Journal of Psychopathology and Behavioral Assessment, Vol. 19, No. 2, 1997

Reimbursement for Professional Psychological Services

Antonio E. Puente[1]

Accepted: July 1, 1997

A brief history of the professionalization of psychology precedes a section of how psychological services became reimbursable. Specific focus is placed on reimbursement for psychological services, especially the distinction between medical and psychiatric diagnoses as well as procedures or services. Specific guidelines for appropriate reimbursement are provided. Future directions for reimbursement for mental health and related services are considered.

KEY WORDS: reimbursement; psychological services.

INTRODUCTION

Witmer is often given credit for fostering the professionalization of psychology (Reisman, 1981). The establishment of a clinic to treat children, appearing rather routine today, was clearly pioneering in 1896 when he founded such a clinic. One hundred years later, the problem does not appear to be with the acceptance of the concept of psychological services, especially for children, but rather one of getting reimbursed for those services [a feeling shared by our psychiatric colleagues (Silberman, 1995)]. There are ample data to suggest that these are not particularly easy times from an economic standpoint for psychology. Bowers and Knapp (1993) reported that Pennsylvania psychologists in private practice had reported increasing problems with decreased fees, increased paperwork, and obtaining authorizations for more unusual or lengthy treatments. Recently, a neuropsychologist colleague from California informed me that she was

[1]University of North Carolina at Wilmington, Wilmington, North Carolina 28401.

0882-2689/97/0600-0091$12.50/0

scheduled for appointments 6 months in advance, quiet unusual even by today's standards. However, the problem was that their largest payer, the Medicare and Medicaid programs serving California, was not reimbursing for their services. Six months of patients is inadequate with no or limited reimbursement for services rendered to those patients. Furthermore, there is evidence that the quality of mental health services is integrally tied to payment (Wallace, 1991). Thus, therapists practical variables appear to be integrally tied to issues such as the termination of therapy and even the manner in which therapy is terminated. This brief paper addresses as much as possible from a scholarly perspective, the history, current practice, and future trends of reimbursement for professional services in psychology.

BACKGROUND

The history of reimbursement for professional services for psychologists obviously begins with the professionalization of the discipline. A review of the membership of the American Psychological Association clearly indicates a lack of professional activities for most of its members until the end of the second World War. Prior to the second World War, Watson (1953) estimated that there were 1000 clinical psychologists in North America. Fifty years later, that number is probably closer to 100,000 when counseling, school, and related specialties are included. This growth occurred in large part because of the establishment of the Veterans Administration system, the National Institute of Mental Health training funding, and the reorganization of the American Psychological Association in 1944, with clinical psychology being one of its divisions. This trend followed with the development of licensure within the states. After a period of one to two decades of growth within the organizational and public setting (e.g., hospitals, etc.), the application of psychology to private settings (i.e., solo practice) was initiated. Two impediments to such an evolution were still present: licensure as an independent practitioner and reimbursement for professional services.

Together with the passage of the Community Mental Health Act of 1963 came the Veterans Administration, National Institute of Mental Health, and U.S. Public Health support of the doctoral degree as the terminal degree for professional psychology. Licensure bills started cropping up in state legislatures around the United States soon thereafter. What was left to address was clearly the matter of reimbursement for such services.

After licensure, it was legally accepted to obtain reimbursement for such services. However, the bulk of health services reimbursement by that time was coming from third parties, primarily insurance companies (e.g., Blue Cross/Blue Shield). These companies had decided not to include psychologists in the reimbursement system. The federal government was the first to decide that psychologists could be reimbursed for their services. It was thought at that time that the only way to obtain third-party reimbursement was through a national health insurance system (Kovacs, 1975). It was not until Robert Resnick and the Virginia Academy of Clinical Psychology filed an antitrust suit, with support from the American Psychological Association, in 1980 that insurance companies decided to reconsider the matter. This brief cogently argued the following: (1) Blue Shield carried out illegal boycott against clinical psychologists, (2) Blue Shield engaged in illegal price control, (3) the U.S. District Court applied inappropriate legal standards, and (4) psychiatrists and psychologists do compete for the same patients (American Psychological Association, 1980).

Thus, by 1980, the third-party system had opened up to psychologists. By 1990, the federal government followed suit, with the full inclusion of psychologists in the Medicare plan. In many respects, the inclusion of psychologists in the Medicare system was considered to be the "final hurdle" (Inouye, 1986). The recent advent of health maintenance organizations, preferred provider organizations, and so forth, suggests that acceptance into the Medicare system, while a critical hurdle, has clearly been only one of many to clear.

APPLICATION

Diagnostic Codes

Receiving reimbursement hinges on a number of factors, of which two are easy but frequently misunderstood: diagnoses and procedures.

Diagnosis involves the numerical description of the psychologist's interpretation of the patient. Specifically, instead of providing a multiaxial assessment of the case, the insurance company requests specific information regarding the diagnosis. Typically, the diagnosis used by psychologists is the DSM system (American Psychiatric Association, 1994). The DSM system assumes two things: (1) the disorder in question is psychiatric rather than medical in nature, and (2) any accompanying procedure would, in turn, be psychiatric and not medical as well. A particularly problematic issue for this is the typical limited reimbursement for psychiatric disorders. Indeed, most payers systems use 50% reimbursement or, alternatively, copay for mental disorders. Furthermore, if the problem is "organic" in nature. the DSM system generally fails to describe the diagnostic issue adequately.

Alternatively, if the problem is "organic," a better system might be the International Classification of Diseases (ICD; World Health Organiza-

tion). At the current time, the ninth edition is being used; but a tenth revision is currently under way and actually being used outside the United States in some instances. Puente and Lazarus (1996) have compiled a list of ICD codes that could be used in diagnosing disorders seen by neuropsychologists. The use of the ICD, instead of the DSM, theoretically allows for emphasizing the physiological rather than the mental. When using an ICD code, more medical procedure codes (discussed later) would similarly be used and thus result in more favorable reimbursement. At this point, the reimbursement would fall into the medical arena, resulting in copays of 20% rather than 50%. Most importantly, one would then escape the cumbersome yearly and lifetime ceilings set for psychological services that are often easily reached with neurological or physical injuries.

It is important to emphasize that the goal is not necessarily that of better reimbursement, but, rather, of better diagnosing. Indeed, inappropriate billing strategies can result in claim denials, delayed payments, ethical complaints, and possible auditing by third parties (Small, 1993). If indeed the problem in question is clearly and only psychiatric (e.g., uncomplicated depression, anxiety, etc.), then it would be unethical and illegal to use a medical diagnosis. In contrast, if the primary problem in question is more physiological (e.g., cerebrovascular stroke), then using the DSM system would similarly be inappropriate. Thus, the goal is to match the problem with the appropriate diagnostic system. In summary, if the disorder is psychiatric, use the DSM; if the disorder is medical, use the ICD.

Unfortunately, this two-tier system of medical–psychiatric has seemingly produced a two-tier system in health care. In other words, psychiatric or mental health care is often considered as a second-class citizen relative to medical assessment and intervention. Where this has particularly hit the hardest has been in the public sector, where long-term psychiatric care is often a public-sector activity (Sharfstein, Stoline, & Goldman, 1993). The long-range implications in terms of both efficiency and perception are far-reaching. As early as the 1980s, Inouye (1983), Democratic representative to Congress from Hawaii, argued not only for the inclusion of psychologists to all health-care delivery but for the parity of mental health. Unfortunately, this goal continues being unattainable as we reach the year 2000—close to half a century after the licensure of psychologist and over a quarter of a century after the inclusion of psychologists in third-party health-care reimbursement.

Procedure Codes

The second major factor in reimbursement is the professional procedure completed. Procedure is broadly defined as any professional activity

completed in order to diagnose and/or treat the patient. Procedure, as Table I headings indicate, involves activity prior to seeing the patient, while in direct contact with the patient, and after seeing the patient. Precontact activity involves the preparation necessary to see the patient. For example, in a testing situation, that might involve choosing the tests, preparing the materials to be used, and so forth. Direct contact with the patient is broadly defined as having some exchange with the patient, whether it is verbal or nonverbal (e.g., with an aphasic patient, a young child, etc.). It is often assumed that the contact will be "face-to-face." However, the definition of "face-to-face" has never been clearly outlined by the federal government or other regulatory agencies. Thus, it could be that emergency telephone contact of an extended duration could meet this criteria. Finally, there is the postcontact time. This involves activity after the patient has left and can involve scoring, interpreting, and dictating tests as well as follow-up with referral sources, making additional appointments and/or referrals, and so forth. In an unpublished study of a small number of neuropsychologists, I determined that it took approximately 0.5 hr of non-face-to-face or direct contact for testing situations. If a standard therapy situation is used, that is, the patient is seen for approximately 45 min it is assumed that the remaining 15 min would be used for this extra or nondirect contact professional activity. Thus, it appears that no additional time would be billed in most therapeutic situations, whether it be the standard psychotherapy or the more specific intervention such as biofeedback or cognitive rehabilitation. However, where this extra time would clearly warrant additional billing time is in testing where a great deal of nondirect professional time is expended in preparing and completing professional activities. For tracking and eventual auditing purposes, it is advised that this extra time be somehow explained in the report.

While there are several procedural code systems, the one most typically used and accepted in the United States is the Current Procedural

Table I. CPT Codes According to Area

Psychiatry
90801, 90820, 90825, 90835, 90841, 90842, 90843, 90844, 90845, 90846, 90847, 90849, 90853, 90855, 90857, 90862, 90870, 90871, 90880, 90882, 90887, 90889
Central nervous assessment/testing codes
96100, 96105, 96110, 96111, 96115, 96117
Biofeedback codes
90901, 90911, 908X
Physical medicine and rehabilitation
97770

Terminology (CPT; American Medical Association, 1996). This system is constantly being revised and the one presently used is the *CPT '97*. The CPT system was developed by the American Medical Association as "a listing of descriptive terms and identifying codes for reporting medical services and procedures" (American Medical Association, 1994, p. 1). It was first published by the American Medical Association (AMA) in 1966, with the second edition appearing in 1970. In 1983, the CPT system was adopted by the U.S. federal government's Health Care Financing Administration (HCFA coding system). In 1987, the Omnibus Budget Reconciliation Act mandated the use of the CPT system.

The CPT system is based on the different medical specialties (which are actually represented in the makeup of the CPT panel). Outside a generic evaluation and management section (which most nonphysicians, including psychologists, cannot use), there are specific areas such as neurology and psychiatry. Traditionally, psychologists and other mental health professionals have used only psychiatric codes. Starting with the development of neuropsychological codes during the 1990s, psychologists can now use not only psychiatric codes but also several others.

Like the diagnostic codes, procedure codes can generally be broken down into separate categories generally based on whether the problem is medical or psychiatric. If the diagnosis is psychiatric, then the procedure code would almost certainly be one of the codes found in Table I. Margolis and Gergen (1989) provide generic guidelines for the use of psychiatric codes. It is important, however, to realize that specific application cannot be achieved because of the continuing alterations of the CPT system (e.g., in 1998, the so-called G codes will be used for psychotherapy). Alternatively, if the problem is medical, it would not be Inappropriate to use one of the Central Nervous System Assessment/Testing Codes (see Table I) or Physical Medicine and Rehabilitation Codes. The only exception at this point would be code 96100 in the CNS section, which often would be used with psychiatric diagnoses.

Valuing Procedure Codes

One of the difficult tasks in determining reimbursement for procedure codes involves assigning some value to that code. For example, neuropsychological testing involves more equipment and training than standard psychotherapy, thus it should be reimbursed at a higher rate. The question becomes: How does one empirically determine such differential reimbursement?

During the 1980s, the Diagnostic Related Group (DRG) system was developed as a means to reimburse for medical problems that were relatively homogeneous. It was predicted that such homogeneity would help predict such critical variables as length of stay in a hospital. The DRG system proved to be fraught with many problems (see Holcomb & Thompson, 1988) and was eventually discarded by both the federal government and private insurers as a method of reimbursement.

Over the last several years, the American Medical Association, again in conjunction and under contract with the Health Care Financing Authority, developed a system of valuing procedures. The Resource-Based Relative Value Scale (RBRVS) takes into account several variables in determining the relative value of a procedure. These include physician work, practice expense, and malpractice. The most salient of the three is physician work, which should take into consideration variables such as the amount of training required to complete the procedure and amount of cognitive demand. Practice expense would include all financial aspects involved in the provision of these services such as the cost of the original test, forms used, and extra materials needed. Each procedure is valued based on a survey completed by professionals in the field using clinical case studies. In the case of practice expense, the costs of commonly used tests and equipment are tabulated based on the frequency of usage of such materials. Furthermore, every area has a benchmark code. In psychiatry, that code is psychotherapy. Thus, other mental codes are valued as either higher or lower compared to the amount of physician work and practice expense compared to psychotherapy.

At this point, it is too early to estimate the ramifications and efficacy of the relative value system. However, such a system is undoubtedly going to affect both practitioner practice patterns and behaviors (Fahey, 1992). The beauty of such a system is that everything can be compared. That is, psychotherapy can theoretically be compared to open-heart surgery. The problem or flaw is that the comparison may be untenable. Thus, if the relative value system is used for compensation and if the relative values of high-end procedures are higher (which they are), the discrepancy between mental health and medical professionals and procedures may actually become more accentuated than equalized.

SUMMARY AND FUTURE DIRECTIONS

This brief article is intended as an overview to the complex issues of reimbursement. It is not intended to be exhaustive, as much more material needs to be considered. The reader of this article is encouraged to obtain the DSM and ICD diagnostic systems, and the CPT from the AMA, and

to keep current on the latest HCFA rulings. The National Psychologist, the American Psychological Association (APA) Monitor, and the APA Practice Directorate Bulletin are a few of the regular publications that should be consulted for the latest information. It is critical to realize that this brief article represents a somewhat scholarly and practical introduction to reimbursement for psychologists. Furthermore, numerous changes are ongoing. By the time this article goes to press, it is likely that many of the issues discussed in the practical application sections of this article will be outdated. For example, it is anticipated that the psychotherapy codes (90842, 90843, and 90844) will have been replaced by the Medicare G codes enacted by HCFA during 1997. The changes will be significant in a number of ways. Thus, reimbursement is going through dramatic changes, and while the historical sections of this article will obviously not change (though they will possibly be reinterpreted), the practical issues will undoubtedly continue experiencing profound and radical changes.

While not in the forefront of these economic changes, litigation is bound to reappear once more, much like the Virginia Blue Shield case of almost 20 years ago. In the Mental and Physical Disability Law Reporter, numerous cases involving litigation and increasing access to mental health are being reported (e.g., Anonymous, 1987). It is anticipated that while these cases have been toward the expansion of psychiatric services into the public sector, future cases will probably involve the question of parity between mental and medical services in terms of copay, ceilings (including per illness, per year, and per lifetime), and accessibility. In the short term, it is predicted that mental health or psychiatric services will probably experience a downturn, something actually predicted in the 1980s (Rodenhauser & Greenblatt, 1989; Rodriguez, 1985). However, it is also anticipated that if the relative value of service can be demonstrated, the future of reimbursement for the more traditional mental health services will actually increase. Ashley, Persel, and Krych (1993) demonstrated that treatment of traumatic brain injury showed not only greater disability reduction but improvements in living status. Clearly, insurance carriers must be convinced with empirical information to suggest that increased involvement from traditionally nonmedical approaches (e.g., psychological) will greatly decrease the overall cost of medical services. Until then, disciplines such as neuropsychology will continue providing the critical bridge between medical and mental health services.

REFERENCES

American Medical Association (1994). *The CPT process.* Chicago: AMA.
American Medical Association (1996). *CPT '97.* Chicago: AMA.

American Psychiatric Association (1994). *The diagnostic and statistical manual, 4th ed.* Washington, DC: APA.
Anonymous (1980). Brief of the American Psychological Association as Amicus Curiae: Virginia Academy of Clinical Psychologists *et al.*, Appellants, v. Blue Shield of Virginia *et al.*, Appellees. *American Psychologist, 35,* 1028–1043.
Anonymous (1987). Reimbursement for psychiatric services. *Mental & Physical Disability Law Reporter, 11,* 131.
Ashley, M. J., Persel, G. S., & Krych, D. K. (1993). Changes in reimbursement climate: Relationship among outcome, cost, and pair type in the postacute rehabilitation environment. *Journal of Head Trauma Rehabilitation, 8,* 30–47.
Bowers, T. G., & Knapp, S. (1993), Reimbursement issues for psychologists in independent practice. *Psychotherapy in Private Practice, 12,* 73–87.
Fahey, D. F. (1992). Projected responses to changes in physicians RBRVS reimbursement: Induced-demand theory versus contingency theory. *Medical Care Review, 49,* 67–91.
Holcomb, W. R., & Thompson, W. A. (1988). Medicare prospective reimbursement for mental health services: A literature review. *Administration in Mental Health, 15,* 127–138.
Inouye, D. K. (1983). Mental health care: Access, stigma, and effectiveness. *American Psychologist, 38,* 912–917.
Inouye, D. K. (1986). Psychology and Medicare: The final hurdle. *Psychotherapy in Private Practice, 4,* 1–7.
Kovacs, A. (1975). Economic legitimacy for professional practitioners. *American Psychologist, 30,* 1160–1162.
Margolis, J. A., & Gergen, ?. (1989). Current procedural terminology codes for psychiatric services. *Hospital & Community Psychiatry, 40,* 625–629.
Puente, A. E., & Lazarus, T. (1996). International Classification of Disease (9th edition) for Neuropsychological Disorders. In: *Membership Directory of the National Academy of Neuropsychology.* Denver, CO: National Academy of Neuropsychology.
Reisman, J. M. (1981). History and current trends in clinical psychology. In C. E. Walker (Ed.), *Clinical practice of psychology.* New York: Pergamon Press.
Rodenhauser, P., & Greenblatt, M. (1989). Transformations in mental health system management: An overview. *Psychiatric Annals, 19,* 408–411.
Rodriguez, A. R. (1985). Current and future directions in reimbursement for psychiatric services. *General Hospital Psychiatry, 7,* 341–348.
Sharfstein, S. S., Stoline, A. M., & Goldman, H. H. (1993). Psychiatric care and health insurance reform. *American Journal of Psychiatry, 150,* 7–18.
Silberman, E. D. (1995). *Successful psychiatric practice: Current dilemmas, choices, and solutions.* Washington, DC: American Psychiatric Press.
Small, R. F. (1993). *Maximizing third-party reimbursement in your mental health practice,* 2nd. ed. Sarasota, FL: Professional Resource Press.
Wallace, D. (1991). Quality of mental health service and method of payment: An empirical study. *Behavioral Sciences and the Law, 9,* 163–177.
Watson, R. I. (1953). A brief history of clinical psychology. *Psychological Bulletin, 50,* 321–346.