North Carolina Psychological Association

April 26, 2002; Charlotte, NC

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Coding, Diagnosing, Billing, Reimbursement & Documentation Strategies for Psychological Services

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3 ## Acknowledgments

- NCPA Board of Directors, Practice Division, & Staff
- NAN Board of Directors, Policy and Planning Committee, & Professional Affairs & Information Office
- Division 40 Board of Directors & Practice Committee
- Practice Directorate of the American Psychological Association
- American Medical Association's CPT Staff
- CMS Medical Policy Staff

4 ## Background

- North Carolina Psychological Association
- American Medical Association's Current Procedural Terminology Committee (IV/V)
- Health Care Finance Administration' Working Group for a Model Mental Health policy
- Center for Medicare/Medicaid Services' Medicare Coverage Advisory Committee
- Development of NAN's new PAIO
- Consultant with the State Medicaid Office; Blue Cross/Blue Shield
- APA; Council of Rep, Division 40, P & P

5 ## Purpose of Presentation

- Increase Reimbursement
- Decrease Fraud & Abuse
- Provide Professional Guidelines
- Increase Range, Type & Quality of Services

- Increase Professional Stature in Health Care

6 Outline of Presentation

- Medicare
- Current Procedural Terminology: Basic
- Current Procedural Terminology: Related
- Relative Value Units
- Current Problems & Possible Solutions
- Future Directions & Problems
- Cases & Questions

7 Outline: Highlights

- New Codes
- Expanding Paradigms
- Fraud, Abuse; Coding & Documentation
- The Problem with Testing

8 Medicare: Overview

- Why Medicare
- Medicare Program
- Local Medical Review

9 Medicare: Why

- ***The*** Standard
  - Coding
  - Value
  - Documentation
- Approximately 50% for Institutions
- Approximately 33% for Outpatient Offices
- Becoming the Standard for Workers Comp.
- Increasing Percentage for Forensic Work

10 Medicare: Overview

- New Name: HCFA now CMS
  - Centers for Medicare and Medicaid Services
- New Charge: Simplify
- New Organization: Beneficiary, Medicare, Medicaid
- Benefits
  - Part A (Hospital)
  - Part B (Supplementary)
  - Part C (Medicare+ Choice)

11 Medicare: Local Review

- Local Medical Review Policy

- Carrier Medical Director
- Policy Panels

12 Current Procedural Terminology: Overview

- Background
- Codes & Coding
- Existing Codes
- New Codes (effective 01.01.02; revised 03.15.02)
- Model System X Type of Problem
- Medical Necessity
- Documenting
- Time

13 CPT: Highlights

- New Codes
- Medical Necessity
- Documentation

14 CPT: Background

- American Medical Association
  - Developed by Surgeons (& Physicians) in 1966 for Billing Purposes
  - 7,500 Discrete Codes
- HCFA/CMS
  - AMA Under License with CMS
  - CMS Now Provides Active Input into CPT
- Congress
  - Trent Lott (2001)

15 CPT: Background/Direction

- Current System = CPT 5
- Categories
  - I= Standard Coding for Professional Services
  - II = Performance Measurement
  - III = Emerging Technology

16 CPT: Applicable Codes

- Total Possible Codes = 7,500
- Possible Codes for Psychology = Approximately 40 to 60
- Sections = Five Separate Sections
  - Psychiatry
  - Biofeedback
  - Central Nervous Assessment
  - Physical Medicine & Rehabilitation
  - Health & Behavior Assessment & Management

17 CPT: Development of a Code

- Initial
  - HCPAC
- Primary
  - CPT Work Group
  - CPT Panel
- Time Frame
  - 3-5 years

18 CPT: Psychiatry

- Sections
  - Interview vs. Intervention
  - Office vs. Inpatient
  - Regular vs. Evaluation & Management
  - Other
- Types of Interventions
  - Insight, Behavior Modifying, and/or Supportive vs. Interactive

19 CPT: Psychiatry (cont.)

- Time Value
  - 30, 60, or 90
- Interview
  - 90801
- Intervention
  - 90804 - 90857

20 CPT: Biofeedback

- Psychophysiological Training
  - 90901
- Biofeedback
  - 90875

21 CPT: CNS Assessment

- Interview
  - 96115
- Testing
  - Psychological = 96100; 96110/11
  - Neuropsychological = 96117
  - Other = 96105, 96110/111

22 CPT: 96117 in Detail

- Number of Encounters in 2000 = 293,000
- Number of Medical Specialties Using 96117 = over 40
- Psychiatry & Neurology = Approximately 3% each
- Clinics or Other Groups = 3%
- Unknown Data = Use of Technicians

23 CPT: Physical Medicine & Rehabilitation

- 97770 now 97532
- Note: 15 minute increments

24 CPT: Health & Behavior Assessment & Mngmt.

- Purpose: Medical Diagnosis
- Time: 15 Minute Increments
- Assessment
- Intervention

25 Rationale: General

- Acute or chronic (health) illness may not meet the criteria for a psychiatric diagnosis
- Avoids inappropriate labeling of a patient as having a mental health disorder
- Increases the accuracy of correct coding of professional services
- May expand the type of assessments and interventions afforded to individuals with health problems

26 Rationale: Specific Examples

- Patient Adherence to Medical Treatment
- Symptom Management & Expression
- Health-promoting Behaviors
- Health-related Risk-taking Behaviors
- Overall Adjustment to Medical Illness

27 Overview of Codes

- New Subsection
- Six New Codes
  - Assessment
  - Intervention
- Established Medical Illness or Diagnosis
- Focus on Biopsychosocial Factors

28 Assessment Explanation

- Identification of psychological, behavioral, emotional, cognitive, and social factors
- In the prevention, treatment, and/or management of *physical health* problems
- Focus on biopsychosocial factors (not mental health)

29 Assessment (continued)

- May include (examples);
  - health-focused clinical interview
  - behavioral observations

- psychophysiological monitoring
- health-oriented questionnaires
- and, assessment/interpretation of the aforementioned

30 Intervention Explanation

- Modification of psychological, behavioral, emotional, cognitive, and/or social factors
- Affecting physiological functioning, disease status, health, and/or well being
- Focus = improvement of health with cognitive, behavioral, social, and/or psychophysiological procedures

31 Intervention (continued)

- May include the following procedures (examples);
  - Cognitive
  - Behavioral
  - Social
  - Psychophysiological

32 Diagnosis Match

- Associated with acute or chronic illness
- Prevention of a physical illness or disability
- Not meeting criteria for a psychiatric diagnosis or representing a preventative medicine service

33 Related Psychiatric Codes

- If psychiatric services are required (90801-90899) along with these, report predominant service
- Do not report psychiatric and these codes on the same day

34 Related Evaluation & Management Codes

- Do not report Evaluation & Management codes the same day

35 Code X Personnel (examples)

- Physicians (pediatricians, family physicians, internists, & psychiatrists)
- Psychologists
- Advanced Practice Nurses
- Clinical Social Workers
- Other health care professionals within their scope of practice who have specialty or subspecialty training in health and behavior assessments and interventions

36 Health & Behavior Assessment Codes

- 96150
  - Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires)
  - each 15 minutes

- face-to-face with the patient
- initial assessment

- 96151
  - re-assessment

37 Health & Behavior Intervention Codes

- 96152
  - Health and behavior intervention
  - each 15 minutes
  - face-to-face
  - individual
- 96153
  - group (2 or more patients)
- 96154
  - family (with the patient present)
- 96155
  - family (without the patient present)

38 Relative Values for Health & Behavior A/I Codes

- 96150 = .50
- 96151 = .48
- 96152 = . 46
- 96153 = .10
- 96154 = .45
- 96155 = .44

39 Sample of Commonly Asked Questions

- When Are These Codes to be Used for Psychotherapy Codes?
  - Depends on the disorder
  - DSM = psychotherapy
  - ICD = health and behavior

40 Samples Questions (continued)

- Do These Codes Include Neuropsychological Testing?
  - No
  - Formal testing should be coded between 96100 and 96117, depending on the situation

41 Sample Questions (continued)

- Who Can Perform These Services?
  - Physicians can perform these services
  - Application of these codes will vary according to licensure/credentialing requirements of the state, area, providence and/or institution
  - Payment may also vary

42 96150 Clinical Example

- A 5-year-old boy undergoing treatment for acute lymphoblastic leukemia is referred for

assessment of pain, severe behavioral distress and combativeness associated with repeated lumbar punctures and intrathecal chemotherapy administration. Previously unsuccessful approaches had included pharmacologic treatment of anxiety (ativan), conscious sedation using Versed and finally, chlorohydrate, which only exacerbated the child's distress as a result of partial sedation. General anesthesia was ruled out because the child's asthma increased anesthesia respiratory risk to unacceptable levels.

43 96150 Description of Procedure

- The patient was assessed using standardized tests and questionnaires (e.g., the Information-seeking scale, Pediatric Pain Questionnaire, Coping Strategies Inventory) which, in view of the child's age, were administered in a structured format. The medical staff and child's parents were also interviewed. On the day of a scheduled medical procedure, the child completed a self-report distress questionnaire.Behavioral observations were also made during the procedure using the CAMPIS-R, a structured observation scale that quantifies child, parent, and medical staff behavior.
- An assessment of the patient's condition was performed through the administration of various health and behavior instruments.

44 96151 Clinical Example

- A 35-year-old female, diagnosed with chronic asthma, hypertension and panic attacks was originally seen ten months ago for assessment and follow-up treatment. Original assessment included extensive interview regarding patient's emotional, social, and medical history, including her ability to manage problems related to the chronic asthma, hospitalizations, and treatments. Test results from original assessment provided information for treatment planning which included health and behavior interventions using a combination of behavioral cognitive therapy, relaxation response training and visualization. After four months of treatment interventions, the patient's hypertension and anxiety were significantly reduced and thus the patient was discharged. Now six months following discharge, the patient has injured her knee and has undergone arthroscopic surgery with follow-up therapy

45 96151 Description of Procedure

- Patient was seen to reassess and evaluate psychophysiological responses to these new health stressors. A review of the records from the initial assessment, including testing and treatment intervention, as well as current medical records was made. Patient's affective and physiological status, compliance disposition, and perceptions of efficacy of relaxation and visualization practices utilized during previous treatment intervention are examined. Administration of anxiety inventory/questionnaire (e.g., Burns Anxiety Inventory) is used to quantify patient's current level of response to present health stressors and compared to original assessment levels. Need for further treatment is evaluated.
- A reassessment of the patients condition was performed through the use of interview and behavioral health instruments.

46 96152 Clinical Example

- A 55-year-old executive has a history of cardiac arrest, high blood pressure and cholesterol, and a family history of cardiac problems. He is 30 lbs. overweight, travels extensively for work, and reports to be a moderate social drinker. He currently smokes one-half pack of cigarettes a day, although he had periodically attempted to quit smoking for up to five weeks at a time. The patient is considered by his physician to be a "Type A" personality and at high risk for cardiac complications. He experiences angina pains one or two times per month. The patient is seen by a behavior medicine specialist. Results from the health and behavior assessment are used to develop a treatment plan, taking into account the patient's coping skills and lifestyle.

47 96152 Description of Procedure

- Weekly intervention sessions focus on psychoeducational factors impacting his awareness and knowledge about his disease process, and the use of relaxation and guided imagery techniques that directly impact his blood pressure and heart rate. Cognitive and behavioral approaches for cessation of smoking and initiation of an appropriate physician-prescribed diet and exercise regimen are also employed.

48 96153 Clinical Example

- A 45-year-old female is referred for smoking cessation secondary to chronic bronchitis, with a strong family history of emphysema. She smokes two packs per day. The health and behavior assessment reveals that the patient uses smoking as a primary way of coping with stress. Social Influences contributing to her continued smoking include several friends and family members who also smoke. The patient has made multiple previous attempts to quit "on her own". When treatment options are reviewed, she is receptive to the recommendation of an eight-session group cessation program.

49 96153 Description of Procedure

- The program components include educational information (e.g., health risks, nicotine addiction), cognitive-behavioral treatment (e.g., self-monitoring, relaxation training, and behavioral substitution), and social support (e.g., group discussion, social skills training). Participants taper intake over four weeks to a quit date and then attend three more sessions for relapse prevention. Each group sessions lasts 1.5 hrs.

50 96154 Clinical Example

- Tara is a 9-year-old girl, diagnosed with insulin dependent diabetes two years ago. Her mother reports great difficulty with morning and evening insulin injections and blood glucose testing. Tara whines and cries, delaying the procedures for 30 minutes or more. She refused to give her own injections or conduct her own blood glucose tests, claiming they "hurt". Her mother spends many minutes pleading for her cooperation. Tara's father refuses to participate, saying he is "afraid" of her needles. Both parents have not been able to go to a movie or dinner alone, because they know of no one who can care for Tara. Tara's ten year old sister claims she never has any time with her mother, since her mother is always occupied with Tara's illness. Tara and her sister have a very poor relationship and are always quarreling. Tara's parents frequently argue; her mother complains that she gets no help from her husband. Tara's father complains that his wife has no time for anyone except Tara.

51 96154 Description of Procedure

- A family-based approach is used to address the multiple components of Tara's problem behaviors. Relaxation and exposure techniques are used to address Tara's father's fear of injections, which he has inadvertently has been modeling for Tara. Tara is taught relaxation and distraction techniques to reduce the tension she experiences with finger sticks and injections. Both parents are taught to shape Tara's behavior, praising and rewarding successful diabetes management behaviors, and ignoring delay tactics. Her parents are also taught judicious use of time-out and response cost procedures. Family roles and responsibilities are clarified. Clear communication, conflict-resolution, and problem-solving skills are taught. Family members practice applying these skills to a variety of problems so that they will know how to successfully address new problems that may arise in the future.

52 96155 Clinical Example

- Greg is a 42-year-old male diagnosed with cancer of the pancreas. He is currently undergoing both aggressive chemotherapy and radiation treatments. However, his prognosis is guarded. At present, he is not in the endstage disease process and therefore does not qualify for Hospice care. The patient is seen initially to address issues of pain management via imagery, breathing exercises, and other therapeutic interventions to assess quality of life issues, treatment options, and death and dying issues.

53 96155 Description of Procedure

- Due to the medical protocol and the patient's inability to travel to additional sessions between hospitalizations, a plan is developed for extending treatment at home via the patient's wife, who is his primary home caregiver. The patient's wife is seen by the healthcare provider to train the wife in how to assist the patient in objectively monitoring his pain and in applying exercises learned via his treatment sessions to manage pain. Issues of the patient's quality of life, as well as death and dying concerns, are also addressed with assistance given to the wife as to how to make appropriate home interventions between sessions. Effective communication techniques with her husband's physician and other members of his treatment team regarding his treatment protocols are facilitated.

54 CPT: Modifiers

- Acceptability
  - Medicare = about 100%
  - Others = approximating 90%
- Modifiers
  - 22 = unusual or more extensive service
  - 51 = multiple procedures
  - 52 = reduced service
  - 53 = discontinued service

55 CPT: Model System

- Psychiatric
- Neurological
- Non-Neurological Medical

56 CPT: Psychiatric Model (Children & Adult)

- Interview
  - 90801
- Testing
  - 96100, or
  - 96110/11
- Intervention
  - e.g., 90806
  - The challenge of New Mexico

57 CPT: Neurological Model (Children & Adult)

- Interview
  - 96115
- Testing
  - 96117
- Intervention
  - 97532

58 CPT: Non-Neurological Medical Model (Children & Adult)

- Interview & Assessment
  - 96150 (initial)
  - 96151 (re-evaluation)
- Intervention
  - 96152 (individual)
  - 96153 (group)

- 96154 (family with patient)
- 96155 (family without patient)

59 CPT: New Paradigms

- Initial Psychiatric
- Next Neurological
- Now Medical
- Medical as Evaluation & Management

60 CPT: Evaluation & Management

- Role of Evaluation & Management Codes
  - Procedures
  - Case Management
- Limitations Imposed by AMA's House of Delegates
- Health & Behavior Codes as an Alternative to E & M Codes

61 CPT: Diagnosing

- Psychiatric
  - DSM
    - The problem with DSM and neuropsych testing of developmentally-related neurological problems
- Neurological & Non-Neurological Medical
  - ICD

62 CPT: Medical Necessity

- Scientific & Clinical Necessity
- Local Medical Review or Carrier Definition of Necessity
- Necessity = CPT x DX
- Necessity Dictates Type and Level of Service
- Necessity Can Only be Proven with Documentation

63 CPT: Documenting

- Purpose
- Payer Requirements
- General Principles
- History
- Examination
- Decision Making

64 Documentation: Purpose

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

65 Documentation: Payer Requirements

- Site of Service
- Medical Necessity for Service Provided
- Appropriate Reporting of Activity

66 Documentation: General Principles

- Rationale for Service
- Complete and Legible
- Reason/Rationale for Service
- Assessment, Progress, Impression, or Diagnosis
- Plan for Care
- Date and Identity of Observe
- Timely
- Confidential

67 Documentation: Basic Information Across All Codes

- Date
- Time, if applicable
- Identify of Observer
- Reason for Service
- Status
- Procedure
- Results/Finding
- Impression/Diagnoses
- Disposition
- Stand Alone

68 Documentation: Chief Complaint

- Concise Statement Describing the Symptom, Problem, Condition, & Diagnosis
- Foundation for Medical Necessity
- Must be Complete & Exhaustive

69 Documentation: Present Illness

- Symptoms
  - Location, Quality, Severity, Duration, timing, Context, Modifying Factors Associated Signs
- Follow-up
  - Changes in Condition
  - Compliance

70 Documentation: History

- Past
- Family
- Social

- Medical/Psych ?

71 ▨ **Documentation: Mental Status**

[1]
- Language
- Thought Processes
- Insight
- Judgment
- Reliability
- Reasoning
- Perceptions

[2]
- Suicidality
- Violence
- Mood & Affect
- Orientation
- Memory
- Attention
- Intelligence

72 ▨ **Documentation: Neurobehavioral Status Exam**

- Attention
- Memory
- Visuo-spatial
- Language
- Planning

73 ▨ **Documentation: Testing**

- Names of Tests
- Interpretation of Tests
- Disposition
- Time/Dates

74 ▨ **Documentation: Intervention**

- Reason for Service
- Status
- Intervention
- Results
- Impression
- Disposition
- Time

75 Documentation: Suggestions

- Avoid Handwritten Notes
- Do Not Use Red Ink
- Document On and After Every Encounter, Every Procedure, Every Patient
- Review Changes Whenever Applicable
- Avoid Standard Phrases

76 Documentation: Ethical Issues

- How Much and To Whom Should Information be Divulged
- Medical Necessity vs. Confidentiality

77 Time

- Defining
  - Professional (not patient) Time Including:
    - pre, intra & post-clinical service activities
- Interview & Assessment Codes
  - Generally use hourly increments
  - For new codes, use 15 minute increments
- Intervention Codes
  - Use 15, 30, or 60 minute increments

78 Time: Definition

- AMA Definition of Time

- Physicians also spend time during work, before, or after the face-to-face time with the patient, performing such tasks as reviewing records & tests, arranging for services & communicating further with other professionals & the patient through written reports & telephone contact.

79 Time (continued)

- Communicating further with others
- Follow-up with patient, family, and/or others
- Arranging for ancillary and/or other services

80 Time: Testing

- Quantifying Time
  - Round up or down to nearest increment
  - Testing = 15 or 60 (probably soon 30)
- Time Does Not Include
  - Patient completing tests, forms, etc.
  - Waiting time by patient
  - Typing of reports
  - Non-Professional (e.g., clerical) time
  - Literature searches, new techniques, etc.

81 Time (continued)

- Preparing to See Patient
- Reviewing of Records
- Interviewing Patient, Family, and Others
- *When Doing Assessments*:
  - Selection of tests
  - Scoring of tests
  - Reviewing results
  - Interpretation of results
  - Preparation and report writing

82 Time: Example of 96117

- Pre-Service
  - Review of medical records
  - Planning of testing
- Intra-Service
  - Administration
- Post-Service
  - Scoring, interpretation, integration with other records, written report, follow-up...

83 Reimbursement History

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

84 Relative Value Units: Overview

- Components
- Units
- Values
- Current Problems

85 RVU: Components

- ***Physician Work Resource Value***
- ***Practice Expense Resource Value***
- Malpractice
- Geographic
- Conversion Factor (approx. $34)

86 RVU: Values

- Psychotherapy:
  - Prior Value =1.86

- New Value = 2.0+ (01.01.02)
- Psych/NP Testing:
  - Work value= 0
  - Hsiao study recommendation = 2.2
  - New Value = undetermined
- Health & Behavior
  - .25 (per 15 minutes increments)

87 RVU: Acceptance

- Medicare
- Blue Cross/Blue Shield 87%
- Managed Care 69%
- Medicaid 55%
- Other 44%
- New Trends: Compensation Formulas

88 Current Problems

- Definition of Physician
- Incident to
- Supervision
- Face-to-Face
- Time
- RVUs
- Work Values
- Qualification of Technicians
- Practice Expense
- Payment
- Prospective Payment System
- ***Focus*** for Fraud & Abuse

89 Current Problems: Highlights

- Work Value
- Provision & Coding of Technical Services (e.g., who is qualified to provide them)
- Mental vs. Physical Health

90 Problem: Defining Physician

- Definition of a Physician
  - Social Security Practice Act of 1980
  - Definition of a Physician
  - Need for Congressional Act
  - Likelihood of Congressional Act
  - The Value of Technical Services of a Psychologist is $.83/hour (second highest after physicist)
  - Consequence of the preceding; grouping with non-doctoral level allied health providers

91 Problem: Incident to

- Definition of Physician Extender

- How
- Limitations

- Definition of In vs. Outpatient
  - Geographic Vs Financial
- Why No Incident to (DRG)
- Solution Available for Some Training Programs
- Probably no Future to Incident to

92 Problem: More Incident to

- When is Incident to Acceptable:
  - Testing (Cognitive Rehabilitation; Biofeedback)
  - Psychotherapy
- Definition
  - Commonly furnished service
  - Integral, though incidental to psychologist
  - Performed under the supervision
  - Either furnished without charge or as part of the psychologist's charge

93 Problem: Incident to & Site of Service

- Outpatient vs. Inpatient
  - Geographical Location
  - Corporate Relationship
  - Billing Service
  - Chart Information & Location

94 Problem:Supervision

- Supervision
  - 1.General = overall direction
  - 2.Direct = present in office suite
  - 3.Personal = in actual room
  - 4.Psychological = when supervised by a psychologist

95 Problem: Face-to-Face

- Implications
- Technical versus Professional Services
- Surgery is the Foundation for CPT (and most work is face-to-face)
- Hard to Document & Trace Non-Face-to-Face Work

96 Problem: Time

- Time Based Professional Activity
- Current =15, 30, 60, & 90
- Expected = 15 & 30

97 Problem: RVUs

- Bad News
  - 2000 = 5.5% increase
  - 2001 = 4.5% increase

- 2002 = 5.4% decrease
- 2003 = 5.7% decrease ($34.14)

- Really Bad News
  - Projected cuts of about 7% more
  - Bush Administration not supportive of changing the conversion formula

98 Problem: Work Value

- Physician Activities (e.g., Psychotherapy) Result in Work Values
- Psychological Based Activities (I.e., Testing) Have *no* Work Values
- RVUs are Heavily Based on Practice Expenses (which are being reduced)
- Net Result = Maybe Up to a Half Lower

99 Problem: Qualification of Technician

- What is the Minimum Level of Training Required for a Technician?
  - Bachelor's vs. Masters
  - Intern vs. Postdoctoral
- Will a Registry be Available?

100 Practice Expense: The Problem with Testing

- Five Year Reviews
- Prior Methodology
- Current Methodology
- Current Value = approximately 1.5 of 1.75 is practice
- Expected Value = closer to 50% of total value

101 Problem: Payment

- Refilling
  - 51% require refilling
- Errors
  - 54% = plan administrator
  - 17% = provider
  - 29% = member
- State Legislation
  - www.insure.com/health/lawtool.cfm

102 Problem: Payment

- Use of HMOs & Third Party
  - Shift in Practice Patterns by Psychiatry (14% increase)
  - Exclusion of MSW, etc.
  - Worst Hit Are Psychologists (2% decrease)
- Compensation
  - Gross Charges
  - Adjusted Charges
  - RVUs
  - Receivables

103 Problem: PPS

- Application of PPS (inpatient rehab)
- Traditional Reimbursement
- Current Unbundling
- Potential Situation

104 Problem: Expenditures & Fraud

- Projections
  - Current
    - 14%
  - By 2011;
    - 17% ($2.8 trillion)
- Examples
  - Nadolni Billing Service (Memphis)
    - $5 million in claims to CIGNA for psychological services
    - $250,000 fine (& tax evasion); July 12th

105 Defining Fraud

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

106 Problem: Fraud & Abuse

- 26 Different Kinds of Fraud Types
- Mental Health Profiled
- Estimates of Less Than 10% Recovered
- Psychotherapy Estimates/Day = 9.67 hours
- Problems with Methodology;
  - MS level and RN
  - Limited Sampling

107 Problem: Fraud
Office of Inspector General

- Primary Problems
  - Medical Necessity (approximately $5 billion)
  - Documentation
- Psychotherapy
  - Individual
  - Group
- Psychological Testing
  - # of Hours

- Documentation

108 Problem: Fraud (cont.)

- Nursing Homes
  - Identification
  - Overuse of Services
- Children
- Experience
  - California; Texas
  - Corporation Audit
  - Company Audit
  - Personal Audit

109 Problem: Fraud (cont.)

- Estimated Pattern of Fraud Analysis
  - For-profit Medical Centers
  - For-profit Medical Clinics
  - Non-profit Medical Centers
  - Non-profit Medical Clinics
  - Nursing Homes
  - Group Practices
  - Individual Practices

110 Problem: Mental vs. Physical

- Historical vs. Traditional vs. Recent Diagnostic Trends
- Recent Insurance Interpretations of Dxs
- Limitations of the DSM
- The Endless Loop of Mental vs. Physical

- NOTE: *Important to realize that LMRP is almost always more restrictive than national guidelines*

111 Current Efforts

- Participants
  - APA Practice
  - Related Organizations (NAN, SPA)
- Activities
  - E & M Documentation Guidelines
  - Medical vs. Mental Health Dx
  - Supervision
    - Three Levels
    - Physician Supervision is not Required for a Psychologist
  - Survey
    - Practice Expense vs. Cognitive Work
    - Professional vs. Technical Component

112 Possible Solutions

- Better Understanding & Application of CPT

- More Involvement in Billing
- Comprehensive Understanding of LMRP
- More Representation/Involvement with AMA, CMS, & Local Medical Review Panels
- Meetings with CMS
- Survey for Testing Codes
- APA: Increased Staff & Relationship with CAPP
- Local Interest Groups and NCPA

113 Possible Solutions: Resources

- Web Sites
  - cignamedicare.org
  - cms.org
  - nanonline.org
  - div40.org
  - clinicalneuropsychology.com
- Publications
  - Testing Times: Camara, Puente, & Nathan (2000)
  - General CPT: NAN & Div 40 Newsletters

114 Future Perspectives

- Income
  - Steadier (if economy does not further erode)
  - Probable incremental declines, up to 10-20%
  - If Medicaid dependent (25% or more), then declines could be even higher
  - "Final" stabilization by 2005
- Recognition
  - Physician Level
  - Mental vs. Physical Health
- Paradigms
  - Industrial vs. Boutique
  - Health vs. Non-Health
  - Primary Care vs. Consulting

115 Future Problems

- What Will be Future of Training Programs?
- Health Care vs. ?
  - Who will take care of "mental health" patients?
  - Will "mental health" & psychotherapy be MS level?
  - What about prescription privileges?
- Boutique Health Care as Income Protection?
  - e.g., $1,500 to $20,000/year for a patient which would include;
    - round the clock availability
    - e-mail, fax to physicians
    - prompt appointments
    - special services (e.g., wellness)

116 Future Perspectives

- New Paradigm = Change

117 Case Examples

- Intake
- Therapy
- Testing

118 Questions? Answers…

- Questions?

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119 Workshop Resources

- Current Procedural Terminology
- RVUs & National Payment Schedules
- Patient Service Forms
- Coding Sheet
- Billing Forms
- CIGNA Local Medical Review Policy
- Office of Inspector General Documents