

Nicole Owings-Fonner: Good afternoon or good morning depending on where you are. Welcome to today's webinar on what insurers need to know about the new psychological and neuropsychological testing codes. 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 to 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.

Along with the recording, there will be a survey with questions. We really encourage you to fill this out so we can know exactly what we need to provide you. Also, if you have any questions about the materials and what's covered in the slides, please include those in the survey and we will be getting back to everyone with responses as we have them.

Our presenters today are Doctors Antonio Puente and Neil Pliskin. I'm going to go ahead and turn it over to Doctor Puente to start.

Dr. Antonio Puente: Well hello, good to be with you this webinar. The webinar is intended primarily, though not exclusively for insurers. Our goal is to partner with our colleagues here in making sure that everybody on both sides understand the new testing codes and definition. We are going to walk you through the crosswalk from the old codes to the new codes, and even though we are not only introducing new numbers, we're also introducing new definitions and more importantly new concepts. It's critical that you appreciate the fact that we are also introducing different time units, which makes this a very different paradigm.

Our goal also is to provide practical examples and at the end have some very frequently asked questions for you to consider. Next slide.

One of the major problems was the issue of the double dip. Specifically there should be a time when a professional and technician interact, but in many cases, this is occurring in each and every unit of episode of activity. As a consequence, this was essentially producing, if you will, an incorrect billing and interpretation of what we were doing. As a consequence, we had to go back to the table and re think from the ground up everything involving the testing codes, and hence what we have here before us today. Next slide please.

Our goal is essentially as I said earlier is to make sure that everybody understands that we were facing the same problems, whether you were a carrier or you were a provider. The double-dip perception has to do with the unique work performed when both the professional and the technician end up doing the activities on the same day. There is a long term misunderstanding of the face-to-face and non-face-to-face work of both the professional as well as the technician. That needed to be clarified. Many carriers have requested that we bill on multiple days; some requested that we bill only on one day. This has been confusing. We will provide some guidance as to how to go about applying these codes and when and how to bill them. Also, a major issue was how do we interpret a single test versus how do we interpret when we have multiple tests, as well as background information. The concept of data integration and specifically how do we engage in clinical decision making, how does a provider end up integrating material to come up with an understanding of the complexities associated with both

psychological and neuro psychological testing. Historically, we've been telling folks when you provide feedback just envelop it within the testing code. It turns out that was not clear, it was not provided, in the original concept and we now have specific guidance and how to do the feedback itself. Finally, the computer screening test, billing as a psychological, neuropsychological testing turned out to be a serious concern. We have solutions to these, and many of the other concerns have been raised over the last year years during the life of these codes. Next slide, please.

The new testing code structure has essentially a base code for testing evaluation and it's basically founded on the concept that there's three parts to every activity. Pre-service work, intra-service work, and the post-service work. Most of us, we understand the intra-service work, and that includes as you see in the slide anything from interpretation of tests to interactive feedback, but there's a pre-service work, as well as a post-service work, and that is in many ways where some of this becomes a bit of a challenge. Our goal was to make sure that we understood exactly what was to occur pre, post, as well as intra.

Now the next slide provides a very, very important concept that we want to make sure we all understand. The base code, which is a foundation for everything that involves the testing includes free, post, and intra-service work. In other words, we select a test, we follow up etc. The biggest activity of course is the intra-service work. When we add on to these base codes, in other words when we add how many additional units of work we're pursuing and activity, then we do not want to if you will double dip by adding the pre and the post service work. The pre and post service work, one more time should only occur when we have a foundational or base code, not when we have the add on codes.

This is not only a new testing code structure, but a new paradigm for how to code and bill. And with this foundation I'm going to turn over to my esteemed colleague, Dr. Pliskin, who will go into detail of all the testing codes. Neil?

Dr. Neil Pliskin: Thank you, Dr. Puente. There are three new main sub-sections that have been added to the section of the CPT codebook entitled Central Nervous System Assessments/Tests, and 12 new codes have been added. These subsections are assessment of Aphasia and Cognitive Performance Testing, Developmental/Behavioral Screening and Testing, and Psychological/Neuropsychological Testing. Next slide.

So the addition of the 12 codes to this subsection allows the reporting of services provided during testing of the cognitive and neurobehavioral functions of the central nervous system. I want to emphasize very clearly that this is not a one-to-one crosswalk between the codes that are about to be deleted and the new codes. These are a new series of codes that is not a one-to-one crosswalk from the deleted codes. It's a new sheet of music that this concerto will be playing on. Next slide.

Dr. Antonio Puente: And before you go on, Neil, let's make sure that we also realize, it's not just a bunch of new codes, but a bunch of new units, so we can't just translate the same number of units that we have historically done.

Dr. Neil Pliskin: Very good. The terms that we want to make sure are well defined and understood are listed on this slide. Neurobehavioral status exam is an existing code and description that we'll talk about, but in the new code system you'll now have something called neuropsychological testing evaluation services and psychological testing evaluation services. As Dr. Puente has already foreshadowed, there is

now an explicit place to document, sorry... code your interactive feedback, which we'll define. Next slide.

So the neurobehavioral status exam is a clinical interview assessment of cognitive functions and behavior. It may include an interview with the patient and other informants or staff, as well as integration of prior history and other sources of clinical data with clinical decision making further assessment and/or treatment planning and report.

Next definition. These terms, psychological testing evaluation services, and neuropsychological testing evaluation services are the services that are uniquely provided by the qualified healthcare professional. If you're doing a psychological evaluation this would typically include professional activities of integration of the patient data with other sources of clinical data, test interpretation, clinical decision making, treatment planning and report. And note, included in this code, the testing evaluation services it may include interactive feedback to the patient, family member, caregiver, when performed. The evaluation domains for psychological evaluation may include emotional and interpersonal functioning, intellectual function, thought processes, personality, and psychopathology.

And when you contrast that to neuropsychological testing evaluation services, the professional activities are still the same. That is integration of patient data, interpretation, clinical decision making, treatment planning and report.

It also includes interactive feedback for your neuropsychological evaluation. For neuropsychological testing evaluation services, those domains include intellectual functioning, attention, executive functioning, language and communication, memory, visual spatial functioning, sensory motor functioning. Note, emotional and personality features, and adaptive behavior. We'll go into more detail as this webinar progresses. Next slide.

We've talked about it, let's define it. Interactive feedback: interactive feedback is used to convey the implications of psychological or neuropsychological test findings and diagnostics formulation. Based on patient-specific cognitive and emotional strengths and weaknesses, interactive feedback may include promoting adherence to medical and/or psychological treatment plans, educating and engaging the patient about his or her condition to maximize patient collaboration in their care, addressing safety issues, facilitating psychologically coping, coordinating care, and engaging the patient in planning given the expected course of illness or condition when performed. This is uniquely a professional services activity, interactive feedback. Using the professional services codes, this is how you will code interactive feedback going forward. Next slide.

So here's an overview, and then we're going to dig into the details. The overview of the new testing code family includes neurobehavioral status exam the testing evaluation services, 96130, 96133 and as Dr. Puente mentioned we're now dealing with a base code, 96130 and an add on code 96131 for psychological professional testing evaluation services, and you're using the base code 96132 and the add on code 96133 for your professional testing evaluation services, provided by your qualified healthcare professional for neuropsychological services. Note, whether you're talking about the neurobehavioral status exam and its add-on, 96121 or you're talking about test evaluation services, whether it's psychological or neuropsychological testing evaluation services, those are coded per hour of service.

When you now move to the test administration and scoring, which has been separated completely from the professional test evaluation services the units have changed. There are now codes, 96136 the base and 96137 for psychological or neuropsychological test administration and scoring by physician or other qualified healthcare professional, two or more tests, first 30 minutes, and 96138 and 96139 the base and add on codes for psychological or neuropsychological test administration and scoring by technician. Again, it has to be two or more tests to use this code and if it's less than two tests we have a different code, which we'll go through shortly, but it has to be two or more tests, and note first 30 minutes and each additional 30 minutes.

Practically, what that means for those of you that have been getting pre-authorization requests for four hours of neuropsychological or psychological test administration the units of coding will be completely new for starting January one, where they will be in half hour units and you can expect both base and add on codes in add on units. Next slide.

Now let's get into the details. Psychological testing services. As before, there's been no change to CPT code 90791. If you're doing a psychological evaluation and you're as part of the psychological evaluation you're conducting a clinical interview a psychiatric diagnostic evaluation you would use 90791 in conjunction with your psychological testing services code, and your psychological test administration and scoring codes. This has not changed. Next slide.

Here are the changes. Let's skip this and let's get into the details. We'll go back to these kinds of slides. Here is the deeper look at this. For your based code, when a psychologist is providing a psychological testing evaluation services, they will be using the base code for their first hour of service, 96130 and the add on code, 96131 for each additional hour of professional services provided by the qualified healthcare professional engaged in these professional activities as provided in this code descriptor. Next slide.

As every psychologist knows, or most of us know I should say, we're a divided group when it comes to test administration and scoring. That is our professional surveys show that roughly half of all psychologists use technicians and half of all psychologists provide their own testing. Their own test administration and scoring, therefore there are separate codes designated for when the psychologist does her or his own testing. So 96136 is psychological or neuropsychological test administration and scoring, so note that in this code, we're not only talking about the face-to-face test administration, but we're also talking about non face-to-face activities scoring by physician or other qualified healthcare professional. Again, the qualifiers. Two or more tests, any method. A frequently asked question is what about the computer testing code and how do you code computer tests. In the new coding structure it's any method. So whether it's paper and pencil, whether it is handheld, whether it is computer, desktop or laptop, any method that the psychologist her or himself administers and scores the test, you will use this code, the base code, 96136 for the first 30 minutes. If there is additional testing ... Please go back. If there is additional testing, then that extends beyond that first half hour, then you will be using, or your psychologist and other qualified healthcare professionals will be using the add on code 96137. Next slide please.

So here's the crosswalk. Right now until December 31st, you... qualified healthcare professionals doing psychological testing are using the single code, 96101. This slide illustrates very clearly now the separation between the testing evaluation services, which are uniquely provided by the qualified healthcare professional and the test administration and scoring services, which could be provided by the professional and if it is, then you use the following code structure. For the first hour of psychological test

evaluation services it will be 96130 and for the base and the add-on will be 96131 for each additional hour. For the test administration and scoring when completed by the professional, 96136, first 30 minutes two or more tests any method and add on code for each additional 30 minutes 96137. So we're going from a single code 96101 to multiple codes that provide a more granular appreciation for the services that are being uniquely provided by in this scenario the professional, but distinguishing between the testing evaluation services, and the test administration and scoring. Next slide.

When the psychological testing and scoring is done by a technician, there is a separate set of codes; that would be 96138 the base code, which again is psychological or neuropsychological test administration and scoring by technician. Again, two or more tests, again any method, and again first 30 minutes. If the testing extends beyond that first 30 minutes, and the technician is administering the test, then each additional 30 minutes is coded with add on code 96139. Here's how the crosswalk looks. Very similar. Next slide.

And that is 96130 and 131 for your professional services, and for test administration and non-face to face activities scoring by technician 96138 is the base 96139 is the add-on. Next slide.

Here's several clinical examples. In example one we have a pediatric ADHD psychological assessment. And for this scenario we have one diagnostic interview conducted by the qualified healthcare professional, three hours of in this case for this example I'm a psychologist so I'll say by psychologist administering tests, and three hours of the professional evaluation services. Take a look how this will be coded now. The diagnostic interview, as has been the case all along ... by all along I mean currently and it won't change, diagnostic interview will be 90791 and that's not a time based code, so it's just a single unit.

The test administration and the scoring and data gathering when conducted by the psychologist in this scenario it's three hours of psychological testing, the base code is 30 minutes, so the first 30 minutes is 96136 and then the remaining two and a half hours of psychological testing is coded in half hour units totaling five units at 96137. Then the formal testing evaluation services provided by uniquely by the qualified healthcare professional in this example is three hours. Since it's an hourly code, hour one is code 96130, the base code. Hours two and three are 96131 two units of add on to cover the three total hours of professional evaluation services. What you can expect when you get these submissions for an assessment where the psychologist is doing or the qualified healthcare professional is doing their own testing you can expect five different codes to be submitted. Next slide.

Dr. Antonio Puente: And many more units than historically we've been billing. It's not just a series of new numbers, but a series of new units. In this particular instance, you can end up with several different codes and a total of 10 different units billed.

Dr. Neil Pliskin: Okay, next slide. Here's another clinical example. This one is of a psychological evaluation for an individual with chronic pain. Perhaps this will be for placement of a spinal cord stimulator. There's lots of different scenarios where this will take place. The scenario that we're describing here is again one diagnostic interview, except this time we have a technician administering the testing for three hours, and then the same three hours of professional evaluation services.

Like the last example, the diagnostic interview is still coded, single code, 90791, except this time the test administration and scoring the data gathering is being conducted by the technician so therefore it's a

different set of codes. The first 30 minutes out of the three hours of technician testing you'll use the base code, 96138. For the remaining two and a half hours coded in half hour units, five units, you'll use the add on code 96139.

As before, the qualified healthcare professional is providing the test evaluation services, in this case example, it's three hours of services, the first hour 96130 is the base code, hours two and three 96131 the add on code, two units.

Finally, third example, next slide. Another very common scenario is where you'll have a qualified healthcare professional and a technician both administer tests as part of the assessment process. In this example we have one diagnostic interview, two hours of technician testing, two hours of qualified healthcare professional administered testing, and two hours of professional evaluation services. The numbers don't line up exactly, but I think you'll follow it pretty clearly that the diagnostic interview is again accomplished through the psychiatric diagnostic interview code, 907, evaluation code 90791.

For test administration and scoring services provided by the psychologist, in this example it's two hours, so the first 30 minutes, the base code 96136, which is test administration and scoring, neuropsychological and psychological test administration and scoring by qualified healthcare professional, first 30 minutes, and for the remaining one and a half hours of testing coded in 30 minute units, we have the add on 96137. Since in this scenario the technician also did some testing, two hours of testing you're also using 96138 the base for the first 30 minutes and 96139 the add on for the remaining 90 minutes or three units.

And then regardless whether it's the QHP, who's doing the testing, test administration and scoring, the technician who's doing the test administration and scoring or both on the same patient, testing evaluation services are uniquely provided by the qualified healthcare professional and that's two hours of professional evaluation services, the base code 96130 the add on code, 96131.

Dr. Antonio Puente: So we could end up with seven different new codes and 11 different units of activity.

Dr. Neil Pliskin: That's correct, but at the same time by looking at the distribution of those codes the carriers will get a much clearer sense of who's providing what service and for how long. A lot of the struggles that you alluded to, Dr. Puente, of what service is being provided by the QHP, what's being provided by the technician, what's a professional service, what's a data gathering service: now I think with this new code structure, while it will take some getting used to the number of codes, the granularity of what are the services being provided will be much clearer. Next slide.

Now let's turn our attention to neuropsychological testing services. And this will be a familiar structure, because we just walked through it with the psychological testing services. Here we go. When conducting a clinical interview for an individual who's undergoing a neuropsychological evaluation, one would typically conduct a neurobehavioral status exam, which we previously defined as a clinical interview based assessment by the physician or other qualified healthcare professional both face to face time and time interpreting test results and preparing the report, first hour. Conducting the clinical interview and clinical exam, 96116, which is the same code that we have in place this year for the first hour, but in the new coding system there's an add-on code. So 96116 now becomes the base for the first hour and if the

neurobehavioral status exam extends beyond the first hour, then you would use the add-on code 96121. Next slide.

Here's the crosswalk. For 96116 neurobehavioral status exam, if it's just for one hour or up to 31 minutes to an hour, then you'll use 96116, the base code. If it extends beyond that first hour, there will now be an add-on code, 96121. Next slide.

This is a snapshot of the neurobehavioral status exam from the CPT code book, which clearly delineates that the neurobehavioral status exam involves cognitive services, it can involve test administration in the context of the clinical interview, and that's done solely by the physician or qualified healthcare professional and the interpretation report or automated result is provided uniquely by the physician or qualified healthcare professional that's 96116 and 121 the neurobehavioral status exam. Next.

And we'll skip this slide and dig into the details instead. For your qualified healthcare professional providing testing evaluation services, which we have defined several times in this webinar, the first hour will be 96132. The second and subsequent hours will be coded with the add on code 96133, so again when your physician or other qualified healthcare professional engages in uniquely professional activities integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning, report, and interactive feedback to the patient family member or caregiver when performed in the first hour 96132 each additional hour add on code 96133. Next slide.

And we've already defined interactive feedback. I'll just say that the interactive feedback should be coded using the add-on code 96133. Since it will be connected to the base code through the evaluation itself. Next slide.

The professional services of 96132 and 96133 and ... let me back up. This chart represents all of the professional services. 96130 and 131 we just finished reviewing, psychological test evaluation services based in add-on. And 96132 and 133, which we're talking about now neuropsychological test evaluation services base and add-on and this chart clearly illustrates that there are cognitive services associated with this, and there's interpretation and report services associated with it, but test administration and scoring are not associated and included in test evaluation services. That's now separated out as we've been saying. Next slide.

When the qualified healthcare professional is the one administering the tests, 96136 the base, 96137 the add-on, 30 minutes any method two or more tests. So whether you're doing psychological or neuropsychological test administration if it's the physician or qualified healthcare professional doing that, you're going to be using the codes 96136 for the base and 96137 for the add on, 30 minutes each. Next slide.

So the crosswalk currently 96118 will be deleted and will be replaced by the professional neuropsychological testing evaluation services, 96132 and 133 and if the professional is going their own testing half hour units 30 minute units 96136 and 137. Next slide.

As we've said, when the technician is administering the testing under the supervision of course of the qualified healthcare professional then you would use the new codes for test administering and scoring by technician 96138 for the first 30 minutes, 96139 for each additional 30 minutes, any method two or more test. Next slide.

The crosswalk will be familiar now. 96119, which will be deleted and replaced with 96132 and 133 for professional services provided, testing evaluation services, and if it's a technician administering the testing and completing the scoring 96138, 96139 30 minutes base and add on. Next slide.

Here's your clinical examples. Here's a two hour neurobehavioral status exam, four hours of psychologists in this case doing their testing own testing, and two hours of professional services. So note, this is a two hour neurobehavioral status exam, hence 96116 is your base and the second hour is now coded 96121 the new add on. For test administration and scoring in this case, in this example by a psychologist or other qualified healthcare professional we said four hours of testing so the first 30 minutes is 96136 and then the remainder of the time in half hour units, which is comprising seven units in this example 96137 and then the distinctly separate neuropsychological testing evaluation services, two hours in this case base code for the first hour 96132 add on code for the second hour 96133. Next please.

Dr. Antonio Puente: And Neil, before you go on, let's emphasize that we are not changing the total amount of hours with these activities. In an effort to be granular and clear about exactly what we are doing, we are just simply breaking things down in such a way that everybody has a very clear vision of how many things are being done and who's doing them. In this case, we have six different units and different codes, excuse me, and a total of approximately 12 different units. That is done not to change the scope of practice, just to clarify the practice itself.

Dr. Neil Pliskin: Next slide. Okay, and these other examples will be familiar to you. We say a 46 year old male with a history of coronary artery disease with reported symptoms of memory loss, anxiety and depression, this is a one hour neurobehavioral status exam four hours of technician testing, which this time will be the first 30 minutes 96138 and then each additional 30 minutes totaling seven units 96139, but the testing evaluation services by the qualified healthcare professional will still remain 96132 for the first hour, and 96133 the add on for the second hour. Next slide.

And just to highlight the point, and I'm not going to dig into the details here, but to highlight the point that again, it's typical practice for both the technician and a psychologist to engage in test administration and scoring services, and so please expect to receive a documentation that reflects different test administration by the qualified healthcare professional versus test administration and scoring by the technician. Next slide.

This just illustrates the test administration and scoring doesn't involve the cognitive services, doesn't involve the interpretation in report or automated result, it's uniquely related to test administration and scoring only. Next.

Finally, what happens if it's not two or more tests if it's a single test? Next slide.

Currently, the codes that are about to be deleted, 96103, and 96120 are neuropsychological testing administered by computer. In 2019 the code will be 96146 psychological or neuropsychological test administration single automated instrument with automated result. Next slide.

That's the code. Next slide.

So the crosswalk will be when it involves a single automated instrument via electronic platform with automated result only the code to use will be 96146. And here's the clinical example of this, next slide. A 70 year old female presents with a history of failing memory, her physician arranges for the administration of a single automated cognitive test handed to her by the clinical staff. That would be psychological and neuropsychological test administration, single automated instrument via electronic platform with automated result only one unit 96146. There is no physician work, just practice expense in this code. If there are two or more tests that are being administered that requires testing evaluation services, in other words you can't just use psychological or neuropsychological test administration two or more tests without it also being coupled with the professional test evaluation services. Just a few more slides. Next please.

It's just an automated result, no cognitive services, no test administration and scoring beyond the single automated test. Next slide. Dr. Puente?

Dr. Antonio Puente: As you can see in this particular slide and the next one, we are presenting for your consideration and understanding the RVUs associated with each of these new codes. For example 96116, which is an old code, the RVU is at 2.70; the 130, it's 3.30. Essentially they're different codes, different descriptors and different RVUs. Again, this is for your consideration. These RVUs would determine [inaudible 00:42:33] as you well know through the different processes associated with the RVU system of the AMA CPT.

The next slide provides additional information regarding these RVUs and as you can see, some are relatively small. For example the by technician 138 is 1.08 and some are basically as Neil said the practice expense four and 46, which is .06. The goal is to provide information regarding these RVUs as you develop your own payment policy.

Now let's move onto the next set of, if you will, the next part of our presentation. We have some questions that we'd like to propose to you for your consideration and the next slide will provide at least some sampling of that. Dr. Pliskin, could you take it away?

Dr. Neil Pliskin: If both the psychologist and the technician provide test administration and scoring services during the evaluation. Can both test administration and scoring codes 96136 through 96139 be used to document the time spent by each? The answer is yes, and the clinical examples that we provided illustrated how both the qualified healthcare professional and the technician can engage in test administration and scoring services and the same patient.

How should we bill for services that take place over multiple days? This is a complicated question, but it's typical for psychologists to provide testing evaluation services, and I say psychologists because I'm a psychologist, but it's typical for qualified healthcare professionals who engage in these services to provide testing evaluation services, and test administration and scoring services across multiple days of service. This could include multiple testing sessions with test scoring, it could include non-face to face time engaged in professional services, it could include interactive feedback sessions. When a service is spread out over multiple visits it's our recommendation that all codes be listed by the date in service and billed together on the last date of service when the evaluation process is completed.

Additionally, a base code should only be submitted for the first unit of service, and only an add-on code should be used to capture the services provided during subsequent days of service. And finally, what

about the scenario where you complete the testing, but can't meet with the family for feedback for a few weeks. I think we've already said that you would code that as an add on code, you would not have a new base code for a feedback session that's based on an evaluation that took place a period of time earlier.

Dr. Antonio Puente: Dr. Pliskin, let me go back to the second question that was posed in this slide number 50. Let me be clear, how is it that I'm supposed to bill? Is it that I in the report, and in the billing sheet provide the different days, but I wait until I have full documentation on the last day of service to submit the bill? Please explain [inaudible 00:45:58] that because some of us are not entirely clear when is it that we actually document, and when is it that we actually bill? Could you please expand on that?

Dr. Neil Pliskin: Well, Dr. Puente, I'm aware that we're very short on time, and that's a more complicated question in terms of how to document all that. So we'll have to address that in subsequent communications, but I think the short answer to the question is that all the codes should be listed by the date and the service. And then billed together on the last date of service.

Dr. Antonio Puente: Thank you. Also, regarding the issue of clinical decision making, will you be providing or will APA be providing additional information to us as to how do we document clinical decision making?

Dr. Neil Pliskin: Absolutely. That will be forthcoming.

Dr. Antonio Puente: Okay, and finally, I wanted to emphasize on behalf of all of APA Practice Organization how thankful we are that we had the opportunity to work with the carriers in helping develop these concerns and questions. We also look forward to making sure that you provide us feedback so we can continue collaborating. A big thank you to the folks at National Academy of Neuropsychology and our other sister associations that have partnered with us in making this particular presentation become a reality. But before we begin to wrap it up and turn it over to Nicole, Neil, you've been working on this for a bunch of years now -- what's your takeaway? How is it that a carrier needs to reconfigure the new testing codes? It's not just a bunch of new numbers and definitions, but it's a new paradigm. What's your takeaway to our colleagues in the carrier industry of what this paradigm means to them?

Dr. Neil Pliskin: Well, what I would say is that it's a new day and a new set of codes and a new set of units associated with those codes. I would tell the carriers that they can't conceptualize services provided in 2019 the way that they have been documented and billed for in 2018. It's a new day, and there will be as an example, there will be authorization requests for twice the number of units than is typically people have grown accustomed to seeing and approving. I encourage the carriers to look carefully at each of the codes, at what's being requested, and to be attuned to the fact that there is no direct crosswalk from 2018 to 2019.

Dr. Antonio Puente: And just for historical purposes before I turn it over to Nicole, the shift in this paradigm that we're presenting was really prompted by CMS realizing that these were highly utilized and valued codes and they were thinking that we were not necessarily capturing what we were actually doing. And as a consequence a comprehensive study was done by APA and the sister associations to make sure that we were clear, very clear what is the activity that is being performed by whom and for

how long. This is not meant to change the scope of practice, this is meant to be granular and clear about the activities that the provider and the technician does.

Dr. Neil Pliskin: And to support that the APA Practice Organization is working on a model LCD and a user's guide to help the carriers, and providers alike understand how to use these codes and the parameters of codes used.

Dr. Antonio Puente: And Nicole, would you tell us a little about the number of things that Dr. Skillings and the Practice Organization staff have been able to put together to make sure that this transition to the new testing codes is effective for both providers as well as for carriers?

Nicole Owings-Fonner: Yes, thank you to both of our presenters today. Unfortunately, we are now running over time, so I encourage you to check out all of the resources that APA Practice Organization on our website at www.apapracticecentral.org. If you click on reimbursement under the testing code section you'll find all of this information and more. If you do have additional questions, please feel free to contact APA's Office of Healthcare Financing at ohcf@apa.org. Additionally, we want to thank you for attending today's webinar. Like I said at the beginning, a link to today's recorded webinar will be emailed to all of you within 48 hours, and we'd really appreciate your feedback through that survey. If you have any other questions that weren't addressed, please include them in that survey so we can get that important information to you. Thank you, and have a great day.