making, but it hasn't been clear to what extent psychologist appreciate the need to document, and accurately report the cognitive work that's inherent in psychological and neuropsychological testing. In this new code system, it will be important for psychologists to capture, and report their clinical decision making. That is work that should not be given away. Next slide.

Dr. Antonio Puente: Neil, as you go to the next slide, let's encourage our peers to understand this is where the rubber meets the road. If you did not document cognitive work, you will not be able to appreciate the changes that we are proposing at this particular time. So, please listen carefully: this is one of the most important sections of this slide deck.

Dr. Neil Pliskin: Okay. In this slide you'll see that in red it says this is especially important to document when using technicians. When the psychologist, neuropsychologist, and other qualified healthcare professional, is not in the room. When the test technician is administering the test, decisions still none the less need to be made. Example, so the psychologist determines how the patient is responding throughout the testing process and making decisions based on that. There are plenty of examples that we could talk about: Level of functioning, level of impairment. You start out by instructing your technician to give a certain series of tests. You meet with your technician and the technician shares the information with you that shows that the individual isn't performing well. Maybe the tests that you are giving need to be altered to accommodate the level of functioning or level of impairment of that patient. Maybe that patient is presenting with symptoms in the room that were unanticipated, and the qualified healthcare provider needs to hear about that, needs to adjust the testing process accordingly. That's time consuming. Very common scenario, individual comes in for testing and they're unhappy. They need to... they need to be calmed down. There needs to be a reaction, a response to the way that the client or the patient is behaving in this session. It gets in the way of being able to do the testing. That's uniquely a professional activity where the... in this case the psychologist would need to go into the room, or the waiting room, and intervene. That's time consuming. You start out doing an evaluation and based on the way that the client or patient is beginning to perform on the tests, it becomes apparent that they are not as literate as they need to be to take certain tests that you have designated for them. Well, you look at the data. You understand that that's what's going on, and you have to adjust your test battery accordingly to account for this level of literacy and maybe you need to test for that level of literacy.

These are in the moment decisions that need to be made that are clinical decisions. You administer a series of tests, or you ask your technician to administer a series of tests, to an individual where English isn't their first language, but they're bilingual. Now you're giving them the test, and you determine in the moment that the testing that you've selected may not best represent what they're capable of doing because of language proficiency, or because of other individual differences or cultural factors. The technician is not going to be able to go forward with the current battery of tests. The psychologist, or other qualified healthcare professional, reviews the progress, alters the test battery, and makes clinical decisions based on how the patient is performing. I imagine many of the people who are listening to this

are nodding their heads and understanding that this is a core component of what psychologists do, especially when using technicians as part of these psychological or neuropsychological testing evaluation process. As a result, your time as the professional needs to be accounted for when you're engaged in this clinical decision making. In the old code series about to be deleted there was a work value attached to the testing technician code 96119. That work value was for the professional time spent monitoring the testing process and the technician as we've been discussing. Now in the new code set, all the professional work rolls under the professional testing evaluation services code, including this clinical decision making. Many of us have had the experience where we begin testing a patient or a client and we determine that that person is not providing valid data. They're not trying hard. They're too upset. They're distracted. One of 50 possibilities. One does just not go forward with the testing; one has to make adjustments based on how that client or patient is performing at that moment. Those are clinical decisions that are uniquely made by the professional provider of services.

Dr. Antonio Puente: Neil, let me emphasize this has to be documented. These decisions are made, but they also have to be documented. For those of you that are wondering, the overall supervision required by Medicare generally, it's called general supervision, rather than direct. But that has to be done and has to be documented.

Dr. Neil Pliskin: Finally, one other example. I just don't want to let it go by, because it's so inherent in our work, that we'll be testing clients, and patients who perform well, but who nevertheless, because they're high functioning, evidence more nuance changes in their testing performance. Those are only changes that the professional who's trained to do this work will recognize, and understand. As a result, decisions will need to be made as to how to modify the test battery to best capture the nuanced changes. For most of us this work is done concurrently as the evaluation process is unfolding. That's clinical decision making. Doctor Puente you're absolutely correct. We can't give this away, this is our work. This is what we do, and we need to be able to record it, capture it, and articulate it in a way so that the third-party carrier will understand what the service is that we're providing. Next slide.

Documenting your work these are our recommendations and suggestions. It's recommended that test evaluation services, the professional services, and test administration and scoring services be documented in a table somewhere within the report. For many of us that's usually at the end of the report. We suggest listing the dates and total times for each activity. That includes scoring and clinical decision making. It might be cumbersome to include all those start and stop times in the actual report itself, and if that's the case, then we suggest adding a separate log sheet that details those start and stop times and having it in the clinical chart, so that at some later point if the question has been raised "how are those total times accounted for?", that you'll have a separate log sheet that will detail those. Next.

When a service is spread out over multiple visits, which will happen of course quite typically. It's recommended that all codes be listed by date and service, and billed together on the last date of service when the evaluation process is completed and listed in your table at the end of the report. A base code should only be submitted for the first unit of service in the evaluation process, and only add-on codes be used to capture the services provided during subsequent days of service, since those subsequent days of service are tied to the original evaluation, and base code. Finally, bill separate interactive feedback session if that occurs on a different day using an add-on code. That would be for psychological testing evaluation services, use the add-on code 96131. For neuropsychological testing evaluation services, use the add-on code 96133.

Dr. Antonio Puente: Neil, this solves a long-standing problem of how do you code feedback sessions. Now we have a very clear suggestion how to address that.

Dr. Neil Pliskin: Yes. Next slide.

Here's one way to document clinical decision making. This is just a suggestion, but I think it conveys the main points. There's intra-session clinical decision making that occurs naturally as a part of the work that the professional psychologist and other qualified healthcare professional provides, and that's test selection, consulting, reviewing the testing, modifying the test battery. If there are issues that come up with the patient or client, documenting that. Those can be the things that we talked about: patient becoming upset, issues of literacy, issues of performance, and symptom validity, issues related behavioral management, symptom monitoring. These are all things that we do typically as part of our process. We have to get used to the idea of codifying them and recording them in a way that other people can look ... other coders and carriers can look and appreciate how that time was accounted for. In addition to the face-to-face ... go ahead.

Dr. Antonio Puente: In other words, if you don't record it, you cannot bill it and don't expect to get reimbursed for it.

Dr. Neil Pliskin: And expect to be questioned if you don't record it but you bill for it, which we're not recommending, of course. Then the final aspects I just listed here with the fact to face interpretive feedback, record review, integration, report generation: the things that are uniquely the work of the professional psychologist. Next slide.

I think Doctor Puente just made this point very eloquently. Transparency and comprehensiveness in your documentation is the key. Psychologists might say, other professionals might say, "that's adding time on to my work. I already have so much that I'm doing. That will be laborious." Well, let me say that whether it's laborious or not, this is something that needs to be done as a standard part of the service that you provide because having that transparency, and comprehensiveness, and documentation will be essential in getting the work that you're doing recognized and reimbursed.

Dr. Antonio Puente: The take away message is very simple. Clinical decision making is the foundation for your reimbursement and the only way you're going to get reimbursed if documentation exists to support that activity. Let's go on to the next slide, where we now turn our attention to non-facility RV use, and the payment structure. In many ways this is basically how do we turn in these concepts that Doctor Pliskin has shared with you into reality, and specifically how do you get reimbursed. The next slide will begin to outline that for you.

First of all, what's an RVU? The Total Relative Value is the flip side of the CPT. We have a code and the code has an RVU. The code is essentially made up of three primary activities, and that's the cognitive work: it's the clinical decision making which we've been talking about - as a rule, represents roughly 52% of the reimbursement dollar. Then the practice expense, which can be relatively high for such activities as testing, and then a very small amount - there's the professional liability. Then all of this is multiplied by a very small geographic price index. But the main one here, and the one that we've been focusing on over the last few minutes is the cognitive work. This is the biggest paradigm shift in this new set of codes. Let's go on to the next one.

This slide provides more specific information regarding each of the codes. As we have discussed already the neurobehavior status exam, the first hour is 2.70, and since you're not having to do as much intense work in the subsequent work, it goes to 2.32. Then we have the test evaluation services 1.30 at 3.30, which again is heavily loaded with pre-activity, and the subsequent hour at 131, at 2.51. For those of you who have... may recall these numbers for earlier days, this is a substantial increase, and you see this again in the neuro psychological testing: first hour at 3.71, and the subsequent hours, each add-on is 2.83. Again, the first hour is heavily loaded because you're having to do more cognitive work. The subsequent hours are a little less so because you're basically moving on, leaving some of the, for example, pre-services out. Next slide, please.

Slide 40, please. Okay, as you can see here, now if we're doing the testing itself -- just the testing, not the evaluation services -- if the professional does at 1.36, it's 1.33, and if it's additional time is 1.23. Now realize that these are only smaller numbers, but they're also smaller units of time. One more time: it's 30 minutes, not 60 minutes. If the technician does slightly less: the first 30 minutes at 1.38, 1.08, and then any additional time is 1.08. If we do a single automated instrument via an electronic platform we code that as 1.46, and as you can see the actual RVU, which is a very small amount is .06. Next slide please.

Now, how does this all come together? Well, first of all, we take all the RVUs and Neil will do that in a couple of upcoming illustrations. Then the total RVUs is then multiplied by the conversion factor, which this year appears to be 36.0391. Now this is something that's actually set by the government, and specifically by Congress, and it varies from year to year depending on a variety of issues including political ones. Now to determine the specific dollar amount per unit of a particular code, you multiply the total non-facility... non-facility RVU value by the conversion factor -- the three numbers that we talked about earlier: primarily 52% the cognitive work, which is critical, so central to making sure that it is captured, and documented. Next slide please.

One of the challenges that we've encountered in doing this is the Medicare facility fee reduction. As part of the trend since 2015, CMS is reducing valuations for facility-based services across all disciplines. This is totally unrelated to our effort, and it's not meant to target psychologists or neuropsychologists in any way shape, or form; it targets all of healthcare. Since some psychologists and technicians are salaried employees at hospitals, and facilities, this is not a direct payment reduction. Rather it's a reduction in fees paid directly to the facility to cover overhead, changes in administrative costs. Now we're still trying to determine this, but two, or three additional points. This probably affects approximately 200 of us and it's important to appreciate that this reduction could be easily recoverable if careful attention is made to address such things as the cognitive work that we've mentioned throughout. Stay tuned; we'll have more information. If you have requests, additional information regarding this, please contact us and we'll provide the specific numbers that we have been able to achieve. Next slide, please.

Here is where I think it's important to attend to how do we change the theoretical things that we've mentioned in the last few minutes to the very practical examples? Doctor Pliskin will take us through a handful of specific practical examples. Neil?

Dr. Neil Pliskin: Okay. These are clinical examples that we have presented in previous webinars, but now we have added in the additional information of the RVU, total RVU values themselves. While each of these examples get quite a lot of information on them, I predict over time it will become much more fluid for those providers who will be using these codes on a regular basis. In example one, we're re-visiting the pediatric ADHD assessment and for this psychological evaluation we're doing a psychiatric

diagnostic interview. Three hours of the psychologist in this case doing the testing, and three hours of professional evaluation services. Reading down here, the diagnostic interview is the code 90791. The total RVU for that is 3.89; it's not a time-based code and so that is the value for it. Now, the psychologist in this scenario is doing three hours of psychological testing. That's in 30-minute units. The first 30 minutes is captured by the code 96136, and each unit is billed at an RVU of 1.33. The base code is 1.33. But the remaining five units representing the additional two and half hours are billed using 96137, and that's five unit at a 1.23 comes up to a total RVU of 6.15. We've said three hours of professional evaluation services. The first hour, the base code is billed at the total RVU rate of 3.30, and then for hours two and hours three, that's two additional units of add-on at 2.51 per add-on unit, for a total of 5.02. In this example, the total RVUs would be 19.69 and you can apply the conversion rate to that to come up with a generic dollar amount recognizing that there will be differences by region of the country. Next.

In this example we have an adult with major depression, and psychotic features getting ... or questionable psychotic features, being referred for a psychological evaluation. In this scenario -- diagnostic interview" this time it's three hours of the technician doing the testing, and three hours of professional evaluation services. Like before, the diagnostic interview is a non-time-based code 90791, and there's your RVU for it, 3.89. In this scenario it's three hours of technician testing. The first 30 minutes is captured by 96138 at a total RVU of 1.08. Then the remaining two and half hours billed in 30-minute chunks will be captured by 96139, the add-on code, and at a total RVU of 5.40. Then the professional testing evaluation services -- also three hours -- the first hour 96130 at the unit of 3.30, which is the base code total RVU. Then hours two and three with the add-on codes that are valued at 2.51 each for a total of 5.02. Total RVUs for this service in this example 18.69. Next.

Here's the same clinical example of major depressive disorder, plus questionable psychosis -- referred for a psychological evaluation, except in this scenario it's busy, but this is typical. Where the qualified healthcare professional, i.e., psychologist in this case, and technician are both involved in the test administration and scoring. This represents an amalgam of the two previous slides that you've seen. In this case, it's two hours of technician testing to go along with the diagnostic interview, and two hours of psychologist testing to go along with the interview, plus the two hours of professional evaluation services. So, bear with me, as I walk you through this. Diagnostic interview code doesn't change, 3.89. For the test administration and scoring done by the psychologist, you're using that particular code, the base 96136, the add-on 96137. You're billing them at the units that we've previously described. The first unit, 30 minutes: 1.33. Subsequent units at 1.23 for your total RVUs. But in this case, the technician is also directed to administer some tests, and we've said that's for two hours, so the first 30 minutes is at 1.08, and the subsequent hour and a half, three units billed in 30-minute chunks at 1.08 for a total RVU of 3.24. Like before, testing evaluation services uniquely provided by the psychologist in this example: Hour one: the base code, hour two: the add-on code. For this entire service, you're seeing a total RVU of 19.04. Next.

Here's a different clinical example: when a neuropsychologist or a psychologist who referred a patient for differential diagnosis of memory loss -- question mark: early Alzheimer disease. In this scenario, we have two hours of the neurobehavioral status exam, four hours of the neuropsychologist doing their own testing, two hours of evaluation services. The clinical interview / neurobehavioral status exam, which we've said is two hours in this case: hour one, the very familiar 96116 billed at the rate of 2.70 for the total RVU, and each additional hour -- in this case, an additional hour -- of add-on 96121, and that's billed at the new rate of 2.32 for the total RVU. Then the rest of it looks the same as in the other examples. For the data gathering, test administration and scoring by psychologist, we've said that's

going to be for four hours. So, the first 30 minutes is captured by the base code at a rate of 1.33, and then each additional 30 minutes -- in this case up to seven units at 1.23 -- for a total RVU of 8.61. Then the neuropsychologist in this case is providing the professional evaluation services: for the first hour 96132, which is billed at a rate of ... an RVU of 3.71, and 96133 for the second code using the add-on code at a new RVU of 2.83. That leads to a total RVUs in this scenario of 21.5 for the evaluation.

Dr. Antonio Puente: Doctor Pliskin, this is significantly different, because in the old days we could use just two actual codes. We have many more codes that we need to be attentive, as we capture the granularity of the [dropped word]

Dr. Neil Pliskin: That's right. Try to say granularity three times fast. But I think the key is that while it's more work for us the professionals on the front end. Documenting all of this, putting it in to a table. Making sure that it's clear, and comprehensive on the back end. Things will be much easier for someone who doesn't do this work to understand what the services were that were provided. Next.

Just a few more examples. This is the same example of the... the differential diagnosis of memory loss. In this scenario, it's the technician providing the four hours of testing, and you can see that a total RVU is 20.2 for this scenario. Next slide.

Then finally, this is the scenario where you have the professional doing testing, the technician doing testing, and the professional -- of course -- providing the evaluation services all with a neurobehavioral status exam. In this neuropsychological evaluation, you have a base code and an add-on code for your clinical interview / neurobehavioral status exam. You have a base code and multiple add-on codes for the test administration and scoring done by the psychologist. You have a base code and multiple add-on codes for the test administration and scoring services done by the technician. Then you have the professional testing evaluation services provided by the qualified healthcare professional using the base and the add-on. In this combination clinical example, the RVUs are 20.9.

Dr. Antonio Puente: A total of [crosstalk 00:50:47] ...

Dr. Neil Pliskin: I'm sorry; go ahead...

Dr. Antonio Puente: And a total of eight different codes.

Dr. Neil Pliskin: Yes. As I said at the beginning it will become second nature to us doing this. It will just eliminate a lot of the ambiguity that we as the professional faced and our colleagues who are coders and third-party carriers will be able to look at our documentation and be able to appreciate much more quickly who's done what activity and for how long. That's what I think is a major step forward with this new series of codes.

Last example. 96146, that's single automated instrument via electronic platform with automated result. Doctor Puente already pointed out that there's a small total RVU associated with that because there's really no professional work associated with that code. Next.

Okay, that concludes the report examples. Now we'll turn to our frequently asked questions. Doctor Puente, in order to use the testing evaluation services codes, must the psychologist first perform test administration and scoring?

Dr. Antonio Puente: Yes. In fact, not only do they have to do that, they actually have to see the patient.

Dr. Neil Pliskin: Furthermore, when you look at what the pre-service activities are, they're things like test selection, determining what the referral question is. It would be very difficult to proceed with test administration and scoring if you don't have a sense of what you're doing the evaluation for. Those are really professional evaluation services, so that's a good answer.

What about the scenario where you complete the testing, but you can't meet with the family for feedback for a few weeks? Doctor Puente, what should you do?

Dr. Antonio Puente: Well, you should submit the entire report and evaluation process as part of the billing and then provide the add-on code for the feedback. Now the question: how long could that be Doctor Pliskin? How long is a few weeks?

Dr. Neil Pliskin: Well, I think that depending on the kind of practice that you have -- I know that, for example, pediatric psychologists, and neuropsychologist often times have to wait for teachers to return rating forms and for all the information to be gathered and collated. The whole process can certainly take additional time. For the purposes of feedback, it might be a period of time before the identified patient and/or family can come in for feedback. I don't think that there's really a set time that you can say. I think that ... obviously you want to have the feedback occur as close to the initial testing sessions as possible, but that's not always possible. Doctor Puente, I'm side-stepping your answer.

Dr. Antonio Puente: Well, and the problem is, Doctor Pliskin, is very often that there is so much variability across patients, and across clinical circumstances. Do the very best that you can. Bill appropriately and make sure you capture the cognitive work.

Let's go to the next question, which is a challenging one. What happens when you do 1.33 for 31 minutes, and then on another day you do your thinking work, your cognitive work. How do I add it to the first 1.33, and then subsequently another one? How does that work, Neil?

Dr. Neil Pliskin: Well, they're all part of the same test evaluation service that you're providing. Again, when you're talking about 96133, you're talking about the add-on code, not a base code. I would say that you're using the add-on code and that it's tied to the original test evaluation services that you're performing. So, I would say that you add it to the first add-on code.

Dr. Antonio Puente: What about the interactive feedback? The patient doesn't want to come in -- what do I do about that?

Dr. Neil Pliskin: Well, it's unfortunate, but I think that interactive feedback really can only be billed when the service is provided face to face.

Dr. Antonio Puente: Yeah, essentially there are actually CPT codes for telephone consultation, but I do not know any insurance company that actually reimburses for that. Yes, this is a face to face activity.

Dr. Neil Pliskin: How should we handle testing cases that are being scheduled, Doctor Puente, or are already scheduled for the end of 2018?

Dr. Antonio Puente: Well, here's my suggestion, and this is Tony Puente and not APA, but I think it might be a useful one. First of all, try as much you can to do at entire evaluation in this calendar year. Do not try to begin an evaluation this year and move it on to the next year. It's two different sets of codes. For that matter, not only do I suggest that you finish the evaluation this year, but beyond that, that you go forward and bill every activity that you can in 2018 before the end of the calendar year. If I may add, sequester some funds, because it may be difficult to make this transition. Not necessarily us, but insurance carriers -- even though we've done a specific webinar for them -- they may not be quite ready. There may be some turbulent air as we move forward from one destination to another.

Dr. Neil Pliskin: Doctor Puente, I've received this question a few times now: what if we administer only one test? What if it has many sub-tests like the Wexler Intelligence Scale? What I would say to that, what we would suggest is that a psychologist is required to give two, or more tests in order to utilize the test administration and scoring codes. A single, standalone test -- even a multi-faceted one -- would not represent a neuropsychological evaluation or a psychological evaluation service. The answer is you have to give two or more tests.

Dr. Antonio Puente: Just because one test has many sub-tests that is not a definition of multiple tests. The WAIS, or WIS, is still one test. What about 146? Can you bill this code twice if you more than one automated test? What about that, Doctor Pliskin?

Dr. Neil Pliskin: No, unfortunately the bill code can only be used one time. If you're giving multiple tests, well then you have other codes in the code series that you can now use. But if you're giving a single automated test with automated result, or you're giving multiple tests with automated results, you can only bill that code one time.

Dr. Antonio Puente: Doctor Pliskin, a question has come in that we probably ought to clarify the answer to our first question and that is, do you have to perform evaluation services before you do testing services, or testing ... Let's not confuse the word "test" alone. Should we do the evaluation before do the test?

Dr. Neil Pliskin: Well again, my answer would be the same. Testing evaluation services involves pre-service work. Pre-service work for testing evaluation services are things like select preliminary selection of test. Determining what the referral question is. In some instances, it's contacting the referral sources. Those are professional activities that would take place before you would give ... typically before you would give any battery of psychological or neuropsychological tests. The answer is yes, you would have to provide some type of professional services before you administer, and score psychological or neuropsychological tests.

Dr. Antonio Puente: Doctor Pliskin, can we turn it over for the last minute or so to Nicole to begin to wrap up this conversation?

Dr. Neil Pliskin: Absolutely.

Nicole Owings-Fonner: Hi, everyone; thank you for this important information. We're actually going to run just a couple minutes long today, because there are two questions from the audience that I want to go ahead and ask. If you do have to bail out soon, please know that rest of the slides are just for your reference, and they include additional resources and information. Please read through them, but I'm

going to go ahead to take a couple minutes to focus on two more questions here. We have some concern from the audience that while for some people it may not be practical to bill all of this all at once on the last day: if folks are required to bill per day, how do they handle the add-on codes and the base codes? Do they do a new base code every day?

Dr. Antonio Puente: Dr. Pliskin...

Dr. Neil Pliskin: No, they would not. They would bill add-on codes for the subsequent days because the services that they're providing are still tied to the original evaluation that's begun. You would only use the base code one time for an evaluation, even if it's conducted over multiple days.

Nicole Owings-Fonner: Thank you. What about in a case example where you're doing both neuropsychological and psychological tests: how do you bill that? Do you need to use neuropsychological testing codes? Do you need to use psychological testing codes too? What would you recommend?

Dr. Neil Pliskin: Doctor Puente always has a good answer to this one.

Dr. Antonio Puente: What's the predominant question? If it's 51% one type of activity, that's how you proceed with it. We have different tests that are used for both activities, but what's the primary activity that you're pursuing? If it's a neuropsychological one, you go with that. You can include, for example, an MMPI as part of the evaluation process, but if the preponderance of the activity is neuropsychological, you go with that. Nicole, do we have any additional webinars coming up that you could briefly announce before we close it out today?

Nicole Owings-Fonner: Thank you, Doctor Puente: we do. It's one of the slides coming up, but just for those of you who want to know now, there will be a question, and answer session with Doctor Pliskin, and Doctor Puente on December 19th, and registration will be provided for that. We understand that we've given you a lot of content over the last three webinars and that there are still some remaining questions. There's two ways that we're handling that. One, after we send out the recording, we're also going to send out a list of more answered questions. We know we didn't get to them, and we want you to have this information. Like I said, we're also going to have a follow up webinar on December 19th, where our two wonderful presenters will tackle just questions that are still remaining.

If you do need more information, you can always check out the APA Practice Organization website. Click on Reimbursement, and we have a lot of resources on this topic as well as other topics. Also if you want to go to psychologycoding.org, there's a lot of information there on how to bill.

We've also included links to several recent articles that we publish on this topic.

Like I said if you still have questions please join us on December 19th. Registration for this opens tomorrow.

Additionally, if you wind up having problems with insurance companies when you try to reimburse for your services, please contact the APA Practice Organization for help. Our legal and regulatory affairs team monitor billing issues. When appropriate, they've taken action against managed care, and insurance company abuses.

Finally, if you're not a member, now would be a great time to join. APA works hard to advocate for psychologists and bring resources like this webinar to its members.

Thank you to our presenters and thank you to everyone who was listening today, and who listens to this later. We really appreciate your time and your input and we will be sending you a survey that we would love for you to complete, so that we can make things better for you, and continue to provide resources like these.

Thank you for your time.