# CPT UPDATE

ANTONIO E. PUENTE
UNIVERSITY OF NORTH CAROLINA WILMINGTON

NATIONAL ACADEMY OF NEUROPSYCHOLOGY
10.17.18
NEW ORLEANS, LA



## Disclaimer

**The information contained in this extended presentation is not intended to reflect the policy of AMA, APA, CMS (Medicare), any division of APA, NAN, NAP, NCPA (or any state psychological association), state Medicaid and/or any private third party. Further, this information is intended to be informative and does not supersede APA or state/provincial licensing boards' ethical guidelines and/or local, state, provincial or national regulations and/or laws. Further, Local Coverage Determination and specific health care contracts supersede the information presented. The information contained herein is meant to provide practitioners, health care institutions (e.g., insurance companies)and policy makers involved in psychological services with the latest information available to the author regarding the issues addressed. This is a living document that can and will be revised as additional information becomes available. The ultimate responsibility of the validity, utility and application of the information contained herein lies with the individual and/or institution using this information and not with any supporting organization and/or the author of this presentation. Suggestions or changes should be directly addressed to the author. Note that whenever possible, references are provided. Finally, note that the CPT system is copyrighted and the information contained should be treated as such. CPT information is provided as a source of education to the readers of the materials contained. Thank you…aep**



## Acknowledgments: Organizations


- ❑ North Carolina Psychological Association (NCPA)
- ❑ American Psychological Association (APA) Practice Directorate (PD); Ethics Committee; Board of Directors
- ❑ 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, and CPT Chairs (e.g., Ken Brill)
- **APA**: ***Randy Phelps***, Arthur C. Evans, Katherine Nordal/Jared Skillings
  - (& APA Testing & Psychotherapy Groups)
- **NAN**: PAIC Former and Present Committees
- **Other**:, ***James Georgoulakis*, Neil Pliskin***, Stephen Gallespey, Pat DeLeon
- **Roger W. Sperry Neuropsychology Laboratory**
  - » **(* posthumeously)**




## "Band of Brothers"



## Roger W. Sperry Neuropsychology Laboratory

- 

## Support Provided

- **AMA** = AMA paid travel and lodging for AMA CPT activities 2009-2016 (no salary, stipend and/or honorarium; stringent conflict of interest and confidentiality guidelines)
- **APA** = Expenses paid and pays for travel (airfare & lodging) associated with past CPT activities (no salary, stipend and/or honorarium historically nor at present) Expenses from 2016-2018 President's (trio) budget.
- **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 included 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. No conflicts of interest outside of the fact that I use CPT codes to generate personal income.



## 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; Board of Directors (e)
- *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)
- APA President- (e)



legend; a = appointment, fa = federal appointment, e = election; *italics implies current appointment/elected position*

## Standards & Guidelines for the Practice of Psychology

- APA Ethics Code (2002)
- HIPAA and other federal regulations
- State or Province License Regulations (e.g., ASPBBB)
- Contractual Agreements with Third Parties
- Professional Standards (e.g., Standards for Educational and Psychological Tests, 2014)



## Definition of a Psychologist

- Medicare
  - clinical psychologist
- According to Social Security Act (1989)
  - Not defined as a physician
  - Therefore defined as a technician
  - Professional does cognitive work whereas a technician does technical work under supervision
- According to CPT system
  - Qualified Health Provider
  - Implied it is a doctoral level provider



## Definition of a Physician

- Two types of personnel
  - "physicians" (think)
  - "technicians" (do)
- Health care bill
  - To include psychologist as a "physician"
  - First introduce in H.R. 5502, Health Care Cost Containment and Reform Act of 1992 (07.22.1992)
  - Being introduced around 1993; being re-introduced



## Medicare: Immediate Impact

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

## 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



## 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



## 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
  - A new set of codes (e.g., interpretation) are here, scheduled for use in 01.01.19

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



## Base Codes

- The core or fundamental code
- Typically billed once per event
- Provides the complete description of procedure
- Must be billed prior to subsequent and related codes are billed



## Add-on Codes

- Further or expands what was started and described in the base codes
- Base code must be billed prior to including add-on codes
- May be billed multiple times

## CPT: Applicable Codes

- Total Possible Codes = Approximately 8,500
- Possible Codes for Psychology = Approximately 70+
- 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
  - Applied Behavior Analysis (Category 3)



## Three Types of Codes

- Psychiatric/Mental Health (1960s?)
- Neuropsychological (added in 1994; most recently revised in 2018)
- Health and Behavior (2000s)
- Miscellaneous
  - Preventative
  - Evaluation & Management (E & M)
  - Telehealth
  - Applied Behavior Analysis



## Misvalued Services

- Medicare Payment Advisory Commission (MedPac)
- Each code will be undergo a Five Year review Identification Workgroup analysis; 16 screens
- By the numbers
  - 1,813 identified
  - 54 referred to CPT currently
  - 347 deleted
  - 788 decreased
  - 170 increased



## Misvalued Services (cont.)

- Rationale
  - Bundled (commonly billed together) services
  - Service shifts
  - Services performed over 250,000 Xs/year
  - Switch in use by specialties
  - 100% growth in each year for three years
  - Services with high number of units per pt.
  - High payments/specialty in the last 5 years
  - Administered by the Relativity Assessment Workgroup
  - TESTING CODES IDENTIFIED IN 2013



## Medicare Utilization: 2016

| Interview | | Prof Testing | Tech Testing |
|---|---|---|---|
| Psych | 904,968 | 213,472 | 44,976 |
| Neuro | 153,102 | 673,692 | 180,512 |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |



## RAW Screen for Testing

(most significant increase 96118)

| 2009 | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|
| $220,855 | $$302,121 | $1,074,661 | $3,369,355 | $6,397,296 |

## New Testing Codes

- All information is confidential and subject to change pending finalization of issues and presentation of the CMS files.
- Codes were determined not to be viable
- Returned to CPT for redesigning codes.
- Process is ongoing.
- On 08.31.18, further details became available.



## Redesigning Testing Codes: Questions/Issues Since Origin of Codes

- Historical Analysis (since 1994)
  - General structure of code set
  - Difference between testing and feedback
  - Billing professional and technical codes together
  - Single Vs. multiple tests
  - Screening Vs. battery
  - Computerized Vs. non-computerized
  - Technical Vs. professional
  - Time – 15, 30, 60 ?
  - Describing professional (cognitive) vs. technical work
  - Defining pre, intra and post work
  - Differentiating "record review" / "analysis of records"



## Problems with Double Dipping

- Professional AND Technician Codes
  - Professional engagement in testing such as selection of tests, etc. should occur regularly in the first unit of activity
  - Professional "supervision" was present in each hour of tech time (approximately 15 minutes)



## New Testing Codes Development

- New testing codes were presented in front of the AMA CPT Panel on 10.01.16 after TAG group design over a period of several months.
- Response from CPT Panel posted on AMA website on 10.28.16.
- Proposed codes were approved then survey occurred during the month of November, submitted to the AMA RUC on 12.13.16.
- *A small number of surveys decided the reimbursement for testing codes.*



## Surveying Proposed Codes

- If a CPT Code is approved by the CPT Panel, it then goes to the RUC to value the code
- That code must be surveyed by professionals using that code in order to empirically develop the value for that code.
- Survey Results
  - Loaf vs slice- many misunderstood that one unit meant one hour (not an entire evaluation)



## New Testing Codes Strategy

- Strategy
  - Two Phases- CPT and RVU
    - Each phase, multiple parts and phases
      - Meetings with CMS Staff (02.09.18, 03.29.18, 04.04.18)
      - Meetings with Congress (House = 25+; Senate = 25+)
    - APA provided additional funding (almost $100k)
  - Personnel- Drs. Phelps, Pliskin, Gillaspie, Evans, Fink and Puente with Doug Walter (APAPO)

# New Testing Codes

- Outcome
  - New Codes
  - Increased in reimbursement
  - National LCD
  - Partnership between APA and other organizations evolving (e.g., NAN)



# New Codes- Basic Crosswalk

| 96116 | 96101 | 96102 | 96119 | 96118 | 96120 |
|---|---|---|---|---|---|
| 96116 | 963X3 /X4 | 963X9 /X10 | 963X9 /X10 | 963X5 /X6 | 96X12 |



# New Codes- SampleCrosswalk Grid

(from APAPO)

| Code # | Unit | Evaluation | Feedback | QHCP/ testing | Technician/ testing | Interpretation/Report |
|---|---|---|---|---|---|---|
| 96105 | Per hour | + | | + | | + |
| 96125 | Per hour | + | | + | | + |
| 96110 | Per test | + | | | + | |
| 963X0 | Per hour | + | | + | | + |
| 963X1 | Per hr/ao | | | + | | + |
| 96116 | Per hour | + | | + | | + |
| 963X2 | Per hr/ao | + | | + | | + |
| 963X3 | Per hour | + | + | + | | + |
| 963X4 | Per hour | + | + | + | | + |
| 963X5 | Per hour | + | + | + | | + |
| 963X6 | Per hour | + | + | + | | + |



| Name | Code # | Request- Description |
|---|---|---|
| Psychological & | 96101-96103 | Add codes to |
| Neuropsychological | 96111 | differentiate |
| Testing | 96118 | technician |
| | 96119 | administration |
| | 96120 | of neuropsychiatric |
| | 963X0 | testing from |
| | 963X1 | physician/psychologist |
| | 963X2 | administration |
| | 963X3 | and assessment of |
| | 963X4 | testing. |
| | 963X5 | Delete codes |
| | 963X6 | 96101-96103, 96111, |
| | 963X4 | 96118, 96119, 96120 |
| | 963X5 | |
| | 963X6 | |
| | 963X7 | |
| | 963X8 | |
| | 963X9<br>963XX<br>96X3X | |



# Challenges

- Understanding Base and Add On Concept
- Appreciating the Importance of Cognitive Work or Clinical Decision Making
- Determining How Best to Document Clinical Decision Making
- Figuring out the Crosswalk- e.g., what is the new 96118?



# A Coding Model

| Psychiatric | Neuropsych | Health Psych |
|---|---|---|
| "DSM" | ICD | ICD |
| Interview 90791 | Interview 96116/revision | Interview 96150 |
| Testing 96101 | Testing 96118/revision | Testing 96150 |
| Therapy e.g., 90834 | Rehab e.g., 96152 | Rehab e.g., 96152 |

## DSM V & ICD X-CM

- DSM IS A *DESCRIPTIVE* SYSTEM LINKED TO PSYCHIATRIC CPT CODES
- ICD IS A *DIAGNOSTIC* SYSTEM LINKED TO ALL CPT CODES

***PROBLEMS?***

CHAPTER 5
VS
OTHER CHAPTERS?



## ICD- 11

- 2019
- Psychologists will be able to use a diagnosis in either "Chapter 5" and the "Non psychiatric medical chapters:
  - Dementia
    - Diagnostic- neurological chapter (neuropsych)
    - Intervention- possibly "chapter 5" (rehab psych)



## 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



## Conversion Factor

- To be re-addressed EVERY year
- Conversion Factor = 2018 is ***$35.9996***



## RVU Summary for Psychology

- 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
  - THIS YEAR PROPOSED, UP TO 6% INCREASE



## Physician Definition

- **Medicare Mental Health Access Act (H.R.1173 / S.448)**
- We continue to make significant progress on our priority legislation, the Medicare Mental Health Access Act, bipartisan legislation that would allow psychologists to provide Medicare services without unnecessary physician supervision. Representatives Kristie Noem (R-SD) and Jan Schakowsky (D-IL), Senators Sherrod Brown (D-OH) and Susan Collins (R-ME) introduced our legislation prior to the Practice Leadership Conference in March

## Physician Definition

- Avelere score
  - $239 million over 10 years
  - Less if rural bonus excluded
- Current status
  - CBO meetings have been initiated



## ACA Repeal

- **Affordable Care Act Repeal**
- Repealing the Affordable Care Act (ACA) has been a top legislative priority for President Trump and Congressional Republicans.
- Unlikely to occur
- More likely is an expansion of Medicare



## 2018 CMS Fee Schedule

- Psychologists who are Medicare providers will have their payments increased by 0.41% as part of the annual update.
-



## 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



## MIPS

- Combination of PQRS, Value Based Modifier (VBM), & Meaningful Use Rules
- Ranks peers nationally
- Reports scores publicly
- Budget neutral (funded by losers)
  - Winners = 9% over base
  - Losers = 9% below base
    - »Difference is 18%



## Qualified Clinical Data Registry Reporting (QCDR)

(www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/qualified-clinical-data-registry-reporting.html)

- Started in 2014
  - Primary purpose to collect and submit PQRS measures
- Focus in 2016 shifted
  - Collects clinical data for patient and disease tracking to improve care
  - Participation in 2016 avoids a 2% penalty in 2018
    - ***APA = PQRSPRO $199/year***

## Emerging Patterns

- Documentation is Support for Medical Necessity
- Medical Necessity is the Basis for the Service
- Integrative
- Shift of Focus from Federal to State
- Accuracy, Transparency and Utility
- Performance Based (but metrics being developed)
- Fast Moving, Major Paradigm Shifting with Increased Focus on Coding (200,000 coders)
- MEDICARE FOR ALL (vs. Medicare for more)



## "TRUMPCARE"?

- Repeal ? No chance.
- Replace ? Attempting but low probability
- Improve ?
  - What ?
  - How ?
  - When?



## What's Next

- #1 APAPO Webinar (Neil Pliskin and Tony Puente) on basic 10.24.18 noon est
- #2 APAPPO Webinar (Neil Pliskin and Tony Puente) on actual applications- 12.05.18 noon est
- Articles with Resources and Webinar Links on APAPO on 10.15.18 &12.13.18

WWW.APAPRACTICECENTRAL.ORG



(Cojimar, Cuba; The harbor from "Old man and the sea")