CODING, BILLING & DOCUMENTING PROFESSIONAL PSYCHOLOGICAL SERVICES: INTRODUCTION TO THE CPT

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WEBINAR OF 05.14.14

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Acknowledgments: Organizations

- North Carolina Psychological Association (NCPA)
- American Psychological Association (APA) Practice Directorate (PD); Ethics Committee
- American Medical Association (AMA) CPT Staff
- National Academy of Neuropsychology (NAN)
- Division of Clinical Neuropsychology of APA (40)
- Center for Medicare & Medicaid Services (CMS) Medical Policy Staff- Medicare
- National Academies of Practice (NAP)

(presented in chronological order of engagement of support for the work outlined)

Acknowledgments: Individuals

- **AMA**: *Marie Mindenman, Tracy Gordy, Peter Hollman*
- **APA**: ***Randy Phelps***, Norman Anderson, *Diane Pedulla*, Katherine Nordal (*APA Testing & Psychotherapy Groups*)
- **NAN**: *PAIC Former and Present Committee*
- **NAP**: Marie DiCowden
- **National Psychologist**: Paula Hartman-Stein
- **Other**: ***James Georgoulakis, Neil Pliskin***, Pat DeLeon
- *(highly instrumental in recent CPT activities)*

Support Provided

- **AMA = AMA pays travel and lodging for AMA CPT activities 2009-present (*no salary, stipend and/or honorarium; stringent conflict of interest and confidentiality guidelines*)**
- **APA = Expenses paid for travel (airfare & lodging) associated with *past* CPT activities (*no salary, stipend and/or honorarium historically nor at present*)**
- **NAN = (from PAIO budget) Supported UNCW activities (*no salary/ honorarium obtained from stipend/paid to the university directly; conflict of interest guidelines adhered to) from 2002-2009***
- **UNCW = University salary & time away from university duties (e.g., teaching) plus incidental support such as copying, mailing, telephone calls, and secretarial/limited work-study student assistance**
- **Stipends = 100% goes to the UNCW Department of Psychology to fund training of students in neuropsychology**

Summary = AMA CPT includes travel/lodging support but no salary/stipend. Any monies obtained, such as honoraria for presentations, are diverted to the UNCW Department of Psychology for graduate psychology student training. No funds are used to supplement the salary or income of AEP.

Personal Background (1988 – present)

- North Carolina Psychological Association (e)
- *NAN's Professional Affairs & Information Committee (a); Division 40 Practice Committee (a)*
- *National Academy of Practice (e)*
- APA's Policy & Planning Board; Div. 40; Committee for Psychological Tests & Assessments (e); Ethics Committee
- *Consultant with the North Carolina Medicaid Office; North Carolina Blue Cross/Blue Shield (a)*
- Health Care Finance Administration's Working Group for Mental Health Policy (a)
- Center for Medicare/Medicaid Services' Medicare Coverage Advisory Committee (fa)
- American Medical Association's Current Procedural Terminology Committee Advisory Panel – HCPAC (IV/V) (a)
- *American Medical Association's Current Procedural Terminology – Editorial Panel (*e; rotating and permanent seat/second term*)*
- *Joint Committee for Standards for Educational and Psychological Tests* (a)

Standards & Guidelines for the Practice of Psychology

- APA Ethics Code (2002)
- HIPAA and other federal regulations
- State or Province License Regulations
- Contractual Agreements with Third Parties
- Professional Standards (e.g., Standards for Educational and Psychological Tests, 1999; in revision)

Outline

- Part I: Coding
- Part II: Economics
- Part III: Resources

Part I: Coding, Billing & Documentation

- Part I:
  - A. Medicare
  - B. CPT Overview
  - C. Professionals & Technicians
  - D Supervision
  - E. Medical Necessity
  - F. Documentation
  - G. Time
  - H. Location of Service
  - I. Correct Coding Initiative

A. Medicare: Why?

- ***The*** Standard for Universal Health Care:
  - Coding (what can be done)
  - Value (how much it will be paid)
  - Documentation (what needs to be said)
  - Auditing (determination of whether it occurred)

Note: While Medicare sets the standard, there is no point-to-point correspondence with private carriers, forensic or consulting activity but it does set the foundation

What Drives Medicare

- Quality
- Expansion of Services
- Patient Experience
- Focus on Primary Care
- Affordability
- Preserving Medicare Trust

Current Goals for Medicare According to CMS

- Lower Prescription Costs
- Addition of Preventative Care
- Doctor Incentives to Coordinate and Perform Better

  – Don Berwick, CMS Administrator, 09.02.11

Medicare: Immediate Impact

- As a Consequence, the Benchmark for:
  - All Commercial Carriers (e.g., HMOs)
  - As Well as;
    - Workers Compensation
    - Forensic Applications
    - Related Applications (e.g., industrial, sports)

Medicare: Long-term Impact

- Currently, $300 billion annually
- By 2015, Medicare will represent approximately 50% of all health care payments in the United States
- Eventually, a national (US) health insurance will be established
- One possible model will be to introduce Medicare to younger citizens will be in age increments (e.g., 60-64, then 50-59, etc.)
- Hence, Medicare will come to set the standard for all of health care

Medicare: Local Review

- Medical Review Policy
  - National Policy Sets Overall Model
  - Local Coverage Determination (LCD) Sets Local/Regional Policy-
    - More restrictive than national policy
    - Over-rides national policy
    - Changes frequently without warning or publicity
    - Applies to Medicare and private payers
    - Information best found on respective web pages

B. Current Procedural Terminology (CPT): Overview

- Background
- Codes & Coding
- Existing Codes
- Model System X Type of Problem

CPT: Copyright

- CPT is Copyrighted by the American Medical Association
- CPT Manuals May be Ordered from the AMA at 1.800.621.8335
- www.ama-assn.org/go/cpt

What Is a CPT Code?

- A Coding System Developed by AMA in Conjunction with CMS to Describe Professional Health Services
- Each Code has a Specific Five Digit Number and Description as well as a Reimbursable Value
- Professional Health Service Provided Across the Country at Multiple Locations
- Many “Physicians” or “Qualified Health Professional” Perform Services
- Clinical Efficacy is Established and Documented in Peer-Reviewed Scientific/Professional Literature
- Regulatory and Royalty Based

CPT: Background

- American Medical Association
  - Developed by Surgeons (& Physicians) in 1966 for Billing Purposes
  - 8,000+ Discrete Codes
  - CPT Meets a Minimum of 3 Times/Year
- Center for Medicare & Medicaid Services
  - AMA Under License by CMS
  - CMS Now Provides Active Input into CPT
  - It is Regulatory and Would Take Congressional Action to Change

CPT: Rationale

- History
  - Outgrowth of the development of Medicare system in mid 1960s
- Purpose
  - Provide a uniform system for all health care procedures
  - Developed, approved and used by all health care professionals and third party carriers (including Medicare/Medicaid)

Anatomy of a CPT Code

- Number (5 digits)
- Inclusion Criteria
- Exclusion Criteria
- Reference
- Description (2-3 lines)

CPT: Composition

- AMA House of Delegates
  - 109 Medical Specialties
- HCPAC
  - 11 Allied Health Societies (e.g., APA)
- CPT Editorial Panel
  - 17 Voting Members
    - 11 Appointed by AMA Board
    - 1 each from BC/BS, AHA, HIAA, CMS
    - 2 Voted on by HCPAC
      - Psychologist (AEP)
      - Occupational Therapist

CPT: Theory

- Order of Value - Personnel
  - Surgeons, Physicians, Doctorate Level Allied Health, Non-Doctorate Level Allied Health
- Order of Value - Costs
  - Cognitive Work, Expense, Malpractice
  - X a Geographic Location Factor
  - X a Conversion Factor Set by Congress Yearly

CPT: Categories

- Current System = CPT 5; 2014 Version
- Categories
  - I= Standard Coding for Professional Services
    - Codes of interest
  - II = Performance Measurement
    - Emerging strongly; will be the future of CPT
  - III = Emerging Technology
    - New technology and procedures

CPT: Code Book

- Basic Information = Codes
- Appendices
  - A = Modifiers
  - B = Additions, Deletions and Revisions
  - C = Clinical Examples (Vignettes)
  - D = Add-on Codes
  - H = Performance Measures by Clinical Condition or Topic

CPT: Abbreviated Glossary

- **CPT**
  - Current Procedure Terminology = professional service code
- **Qualified Health Professional**
  - The person who has the contract with the insurance carrier
  - Defined by training (e.g., see Division 40, NAN % APA statements), state (e.g., licensing boards) and federal statutes/laws/regulations (e.g., Medicare)
  - May not include Master's level Associates
- **Technician**
  - Anybody else
- **Facility vs. Non-facility**
  - Non-facility = all settings other than a hospital or skilled nursing facility
- **Units**
  - Time based factor which is applied as a multiplier to the RVUs agreed to by AMA CPT and CMS
- **Face-to-face**
  - In front of the patient

CPT: Development of a Code

- Initial
  - Health Care Advisory Committee (non-MDs)
- Primary
  - CPT Work Group (selected organizations)
  - CPT Panel (all specialties)
- Likelihood
  - HCPAC = 72% of codes submitted are approved
- Time Frame
  - 2 to 12 years

CPT:

CNS Assessment Codes Timetable: An Example of Time from Idea to Reality

- Activity x Date
  - Codes Without Cognitive Work Obtained, 1994
  - Ongoing Discussions with CMS About Lack of Work Value, 1995-2000
  - Request by CMS/AMA to Obtain Work Value, approximately 2000
  - Initial Request for Practice Expense by APA, Summer, 2002
  - APA Appeared Before AMA RUC, September, 2003
  - Initial Decision by AMA CPT Panel, November 7, 2004
  - Call for Other Societies to Participate, November 19, 2004
  - Final Decision by AMA CPT Panel, December 1, 2004
  - Submission of CPT Codes to AMA RUC Committee immediately thereafter
  - Review by AMA RUC Research Subcommittee in January, 2005
  - Review by AMA RUC Panel in February 3-6, 2005
  - Survey of Codes, second & third week of February, 2005
  - Analysis of Surveys, March, 2005
  - Presentation to RUC Committee in April, 2005
  - Inclusion in the 2006 Physician Fee Schedule on January 1, 2006
  - Meeting with CMS, April 24, 2006
  - CMS Transmittal and NCCI Edits published September, 2006
  - AMA *CPT Assistant* articles published November, 2006
  - AMA *CPT Assistant* Q & A published December, 2007
  - Presentation to AMA CPT Panel February 9, 2007
  - Presentation to CMS a series of Q and As July, 2007
  - Acceptance and publication of new CPT testing code language, October, 2008
  - Initial acceptance of clarification of testing codes by CMS, October, 2008
  - Continued involvement in the explanation of their use (e.g., AMA CPT presentation, October, 2010)
  - Working on compliance officers interpretation of simultaneous use of professional and technical codes
  - Now contemplating on the possibility of a new code for interpretation

For more information: www.ama-assn.org/go/cpt-processfaq

Category I Codes

- Clinical recognized
- Scientifically validated
- National in scope

Levels of Evidence

- Ia-Evidence obtained from meta-analysis of randomized controlled trials
- Ib- Evidence obtained from at least one randomized controlled trial
- IIa-Evidence obtained from at least one well-designed controlled study without randomization
- IIb-Evidence obtained from at least one other type of well-designed quasi-experimental study
- III- Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies
- IV- Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities
- V -Evidence obtained from case reports or case series

(based on AHCPR 1992)

Category II Codes

- Performance Codes
- Pre-cursor to Pay for Performance/Quality
- Initially Starts with Documentation
- Will Evolve into Performance and not Service as the Determination of Payment
- At present- Depression is primary focus
- (COULD END WITH ELECTRONIC RECORDS)

Primarily developed by the Performance Measures Advisory Group (2001)

www.ama-assn.org/go/cpt-cat2

Category II: Information

- Developers

-National Committee for Quality Assurance

-Quality Improvement Organizations

-Physicians Quality Reporting Initiative (CMS)

-Physician Consortium for Performance Improvement (AMA)

(Note: US is last of 7 countries that use performance measures)

Category II: Direction

- Specialty Society Driven
- Defining the Work Group (due to some of the organizations have not continued)
- May End with Electronic Health Records

Elements for Category II Measures

- Denominator
  - Applicable population
- Numerator
  - Segment of population in compliance with measure
- Exclusions
  - Segment of population not in compliance with measure

Category III Codes

(*CPT Assistant*, May 2009)

- Temporary Codes for emerging technology, services and procedures
- Intended to eliminate local codes and get those codes to eventually become part of the CPT system (but may produce $)
- Conversion may be requested by a society or by CPT
- 10 year history of Category III
- www.ama-assn.org/go/cpt-cat3

Shifting Between Codes

- When a significant disruption of service occurs, a new service is then coded.
- Assumption is that the professional would not return relatively soon to the original service that was started.
- A continuous service is then broadly defined as the total number of units completed during the provision of that service.

CPT: Applicable Codes

- Total Possible Codes = Approximately 8,000
- Possible Codes for Psychology = Approximately 60
- Sections = Five Primary Separate Sections
  - Psychiatry (e.g., mental health) *undergoing study & possible revision*
  - Biofeedback
  - Central Nervous System Assessment (testing)
  - Physical Medicine & Rehabilitation
  - Health & Behavior Assessment & Management
  - Team Conference
  - Evaluation and Management

Three Types of Codes

- Psychiatric/Mental Health (1970s?)
- Neuropsychological (added in 1990s)
- Health and Behavior (2000s)
- Miscellaneous
  - Preventative
  - Evaluation & Management (E & M)
  - Telehealth

C. Providers & Technicians

(*Corrections Document- CPT 2012; front matter*)

- "It is important to recognize that the listing of a service or procedure of this book (i.e., CPT) does not restrict is use to a specific specialty".
- "A "physician or other qualified health professional" in an individual who is qualified by education, training, licensure/regulation(when applicable) and facility privileging (when applicable) who performs a professional service within his/her score of practice and independently reports that professional service."

CPT & Clinical Staff

(*Corrections Document- CPT 2012; front matter*)

- "A clinical staff member is a person who under the supervision of a physician or other qualified healthcare professional and who is allowed by law, regulation and facility to perform or asset in the performance of a specific professional service, but who does not individually report that professional service."

Technician: Definition

Federal Register, Vol. 66, #149, page 40382

- Requirement
  - Employee (e.g., 1099); "employees, leased employees, or independent contractor"
  - Most common is independent contractor
  - "We do not believe that the nature of the employment relationship is critical for purposes of payment to the services of physician…as long as…(the personnel) is under the required level of supervision."
- Common Practice
  - Independent Contractor
  - In Institutional Settings – institutional contract (source- NAP)

Technician: Federal Government's Definition

- DM & S Supplement, MP-5, Part I
  - Authority: 38 U.S.C. 4105
  - Appendix 17A Change 43
  - Psychology Technician GS-181-5/7/9
- Definition
  - Bachelor's degree from accredited college/ university with a major in appropriate social or biological sciences (+ 12 psy. hours)

Technicians

- What is the Minimum Level of Training Required for a Technician?
  - Malek-Ahmadi, M., Erickson, T., Puente, A.E., Pliskin, N., & Rock. R. (in press). The use of psychometrists in clinical neuropsychology: History, current status and future directions. *Applied Neuropsychology*.
  - National Association of Psychometrists/Board of Certified Psychometrists
    - www.napnet.org/www.psychometriciancertification.org
  - 40 & NAN Position Paper
    - Level of Education- Minimum of Bachelors
    - Level of Training
    - Level of Supervision

Technician: 1500 Forms

- HCFA/CMS Line 25
  - This is the line that identifies in a common insurance form who is the “qualified health provider” that is responsible for and completing the service
  - That individual is the person with whom the contractual relationship is established
  - Anybody else, from high school graduate to post-doctoral fellow to independently licensed psychologist (but not contractually related professional), is, for all practical purposes, a technician
  - That technician is not a new class of provider and cannot bill independently of a doctoral level provider

Technician: NAN's Definition

- Approved by NAN Board of Directors
  - 08.2006
- Archives of Clinical Neuropsychology-
  - 2006 (e.g., Puente, et al)

Technician: NAN's Definition Explained

- Function- administration & scoring of tests
- Responsibility- supervisor
- Education- minimum, bachelor's level
- Training- include ethics, neuropsy, psychopath, testing
- Confidentiality- APA ethics, HIPAA…
- Emergencies- contingencies must be in place
- Cultural Sensitivity- must be considered
- Supervision- general (Medicare) level
- Contract- must be in place
- Liability Insurance- must be in place

Technicians: Application

- Practice Expense & Practice Implications
  - Each tech code has .51 work value
  - This means that the professional is engaged in the work, namely, supervision (and interpretation)
  - That supervision would include;
    - Selection of tests
    - Determination of testing protocol
    - Supervision of testing
    - Interpretation of individual tests
    - Reporting on individual tests
    - Assisting with concerns raised by the patient

Technicians: Interfacing with Professionals

- The Qualified Health Provider must;
  - See the patient first
  - Supervise the activity
  - Interpret and write the note/report
  - Engaged in an ongoing capacity

NOTE: Pattern similar to medical and other health providers

Technicians: Facility

- Technicians in a “Facility”
  - A “facility” in essentially an inpatient setting
  - If a technician is an employee of a private provider but the service is provided in an inpatient setting, the inpatient fee would be used
  - If a technician is an employee of a facility, there is some question as to whether they could be supervised by a provider who is not an employee of the facility

Students as Technicians

- Medicare Interpretation
  - Medicare has never reimbursed for student training for any health disciplines
  - The assumption is that GME pays training programs and double dipping would occur if the Medicare and the CPT reimbursed for student activity
  - Two caveats:
    - This limitation probably applies to Medicare only
    - Students can perform as technicians as long as they are not being trained and their activity is not part of their educational requirements (e.g., a neuropsychologist in the community employees the student as a technician in their practice)

Students as Technicians

- This is from the Medicare Benefit Policy Manual, Chapter 15, Section 80.2 :
- Payment and Billing Guidelines for Psychological and Neuropsychological Tests
- The technician and computer CPT codes for psychological and neuropsychological tests include practice expense, malpractice expense and professional work relative value units. Accordingly, CPT psychological test code 96101 should not be paid when billed for the same tests or services performed under psychological test codes 96102 or 96103. CPT neuropsychological test code 96118 should not be paid when billed for the same tests or services performed under neuropsychological test codes 96119 or 96120. However, CPT codes 96101 and 96118 can be paid separately on the rare occasion when billed on the same date of service for different and separate tests from 96102, 96103, 96119 and 96120.

Students as Techs (cont.)

- Under the physician fee schedule, there is no payment for services performed by students or trainees. Accordingly, Medicare does not pay for services represented by CPT codes96102 and 96119 when performed by a student or a trainee. However, the presence of a student or a trainee while the test is being administered does not prevent a physician, CP, IPP, NP, CNS or PA from performing and being paid for the psychological test under 96102 or the neuropsychological test under 96119.

D. Supervision

(*Federal Register*, 69, #150, August 5, 2004, page 47553)

- Hold Doctoral Degree in Psychology
- Licensed or Certified as a Psychologist
- Applicable Only to “clinical psychologists” (and not “independent” psychologists as defined by Medicare)
- Rationale
  - Allows for higher level of expertise to supervise
  - Could relieve burden on physicians and facilities
  - May increase services in rural areas

Supervision

Program Memorandum Carriers
Department of Health and Human Services- HCFA
Transmittal b-01-28; April 19, 2001

- Levels of Supervision
  - General
    - Furnished under overall direction and control, presence is not required
  - Direct
    - Must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure
  - Personal
    - Must be in attendance in the room during the performance of the procedure

Supervision: Levels
42 CFR 410.32

- According to Medicare published guidelines as of July, 2006;
  - General- activity is directed and supervised by the doctoral level provider but the provider does not need to be in office suite

Supervision: Supervision Vs. Incident to

- Supervision - Clinical Concept
  - Behavior of a “qualified health professional” and a “technician”
- Incident to - Economic Concept
  - The concept of a contractual relationship (e.g., 1099) between a “qualified health professional” and a “technician”

Supervision: Malpractice Issues

- Adding a Psychometrist to Malpractice Insurance, as a Independent Contractors, Makes Good Sense
- However, This Protects the Doctoral Level Provider From Illegal and/or Ethical Acts by the Psychometrist but Not the Reverse
- Hence, the Psychometrist May Want to Obtain Insurance on Their Own

E. Medical Necessity

- Scientific & Clinical Necessity
- Local Medical Determinations of Necessity May Not Reflect Standard Clinical Practice
- Necessity = CPT x DX formulary
- Necessity Dictates Type and Level of Service
- Will New Information or Outcome Be Obtained as a Function of the Activity?
- Typically Not Meeting Criteria for Necessity;
  - Screening
  - Regularly scheduled/interval based evaluations
  - Repeated evaluations without documented and valid specific purpose

Medically Reasonable and Necessary

Section 1862 (a)(1) 1963
42, C.F.R., 411.15 (k)

- "Services which are reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member"
- Re-evaluation should only occur when there is a potential change in;
  - Diagnosis
  - Symptoms

Simple Explanation of Medical Necessity and Eventual Coverage

Existence of Evidence

for

Therapeutic Decision Making

(*will it make a difference?*)

National Coverage Policy Exclusions

- Services That Are Not Reasonable and Necessary for the Diagnosing and Treatment of an Illness or Injury
- Screening Services, in the Absence of Symptoms or History of Disease are Denied

F. Documentation

- History
- General Principles
- Assessment
- Intervention

Electronic Health Records

- Lifetime and Portable Health Record
- Available 24/7 to All
- Performance Measurement
- Reduction of Duplicative Services
- Population/Disease Management
- Source for Research & Public Health

Electronic Health Records

(APA Practice; Stacey Larson & Nate Tatro)

- **A short web presentation describing the difference between OMS and EHRs, and what EHRs are:**

http://www.apapracticecentral.org/update/2012/11-29/electronic-records.aspx

- **Top 10 Tips for Selecting an EHR**

http://www.apapracticecentral.org/good-practice/secure/health-record-systems.pdf

- **Putting EHRs into practice:**

http://www.apapracticecentral.org/good-practice/secure/electronic-records.pdf

- **How the HITECH Act relates to psychologists in professional practice:**

http://www.apapracticecentral.org/update/2012/07-30/hitech-act.aspx?__utma=12968039.2038223232.1396886919.1397052976.1397225756.4&__utmb=12968039.13.9.1397225778184&__utmc=12968039&__utmx=-&__utmz=12968039.1397225756.4.3.utmcsr=apapracticecentral.org|utmccn=(referral)|utmcmd=referral|utmcct=/search.aspx&__utmv=-&__utmk=158284602

Promotion of EHR

- Enhanced Billing/Revenue Collection
- Closer Relationships with Health Systems
- Increased Productivity
- Increased Coordination of Care
- Will be Required Relatively Soon (2016?)

Documentation: History

(www.cms.hhs.gov/medlearn/emdoc.asp)

- Began with in February, 1988 with development of Evaluation and Management codes (published in 1992)
- Formalized with the 1995 & 1997 Medicare Documentation Guidelines

Documentation: General Purpose

- Medical Necessity
- Evaluate and Plan for Treatment
- Communication and Continuity of Care
- Claims Review and Payment
- Research and Education

Documentation: Basic Components

(CPT Assistant, November, 2008, *18*, #11, 3-4)

- History
- Examination
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time

Documentation: General Principles

- Rationale for Service
- Procedure
- Results/Progress
- Impression and/or Diagnosis
- Plan for Care/Disposition
- If Applicable, Time
- Date and Identity of Observer

Decision Tree for New Vs. Established Patients

(*CPT Assistant*, August, 2009, Vol. 19, #8, pg. 10)

Service Within 3 Years ?

yes no

Same specialty ?

yes no

Established?

yes no

Documentation: Basic Information

- Identifying Information
- Date
- Time, if applicable (total time Vs. *actual time*)
- Identity of Observer (technician ?)
- Reason for Service
- Status
- Procedure
- Results/Findings
- Impression/Diagnosis
- Plan for Care/Disposition

Documentation: CPT X Report

- Each CPT Code Should Generate a Separate Report (or at least a separate section)
- If Separate Sections Within One Report, Clearly Label/Title Sections of the Report to Match Code Used (e.g., Neuropsychological Testing by Technician)

Documentation: Suggestions

- Consider Having a Multi-level System of Documentation;
  - Raw data (e.g., test protocols)
  - Internal routing sheets documenting such information as start/stop time, technician name, dates, etc. (a master sheet could track technician as well as professional time)
  - Final report

G. Time

- Time is Broadly Defined as What the Professional Does
- For Intervention – Time is face-to-face
- For Assessment - Time could be either face-to-face (i.e., H & B) or professional time (e.g., Psych & Neuropsych)

Time: Conceptual

- Defining
- Professional (not patient) Time Including:
  - pre, intra & post-clinical service activities
- Interview & Assessment Codes
  - Use 15 or 60 minute increments, as applicable
- Intervention Codes
  - Use 15, 30, 45, or 60 minute increments, as applicable
  - Prolonged service codes is being considered and probably forthcoming

Time (continued)

- Communicating Further With Others
- Follow-up With Patient, Family, and/or Others
- Arranging for Ancillary and/or Other Services

Recent Interpretations of Time

- Non face-to-face time (pre and post) sometimes is not included in the measurement of billed time but it has been included in calculating total work of the service during the survey process.
- A unit of time is obtained when the mid-point has passed.
- When a time service is reported along with a non-timed service, the two are not added.

Time Interpreted

(*AMA CPT Assistant*, October, 2011, Vol. 21, Issue 10, pgs. 3-4, 11).

- Time refers to “face-to-face” unless otherwise stated.
- Unit of time = “when the midpoint has been passed”
- Do not count time twice
- When multiple days are involved, time is not reset with each and create a new hour.

Time Across Days

- “If a continuous service was provided, report all units as performed on the date that the service was started”
- However, a disruption in service creates a new initial service.

“Missed” Time Section 20.3.1.

- Billing for Services That Were Not Provided” is Fraud
- The Patient Possibly Could be Billed for Missed Appointment (not for missed service), Assuming a Contractual Relationship and Understanding Has Been Previously Established

Time: Definition

(*CPT Assistant*, 08.05, 15, #8, pg. 12)
(www.cms.hhs.gov/providers/therapy)

- For Timed Codes in Physical Medicine: Beginning and Ending Time Should be Documented
- Time Should be Documented Along with the Treatment Description

Time: Defining Non-Face-to-Face Time

- communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care,
- communication with home health agencies and other community services utilized by the patient,
- medication management,
- patient and/or family/caretaker education to support self-management, independent living, and activities of daily living,,
- assessment and support for treatment regimen adherence,
- identification of available community and health resources,
- facilitating access to care and services needed by the patient and/or family,
- advocating for services to meet patient's needs, and/or

- development and maintenance of a comprehensive care plan.

Time: Defining 15 Minutes

(from CPT Assistant, 08.05, 11-12)
(www.cms.hhs.gov/manuals/104_claims/clm104c05.pdf)

- 15 Minute Increments/ The 8 Minute Rule
  - Units — Amount of Minutes
    - 1 — >08; <23
    - 2 — >22; <38
    - 3 — >38; <53
    - 4 — >53; <68
    - 5 — >68; <83
    - 6 — >83; <98
    - 7 — >98; <113
    - 8 — >113;<128
    - Over 2 hours — similar pattern as above

Time: Defining 60 Minutes

"The Rounding Rule"

- 1 unit > or equal to 31 minutes to < 91 minutes
- 2 units > or equal to 91 minutes to < 151 mns.
- 3 units > or equal to 151 minutes to < 211s mns.
- 4 units > or equal to 271 minutes to < 331 mns.
- And so on…

Location of Time

- Intraservice times are defined as **face-to-face** time for office and other outpatient visits and as **unit/floor** time for hospital and other inpatient visits. This distinction is necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient's floor or unit.

H. Place of Service

#	Location
11	Doctor's Office
12	Patient's Home
21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
56	Psychiatric Residential
61	Inpatient Rehabilitation

Location of Service

- Hospital/facility vs. Outpatient
- Definition of location depends on;
  - Geography of office (similar structure?)
  - Charts/documentation system (same chart?)
  - Reimbursement system (bundled?)
  - Type of relationship (including employment)

I. Correct Coding Initiative

- Purpose
  - Used to evaluate submissions when provider bills more than one service for the same beneficiary and same date of service
  - Example; psychotherapy and testing
- Activation
  - Automatic edits
  - 99477 is mutually exclusive with the series of psychotherapy codes (e.g., 90834)

Physician Referral

- Most Medicare carriers do not require physician referral
- It is not a federal guideline but a carrier one
- Most carriers do not require it
- If so, the NPI # for physician must be on the claim form – 17b on claim form

(from National Uniform Claims Committee's CMS-1500 instructions)

Part II: Economics

- A. Reimbursement
- B. Coverage and Payment
- C. Fraud and Abuse
- D. Pay 4 Performance

A. Reimbursement: History

- Cost Plus
- Prospective Payment System (PPS)
- Diagnostic Related Groups (DRGs)
- Customary, Prevailing & Reasonable (CPR)
- ***Resource Based Relative Value System (RBRVS)***

Note: On average, insurance companies will pay approximate 75% of its income)

Reimbursement: Relative Value Units

- Components
- Units
- Values

Relative Value System: Information

- System was started on 01.1992
- Over 4,000 codes have been valued since then.
- It is a payment system based on costs associated with the delivery of that service

RVU: Acceptance

- Medicare (100% since 01.01.92)
- Medicaid = 100%
- Private Payers = 74% and increasing to 95%
  - Blue Cross/Blue Shield = 87%
  - Managed Care = 69%
- Other = 44%
- New Trends:
  - RVUs as a Model for All Health Practice Economics
  - RVUs as a Basis for Compensation Formulas, especially in for-profit institutions

CMS Acceptance of RVU

(*CPT Assistant,* January, 2009, *19*, 8-9).

- In 2008, CMS accepted 97% of the RUC recommendations
- In 2009, CMS accepted 98% of the RUC recommendations

- NOTE: carrier pricing and policy decisions is left to each intermediary

RVU: Components

- ***Physician Work Resource Value***
- ***Practice Expense Resource Value***
- Malpractice
- Geographic (sometimes referred as the GPCI); urban higher than rural)
- Conversion Factor ($36.0666 down from $37.8975)

RVU: Components

- Physician (professional)
  - Physician defined in 1989 Social Security Law
  - Psychology is not part of that definition; hence they are technicians
  - Technicians = 0 work value
- Geographic
  - Geographic Practice Cost Indices

    only 25% is required to be reflected

    Alaska = 1.5%

    Frontier States = 1%

RVU: Components Percentages

- Physician Work = 50%
- Practice Expense = 44%
- Liability = 4%

- NOTE: Within 5-10 years, another major component will be performance; in other words, not only the work must be performed but some results should occur as a function of the service

Concept of Costs

- Direct Costs (based on data)
  - Supplies
  - Equipment
  - Clinical Staff Time
- Indirect Costs (based on mean hrs. billed)
  - Rent
  - Utilities
  - Administrative Staff Time

Both affected by Conversion and Budget Neutrality Factors

Medicare RVU Breakdown

(*Federal Register*, Vol. 72, #133, July 12, 2007, page 38190; Table 14)

• Physician Compensation	52.466	
– Wages and Salaries		42.730
– Benefits		9.735
• Practice Expense	47.534	
– Non-Physician Wages		13.808
• Technical Wages		5.887
• Manager Wages		3.333
• Clerical		3.892
• Employee Benefits		4.845
– Other Practice Expenses	18.129	
• Office Expenses		12.209
• Liability Insurance		3.865
– Drugs and Supplies	4.319	
– Other Expenses	6.433	

- Effective decline by 2010 is approximately -7 % (table 24)
- Budget Neutrality and Increase for E & M is Based on a reduction of .88994 to work values

RVUs Through 12.31.12

- 96020 C Functional brain mapping 0.00 0.00 0.00 NA NA 0.00 XXX
- 96020 TC C Functional brain mapping 0.00 0.00 0.00 NA NA 0.00 XXX
- 96020 26 A Functional brain mapping 3.43 1.03 1.27 1.03 1.27 0.23 XXX
- 96040 B Genetic counseling, 30 min 0.00 1.05 1.11 NA NA 0.01 XXX
- 96101 A Psycho testing by psych/phys 1.86 0.24 0.39 0.23 0.38 0.05 XXX
- 96102 A Psycho testing by technician 0.50 0.98 0.94 0.10 0.12 0.03 XXX
- 96103 A Psycho testing admin by comp 0.51 1.10 0.85 0.15 0.14 0.02 XXX
- 96105 A Assessment of aphasia 0.00 2.46 2.04 NA NA 0.03 XXX
- 96110 A Developmental test, lim 0.00 0.20 0.19 NA NA 0.01 XXX
- 96111 A Developmental test, extend 2.60 1.00 0.89 0.87 0.79 0.12 XXX
- 96116 A Neurobehavioral status exam 1.86 0.58 0.61 0.45 0.47 0.07 XXX
- 96118 A Neuropsych tst by psych/phys 1.86 0.57 0.88 0.21 0.37 0.05 XXX
- 96119 A Neuropsych testing by tec 0.55 1.17 1.31 0.07 0.12 0.02 XXX
- 96120 A Neuropsych tst admin w/comp 0.51 1.77 1.49 0.14 0.13 0.02 XXX
- 96125 A Cognitive test by hc pro 1.70 1.03 0.85 0.61 0.45 0.05 XXX
- 96150 A Assess hlth/behave, init 0.50 0.06 0.11 0.05 0.10 0.01 XXX
- 96151 A Assess hlth/behave, subseq 0.48 0.06 0.11 0.05 0.10 0.01 XXX
- 96152 A Intervene hlth/behave, indiv 0.46 0.06 0.10 0.05 0.09 0.01 XXX
- 96153 A Intervene hlth/behave, group 0.10 0.02 0.03 0.01 0.02 0.01 XXX
- 96154 A Interv hlth/behav, fam w/pt 0.45 0.05 0.10 0.05 0.09 0.01 XXX
- 96155 N Interv hlth/behav fam no pt 0.44 0.16 0.16 0.16 0.16 0.02 XXX

Mental Health Reduction

- The Mental Health Limitation should not be applied to diagnostic service that are performed to establish a diagnosis. Further, this limitation only applies to diagnostic codes ranging from 290 to 319 (or DSM codes).

RVU: Defining Physician Work

- Clinical Work
  - Mental Effort and Judgment
  - Technical Skill/Physical Effort
  - Psychological Stress

RVU: Defining Practice Expense

- Constitutes 43% of Medicare Payments
- Based on 50% of previous expense and new PPI Survey data.
- Components of Practice Expense
  - Clinical non-physician labor (43 categories)
    - RN/LPN/MTA = $.37/minute ($37,440/year)
  - Medical disposable supplies (842 items)
  - Equipment (553 items)

RVU vs. UCR

- Many commercial carriers prefer to set rates, or UCR (usual and customary rates), are based or regional market analyses instead of RVUs

RVU: Values

- Psychotherapy:
  - Prior Value =1.86
  - New Value = 2.65
- Psych/NP Testing:
  - Work value until 2005= 0
  - Hsiao study recommendation = 2.2
  - New Value = varied (see upcoming slides)
- Health & Behavior
  - .25 (per 15 minutes increments)

RVU: 2006 Changes

(*CPT Assistant*, January, 2006, 16, 1)

- 283 RVU Changes Submitted, Including the Testing Codes
- Medicare Accepted 97%
- Professional Liability to Change to 1.00
- Geographic Index is Revised Every 3 yrs.
  - For Montana, Wyoming, Nevada, North and South Dakota (permanent 1.0 floor)
  - For Alaska 1.50 floor

RVU Summary for Psychology

(from APA PD Press Release, 2014)

- Provision of Services
  - Psychologist provide 40% of outpatient and 70% of inpatient mental health services
- Income Loss over Time
  - 37% loss over 12 years
- Medicare
  - Approximately ¼ of psychologists have resigned from Medicare program

Developing a Fee Schedule

- Medicare
  - Conversion Factor in 2014 = XXXXXX
- Standard Method of Developing Fee Schedule
  - Obtain Medicare RVU values for selected CPT codes
  - Multiply by 150%
  - Revise fee schedule as RVUs change

Pricing of Codes

- Carrier Based
- CMS
- AMA RUV (most widely accepted)

Alternative Payment Models

- Quality Metrics
- Outcome Metrics
- Bundled Payment/Episode Care System
- Population Based Systems (e.g., Accountable Care System)

- CPT is excellent for single episode of care

B. Coverage & Payment

- Origins of the Problem
  - Balanced Budget Act of 1997
  - Employer's Cost for Health Care in 2002 = $5,000 per employee
- What Should Your Code Be Payed at?
  - www.webstore.ama-assn.org-
- State Legislation
  - www.insure.com/health/lawtool.cfm

CMS Determination of Coverage

- **Coverage Types**
  - Coverage with Conditions (specific DX, facility or provider)
  - Coverage without Conditions
- **Data Reviewed**
  - Benefit
  - Risks Vs. Benefits
  - Available Clinical Studies
    - Databases
    - Longitudinal or cohort studies
    - Prospective studies
    - Randomized clinical trials

Coverage of Category 1 and 3 Codes

- **Category 1 vs. Category 3 (Carriers)**
  - **Until otherwise reviewed and rejected, Category 1 codes are typically covered**
  - **Until otherwise reviewed and accepted, Category 3 codes are typically non-covered**

Evolution of Payment Practices

- Evolution of Compensation
  - Gross Charges
  - Adjusted Charges
  - RVUs
  - Receivables

Compensation: Psychiatry

- Half of physicians are on salary, increasing percentage on productivity
- Mean pay: approximately $200,000
- Mean collection: approximately ¾
- 64% use productivity instead of salary
  - (AMA Policy Research Perspectives, 01.14)

Medicare: Payment Questions

- Cannot Impose a Limitation on a Medicare Patient That is Not Imposed on Other Pts.
- Non-Covered Services Can Be Charged if Patient Knows and Agrees Ahead of Time
- Records Should be Retained, state law or;
  - Adult- 5 years post service
  - Children- until 21

Medicare: Billing Suggestions

- When to Bill
  - Overall = after documentation is in place
  - Mental Health Reduction should not be applied when diagnostic services are used to establish a diagnosis.
  - Diagnostic Services
    - After the interview
    - After all testing is completed a*nd* a report with integration has been completed
    - Billing should occur only once after testing is complete
    - Some question regarding that all billing is not only done after all testing is complete and documented but that such billing reflect only one date of service
  - Therapeutic Services
    - Could occur after each session
    - Should occur at least by the end of the month

Recent Billing Problems

- Professional Contact
  - Professional must do some of the testing
- Incorrect Bundling
  - Billing interview under testing codes
- Incorrect Use of Modifier
  - Lack of or inclusion of, depending on carrier
- Incorrect Use of Procedural Codes
  - Mixing Psychiatric and Neuropsychological codes
- Incorrect Day of Service
  - Bill the last day that service is provided for testing
  - Reflect in the CMS form the specific date of service

Billing Concerns

(*CPT Assistant Bulletin*, Vol. 18, #1, pages 1-2, 2008)

- Electronic Vs. Manual
  - Electronic verification of benefits = $0.74
  - Manual verification of benefits = $3.70
  - Electronic submission of benefits = $6.63
  - Manual submission of benefits = $2.90

Billing Solutions

- Become knowledgeable of LCD criteria
- Bill in house or have billing clerk responsible for tracking information (billing systems charge 8-15% of gross)
- Bill/collect patient portion at time of service
- If possible, collect within 15 days with a window not to exist 60-90 days
- If possible, bill electronically
- If payment not provided by 30 days, follow up
- Establish criteria for obtaining payment (e.g., 90% of allowable rates)

Payment: Patient Denial Rates

(coverage denial frequency)

- Blue Cross-Blue Shield = 1.0%
- Commercial = 1.0%
- Medicare = 0.5%
- Medicaid = 5.0%

- Martirosov, J. (2006). *Physicans' Practice*, April 2006, page 49-52.

Psychologists' Experience with Specific Carriers

(*APA Good Practice*, Summer, 2010, pgs. 10=14)

- Problem Areas (in order of importance)
  - Health and Behavior Codes
  - Psychotherapy and Testing Codes
  - Speed and Accuracy of Reimbursement
  - Authorization and Billing Procedures
  - Transparency of Company Procedures and Policies
  - (average satisfaction of approximately 50%)

Payment Problems

- Mental Health or Medical Health
  - Contract directs payment
  - Training/Degree directs type of contract
  - CPT is secondary to all of the preceding
- Mental Health and Medical Health
  - CPT may describe the procedure
  - Payment may come from medical side
  - Rate would be from contract (i.e., mental health)

An Example of A Private Payers' Payment Policy

- http://www.mckesson.com/static_files/McKesson.com/MHS/Documents/IQ-BH-2007-Adult-Criteria-sampler-0807.pdf
- May not reflect national guidelines and/or practice standards

Payment: Billing Model

- Components
  - Procedure Completed
  - Number of Units of that Procedure
  - Location or Site Where the Service was Provided
  - Date of Service
- CPT ***X*** # of Units ***X*** Dx ***X*** Site of Service ***X*** Date

Payment to Practice

- Economics (e.g., GDP) Shapes Payment Policy
- Payment Policy Shapes Practice
- Payment Shapes Documentation
- Documentation Shapes Cognitive Processes
- Cognitive Processes Shapes Practice Patterns

Current Payment Problems

- Continued challenges with compliance officers relative to the use of professional and technical testing codes on the same day
- Shifting from *salary to productivity*
- When compensated by productivity shifting *from CPT codes to RVUs*

Prompt Payment

- State Guidelines
  - Vary significantly
  - http://www.theverdengroup.com/PromptPayByState_2010.pdf
- Federal Guidelines
  - 45 days
  - http://www.dfs.ny.gov/insurance/hppmtlaw.htm.

Sustainable Growth Rate

- Sustainable Growth Rate
- Based on percentage changes;
  - Fees
  - Beneficiaries
  - Gross Domestic Product
  - Laws and regulations
- Ranges;

  --.3% to 5.5% per year

SGR: Current Status

- History of Sustainable Growth Rate (SGR) – 15 years (and counting)
- The scheduled 26.5% Sustainable Growth Rate (SGR) cut, was averted on New Year's Day when the Senate passed the one-year delay through 2013 as part of the "American Taxpayer Relief Act" (HR 8) by a vote of 89-8< http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=112&session=2&vote=00251>. The House then passed the measure by a 257-167<http://clerk.house.gov/evs/2012/roll659.xml.
- Temporary fix for 12 months; to be revisited in 2015
- Primary focus by the Senate but moving to performance model
- $300+ BILLION TO GET RID OF SGR AT THIS POINT

Conversion Factor

- To be re-addressed around 06.2015
- Alternatives-
  - Brief period of suspension (e.g., 2 months)
  - Longer period of suspension (e.g., 5 years)
  - Permanent (cost = $300 billion)
- Conversion Factor = shifted from $34.0230 effective 06.2014 it is ***XXXXX***

C. Fraud: Definition

- Fraud
  - Intentional
  - Pattern
- Error
  - Clerical
  - Dates

Safeguarding Program Integrity

(*CPT Assistant*, 11.10, *20*, #11, 7-10)

- 11.09- President Obama signed Executive Order calling for reduction of improper payments
- 03.10, President Obama announced expansion of recovery audits & broadens authority of federal agencies for audits
- CMS refocuses efforts (Peter Budetti)
- PPACA contains program integrity provisions

Fraud: Medicare's Interpretation of Physician Liability

- Overpayment From Incorrect Charge
- Mathematical or Clerical Error
- Billing for Items Known Not to be Covered
- Services Provided by Non-qualified Practitioner
- Inappropriate Documentation

Federal Definition of Fraud
(*CPT Assistant*, 2010, *20,* 2)

- Billing Unnecessary Services
- Failure to Produce Documentation
- Billing for Ineligible Patients
- Billing for ineligible Providers

OIG Report (continued)

- Provider Not Qualified = 11%
- Medically Unnecessary = 23%
- Billed Incorrectly = 41%
- Insufficient Documentation = 65%

Fraud: Review History (10 years)

- Initial Review (14 points of submitted claims)
  - Legibility
  - Coverage
  - Matching dates
  - Signature
- Subsequent Review (occurs if over 5-6 items are failed in initial review)
  - Does the service affect a potential change in medical condition?

Fraud: CERT Program

www.oig.hhs.gov

- Comprehensive Error Rate Testing Program
  - National
  - Contractor-specific
  - Service-specific
  - Reviews both denied and accepted claims
  - An initial written request is followed by 4 letters and 3 phone calls followed by an overpayment demand letter and interpreted as services non-rendered

CERT

(Carolyn Cunningham, M.D., AMA CPT Symposium 11.13.14)

- Part A Improper Claims Payment Rate- 2012
  - Total = 20.5 % or $13 billion
  - Home Health = 8 %
  - Skilled Nursing Facility = 9.4 %
  - Hospital Outpatient = 6.3 %
- Reasons (Estimates)
  - Insufficient Documentation = 80 %
  - Medical Necessity = 20 %

CERT

(Carolyn Cunningham, M.D., AMA CPT Symposium 11.13.14)

- Part B Improper Payment Rates – 2012
  - Total = 27.3 % or $ 8.9 billion
  - Areas of concern
    - E & M
    - Emergency Department
    - Critical Care
    - Minor Procedures
    - Labs
    - Drugs
    - Ambulance
    - Chiropractic

Fraud: New Information

- The Good Enough or Common Sense Approach
- If Medicare Audit Occurs then an Increased Likelihood of Medicaid Audit
- Practice Situations That Increase Potential Audits;
  - Skilled Nursing Facilities
  - Statistical Outliers
  - Testing
- States with Increased Audit Activity;
  - TX, CA, FL, PR

(Note: In August 27, 2007, Report on Medicare Compliance stated that “Federal Court Orders Government to Pay Doctor’s Legal Fees for Frivolous Prosecution”)

Fraud: 2006 Red Book

- Section 1862(a)(1)(A) of the Social Security Practice Act requires all services to be reasonable and necessary for the diagnosis or treatment of an illness or injury.
- Claim errors have exceed 34%

Fraud: Red Book (continued)

- Problem Areas
  - Acute Hospital outpatient Services ($224)
  - Partial Hospitalization ($180)
  - Psychiatric Hospital outpatient ($57)
  - Nursing Home ($30)
  - General Mental Health ($185)
    - Beneficiaries who are unable to benefit from psychotherapy services
    - Note: in millions (total for 2005 - $676,000,000)

CMS 2007

- 47% Mental health did not meet payment requirements
- 26% were miscoded
- 19% were undocumented

From 1996, 2001 to 2007

- 1996 to 2001 – 33% incorrect
- 2001 to 2007 – 47% incorrect

Total Estimates = $718 million

RAC: Audit Review

(no reviews prior to 10.01.07)

- Estimated Profit to RAC: 9 to 12.4%
- Automated
  - No records involved
- Complex
  - Records requested
  - 45 days turn around time
  - Expect accusatory and vague letter

(in place by 2010 based on Section 302 of the Tax Relief and Health Care Act of 2006)

Economic Audits RAC Vs. CERT

- CERT
  - Contract performance
- RAC
  - Past payment review (may be peer review)

Recovery Audit Contractor

- 2003- Demonstration Project
- 2005- CA, FL, NY
- 2007- AZ, MA, SC
- 2014 – in every jurisdiction
- Adjusted $1.03 billion
- 85% inpatient hospital providers
- 6% inpatient rehabilitation facilities
- Cost- 20 cents for each dollar recovered

RAC: continued

- Automatic- DRG validation, coding errors and medical necessity
- Focus starting 2010- Medical necessity
- 2014-
  - Coding Errors
  - Medical Necessity

RAC Appeals

- Appeals possible
- 22.5% were appealed
- 34% in favor of providers

RAC

(*The National Psychologist*, 02.11, pg. 7)

- Percentage Paid to Auditors
  - Between 9 and 12%
- Protection Advise
  - Review records regularly
  - Compliance is a must, especially for government programs
  - Keep abreast of changes (e.g., attend workshops)

RAC

(*CPT Assistant*, November 2010, pgs. 10-11)

- Purpose
  - "Identify overpayments and underpayments:
- Current Focus
  - Diagnosis related groups (DRGs)
  - Coding errors
  - Medical Necessity
- Prevention
  - Internal assessment
  - Proper justification and documentation
  - Codes should match procedure

Private Payer Audits

- 70% (and increasing #) of Private Payers are Auditing
- Private, Incentive Driven Companies
- Incentive Driven “whistle-blowers”

Potential Overpayment Law

- 11.2009 signed Executive Order for a reduction in improper payments and decrease in waste
- 03.2010, President Obama announced expansion of payment recovery audits; law to re-capture lost funds signed
- Patient Protection and Affordable Care Act contain integrity provisions

Privacy Audits: HIPAA Compliance

- Effective Date
  - July, 2012
- Company
  - $9 million to KPMG
- Method
  - 20 protocols
  - 10 business days to respond

Decreasing Audit Potential
(*CPT Assistant*, 11.10, *20*, #11, 10)

- Internal Assessment of Billing Practices
- Match Practice to Carrier Policy
- Good Documentation
- Knowledge of Coding Guidelines and Payor Policies
- Identify and Correct Variances
- Focus Tend to be on:
  - High frequency and high cost services.

Decreasing Audit Potentials

- Avoid Repeat Evaluations
- Avoid Multiple Similar Doctors
- Avoid Spikes in Billing Activity
- Consider Self and "Group" or Peer Auditing
- Attend Workshops and Document Such Attendance

Increasing Probability of Successful Audits

- Potential Solutions;
  - Document Everything That You Do
  - Establish Formal Internal Auditing System
  - Engage in Informal Internal Peer Review
  - Consider Periodic External Peer Review
  - Keep Abreast of Carrier Changes
  - Understanding of Medical Necessity
  - Match Procedure Codes
  - Match Diagnostic & Procedure Codes
  - Document Properly; Document Again
  - Do Change Records After Request for Audit
  - If Audited, Comply (thoroughly & quickly)
  - If Trial, Appreciate & Appraise Situation
  - Once Audit Begins, Do Not Change Existing Documentation (possibly acceptable to clarify)

If Audited…

- Possible Outcomes
  - No further questions
  - Bill for overpayment
  - Request additional records
  - Discuss records
  - Schedule administrative hearing
  - Determine compliance plan
  - Schedule criminal hearing

Online Coding Discussions

(KZAlert)

- Proclaiming Knowledge = Correct Information
- No Industry Standards
- Anything Posted Could be Used Against You

Fraud: Effects on Abuse on Clinical Services and Outcomes

(Becker, Kessler & McClellan, 2004)

- Increased enforcement results in;
  - Lower billings
  - No adverse consequences

Fraud: Web Site

- http://oig.hhs.gov/publications/docs/mfcu/MFCU%202004-5.pdf

Malpractice Claims

(*New England Journal of Medicine*, 2011)

- Small fraction of mistakes actually file claims
- About 5-7.5% on average per year of MDs have had a file a malpractice claim
- Fewer than 2% of MDs had a successful claim against them
- Neurosurgeons were sued the most (19%) and psychiatrists the least (3%)

D. The Future: Pay for Performance (P4P) Initiatives

- Premise
  - Evidence-based guidelines
  - Outcome more than procedure based
- Estimated Application in Payment Systems
  - First Set 01.01.07
  - Work Group included Jean Carter, Katherine Nordal, & *Paula Hartman-Stein*

Information in P4P section comes primarily from Hartman-Stein (Center for Healthy Aging)

Physician Quality Reporting Initiative

- Definition- A financial incentive to improve quality of health care (approx. 2%)
- Began 2011. If not participating by 2015, a 1.5% penalty being raised to 2%
- 119 Measures
- Focus on measurement of process and documentation

PQRS Measures

- Measure #280 – Staging of Dementia
- Measure #281 – Cognitive Assessment
- Measure #282 – Functional Status Assessment
- Measure #283 – Neuropsychiatric Symptom Assessment
- Measure #284 – Management of Neuropsychiatric Symptoms
- Measure #285 – Screening for Depressive Symptoms
- Measure #286 – Counseling Regarding Safety Concerns
- Measure #287 – Counseling Regarding Risks of Driving
- Measure #288 – Caregiver Education and Support

Other PQRS Measures

- Advising Smokers to Quit (#115)
- Preventive Care and Screening: Body Mass Index Screening and Follow-Up (#128)
- Documentation of Current Medications in the Medical Record (#130)
- #173 - Preventive Care and Screening: Unhealthy Alcohol Use – Screening
- #181 - Elder Maltreatment Screen and Follow-Up Plan
- #226 - Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention

PQRI Example: Screening for Cognitive Impairment

- Instructions
- Numerator
- Denominator
- Rationale
- Recommendations

Staging of Dementia

Measure #280	Staging of Dementia	
Numerator	Patients whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period. Dementia severity can be assessed using one of a number of available valid and reliable instruments available from the medical literature, including formal neuropsychological assessment.	
QDC	CPT II 1490F	Dementia severity classified, mild
	CPT II 1491F	Dementia severity classified, moderate
	CPT II 1493F	Dementia severity classified, severe
	1490F with 8P	Dementia severity not classified, reason not otherwise specified

Cognitive Assessment

Numerator	**Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period. Cognition can be assessed by direct examination of the patient using one of a number of instruments, including several originally developed and validated for screening purposes. Formal neuropsychological assessment also satisfies this requirement.**	
QDC	CPT II 1494F	**Cognition assessed and reviewed**
	1494F with 1P:	**Documentation of medical reason(s) for not assessing and reviewing cognition**
	1494F with 2P	**Documentation of patient reason(s) for not assessing and reviewing cognition**
	1494F with 8P:	**Cognition not assessed and reviewed, reason not otherwise specified**

Functional Assessment

Numerator	**Patients for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period. Functional status can be assessed by direct examination of the patient or knowledgeable informant. An assessment of functional status should include, at a minimum, an evaluation of the patient's ability to perform instrumental activities of daily living (IADL) and basic activities of daily living (ADL).**	
QDC	CPT II 1175F	**Functional status for dementia assessed and results reviewed**
	1175F with 1P	**Documentation of medical reason(s) for not assessing and reviewing functional status for dementia**
	1175F with 8P	**Functional status for dementia not assessed and results not reviewed, reason not otherwise specified**

Neuropsychiatric Symptom Assessment

Numerator	Neuropsychiatric symptoms can be assessed by direct examination of the patient or knowledgeable informant.	
QDC	CPT II 1181F	Neuropsychiatric symptoms assessed and results reviewed
	1181F with 8P	Neuropsychiatric symptoms not assessed and results not reviewed, reason not otherwise specified

Neuropsychiatric Symptoms: Management

Numerator	**Patients who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period. (Note: (One G-code [G8947] & one CPT II code are required on the claim form to submit this numerator option)**	
G-Code	G8947	**One or more neuropsychiatric symptoms**
	G8948	**No neuropsychiatric symptoms**
QDC	CPT II 4525F	**Neuropsychiatric intervention ordered**
	CPT II 4526F	**Neuropsychiatric intervention received**
	4525F with 8P	**Neuropsychiatric Intervention not ordered, reason not otherwise specified**
	4526F with 8P	**Neuropsychiatric Intervention not received, reason not otherwise specified**

Screening for Depression

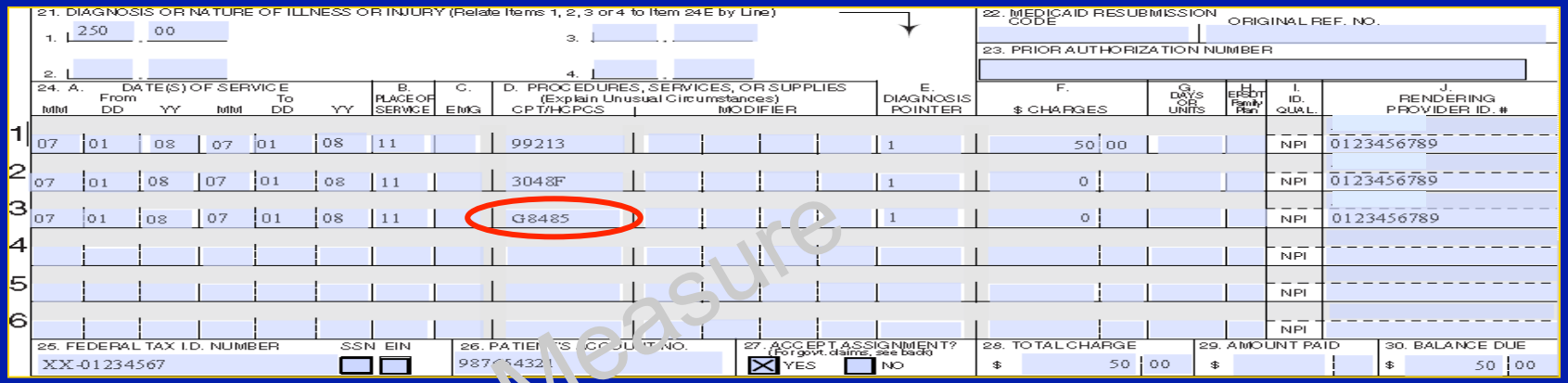
Numerator	Patients who were screened for depressive symptoms within a 12 month period	
QDC	CPT II 3725F	Screening for depression performed
	3725F with 8P	Screening for depression not performed, reason not otherwise specified

Pay for Performance Status

- Pay for Performance at Present = Pay for Reporting
- Diagnoses
  - Medication Verification
  - Pain Assessment
  - Screening for Depression
  - Treatment Planning
- Mild Cognitive Disorder
  - Specific Diagnoses
  - Specific Process (Documentation?)
  - Eventually Measure Development
- Outcome
  - Increased Accountability
  - Increased Remuneration
- Minimum of 50% (vs. 80% historically) of patients in program
- Bonus is 1% (with additional .%% per year if MOC)
- Check www.usqualitymeasures.org

How to report PQRI measures

- Example of a CMS 1500 claim form with G code reported- Note that there is no monetary value for code.



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
1. 250 . 00 3. . 2. . 4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	07	01	08	07	01	08	11		99213		1	50 00			NPI	0123456789
2	07	01	08	07	01	08	11		3048F		1	0			NPI	0123456789
3	07	01	08	07	01	08	11		G8485		1	0			NPI	0123456789
4															NPI	
5															NPI	
6															NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: XX-01234567
26. PATIENT'S ACCOUNT NO.: 987654321
27. ACCEPT ASSIGNMENT? (For govt. claims, see back): YES NO
28. TOTAL CHARGE: $ 50 00
29. AMOUNT PAID: $
30. BALANCE DUE: $ 50 00

Measure #2

PQRI: Performance

- Five years of program
- Over 100,000 participants
- $36 million in incentives or 1.5% with similar penalties
- Major problems
  - Reporting of codes
  - Denominator mistakes
  - Dx/Rx mismatch

CMS PQRI WEBSITE

Use the following link to access the Medicare 2008 PQRI web page. On the left of the page is a button for the PQRI Tool Kit. At the bottom of the page is the link to all the PQRI measures.

http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp

Status of PQRS

- Enrollment Should Occur by 2013
- But Open 04.01.14 to 09.30.14
- Bonus
  - .5% per year through 2014
- Provider groups over 10 have to be enrolled
- Penalties
  - Starting 2015

Problems With P4P

- California Medicaid System
- Five Measures of Clinical Quality Collected Between 2004-2007
- Comparisons of Counties That Used Measures Vs. Counties that Did Not Use Measures
- No Differential Effect of Health Care Was Found

(Guthrie, Bindman & Auerback, 2010)

Summary

- CPT Overview
- Major Points
- Directions

Upcoming Free Webinars

- Psychotherapy
  - Wednesday
  - June 19, 2014
  - 7:00 – 9:00 pm
- Testing
  - Wednesday
  - July 09, 2014
  - 7:00 - 9:00 pm

Resources (continued)

- Payment/Coverage
  - www.myhealthscore.com/consumer/phyoutcptsearch.htm
  - www.cms.hhs.gov/statistics/feeforservice/defailt.asp (covered services)
  - www.cms.hhs.gov/mcd/viewtrackingsheet.asp?id=167 (non-covered)
  - www.apa.org/pi/aging/lmrp/toolkit/homepage.html (apa lcd)
  - www.cms.hhs.gov/providers/mr/lmrp/asp (medicare lmrp)
  - www.quickfacts.census.gov/qfd (census x type of procedure data)
  - www.usqualitymeasures.org (payment for performance)
- LMRP Reconsideration Process
  - www.cms.gov/manuals/pm_trans/R28PIM.pdf
- PQRS
  - www.centerforhealthyaging.com
- Compliance Web Sites
  - www.oig.hhs.gov (office of inspector general)
  - www.cms.hhs.gov/manuals (medicare)
  - www.uscode.house.gov/usc.htm (united states codes)
  - www.apa.org (psychologists & hipaa)
  - www.cms.hhs.gov/hipaa. (hipaa)
  - www.hcca-info.org (health care compliance assoc.)
  - www.cms.gov/oas/cms.asp

Resources (continued)

- ICD
  - www.who.int/icd/vol1htm2003/fr-icd.htm (who)
  - www.cdc.gov/nchas/about/otheract/icd9/abticd9.htm (ccd)
- PQRS
  - www.centerforhealthyaging.com
- Coding Web Sites
  - www.catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp (ama cpt)
  - www.aapcnatl.org (academy of coders)
  - www.ntis.gov/product/correct-coding (coding edits)

Additional Sample Forms

- Office Forms
  - CPT Routing
  - PQRS
- Clinical Forms
  - Psychiatric Interviewing
  - Psychotherapy
  - Neurobehavioral Status Exam
  - Neuropsychological Testing (prof & technical)

AMA Contact Information

- Website
  - www.amabookstore.com
  - Link to;
    - catalog.ama-assn.org/Catalog/cpt/issue_search.jsp
- Telephone
  - 312.464.5116

APA Contact Information

- American Psychological Association
  - Katherine Nordal, Ph.D.
    Practice Directorate, Director
    American Psychological Association
    750 First Street, N.W.
    Washington, D.C. 2002
- Association for the Advancement of Psychology
  - www.aapnet.org

Puente Contact Information

- Websites
  - Coding= www.psychologycoding.com
  - Univ = www.uncw.edu/people/puente
  - Practice = www.clinicalneuropsychology.us
  - Vita/Academic= www.antonioepuente.com
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