FROM CPT TO MACRA: Fee for Service to Alternative Payment Models

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TEXAS PSYCHOLOGICAL ASSOCIATION
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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, Katherine Nordal (APA Testing & Psychotherapy Groups)

• **NAN**: PAIC Former and Present Committee

• **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)
- *Joint Committee for Standards for Educational and Psychological Tests (a)*
Standards & Guidelines for the Practice of Psychology

- 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, 2014)
Primary Goals & General Outcomes

• **Goal (since 1988)**
  - Parity with Physicians
  - Expansion of Scope of Services Reflective of Science and Practice

• **Outcome (presently)**
  - Intended/Anticipated/Hoped
    • Similar reimbursement as physician services
    • General increase in the scope of practice
    • *Greater inclusion into health care system*
  - Less Anticipated
    • Transparency
    • Increased Accountability
    • Uniformity
    • Potential impact on certain practice patterns
  - Not Anticipated
    • *Focus on performance*
    • *Constant change*
    • *Shift from national to local fronts*
Why This Information is Important?

• Medicare Cuts
• Health Care Law Which Will Change Health Care (largest change in 50 years)
• An Entirely New Diagnostic System Began 10.01.15
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: Composition

- **AMA House of Delegates**
  - 122 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), permanent seat
      - Occupational Therapist
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
Shifting 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.
Three Types of Codes

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

- Neuropsychological
- Health and Behavior
Time & Intensity in Psychotherapy

• Time
  – 30 Minutes
  – 45 Minutes
  – 60 Minutes
  – 90 Minutes

• Intensity
  – Standard
  – Interactive
  – Crisis
Psychiatric Interviewing

90791
- History and Mental Status
- Review and Order of Diagnostic Studies as needed
- Recommendations (including communication with family or other sources)

90792
- Examination (CMS psychiatric specialty examination)
- Prescription of Medications when appropriate
- Ordering of Laboratory Tests as needed
# Psychotherapy Overview

<table>
<thead>
<tr>
<th>TYPE of THERAPY</th>
<th>TIME of THERAPY</th>
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<tbody>
<tr>
<td></td>
<td>Brief</td>
</tr>
<tr>
<td>Standard</td>
<td>30’</td>
</tr>
<tr>
<td>Interactive</td>
<td>30’</td>
</tr>
<tr>
<td>Crisis</td>
<td>30-74’</td>
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</table>
Psychotherapy

- 30 minutes = 16-37 mins.
- 45 minutes = 38-52 mins.
- 60 minutes = 53 + mins.
- 90 minutes =
  - Use 60 minute code plus 22 modifier, or
  - Prolonged E & M service
Interactive Complexity

To report **90785** at least one of the following factors must be present:

1. The need to manage maladaptive communication (related to, e.g., high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicates the delivery of care.

2. Caregiver emotions or behavior that interferes with the caregiver’s understanding and ability to assist in the implementation of the treatment plan.

3. Evidence or disclosure of a sentinel event and mandated report to a third party (e.g., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient or other visit participants.

4. Use of play equipment, other physical devices, interpreter or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician or other qualified health care professional and a patient who;
   1. Is not fluent in the same language as the physician or other qualified health care professional, or
   2. Has not developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to treatment or receptive skills to understand the physician or other qualified health care professional if he/she were to use typical language for communication.

(tip = time is determined by original base code)
Neuropsychological (and Psychological) Testing

- Psychiatric
- Health and Behavior
Neurobehavioral Status Exam
(01.01.06; Revised 02.09.07; Implemented 01.01.08)

• **96116** - Neurobehavioral status exam
  – Clinical assessment of thinking, reasoning and judgment (e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual-spatial abilities) per hour of **psychologist’s or physician’s** time, both face-to-face time with the patient and time interpreting test results and preparing the report
Neuropsychological Testing - By Professional (01.01.06)

• **96118** - Neuropsychological testing
  - (e.g., Halstead-Reitan Neuropsychological, WMS, Wisconsin Card Sorting) per hour of the *psychologist’s or physician’s* time, both face-to-face time with the patient and time interpreting test results and preparing the report

(estimated total Medicare claims/year = 500,000)
Neuropsychological Testing: By Technician (01.01.06)

- **96119** - Neuropsychological testing
  - (e.g., Halstead-Reitan Neuropsychological, WMS, Wisconsin Card Sorting) with qualified health care professional *interpretation and report*, administered by a *technician* per hour of technician time, face-to-face
Neuropsychological Testing - By Computer (01.01.06)

- 96120 - Neuropsychological testing
  - (e.g., WCST) administered by a computer with qualified health care professional interpretation and the report
Computerized Testing: Use by Physicians

• 96103
  – Neurologists = 27%
  – Family Physicians/Internal Medicine = 22%

• 96120
  – Neurologists = 47 %
Screening Testing Code
(Effective 01.01.15)

• 96127
• Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit, hyperactivity disorder (ADHD) scale, with scoring and documentation, per standardized instrument

Telehealth Services

- Individual Psychotherapy
- Psychiatric Diagnostic Interviewing
- All Health and Behavior Codes
- Neurobehavioral Status Exam
- Presently discussing Testing Services
Health and Behavior

- Psychiatric
- Neuropsychological
Health & Behavior: Assessment

- **96150**
  - Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires)
  - each unit = 15 minutes
  - face-to-face with the patient
  - initial assessment

- **96151**
  - re-assessment
  - each unit = 15 minutes
  - Face-to-face with the patient
Health & Behavior: Intervention

- **96152**
  - Health and behavior intervention
  - each 15 minutes
  - face-to-face
  - individual
- **96153**
  - group (2 or more patients) ((usually 6-10 members))
- **96154**
  - family (with the patient present)
- **96155**
  - family (without the patient present; not being reimbursed)
Integrated Care: Existing Codes
(with varied reimbursement)

- Coordinated care
- Prolonged care
- Telephone service
- Online evaluation
- New inter-professional consultation code
- Interactive complexity
- Education and training
- Alcohol, tobacco screening
# A Coding Model

<table>
<thead>
<tr>
<th>Psychiatric</th>
<th>Neuropsych</th>
<th>Health Psych</th>
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<tr>
<td>DSM</td>
<td>ICD</td>
<td>ICD</td>
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<tr>
<td>Interview</td>
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<tr>
<td>90791</td>
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<tr>
<td>96101</td>
<td>96118</td>
<td>96150</td>
</tr>
<tr>
<td>Therapy</td>
<td>Rehab</td>
<td>Rehab</td>
</tr>
<tr>
<td>e.g., 90834</td>
<td>e.g., 96152</td>
<td>e.g., 96152</td>
</tr>
</tbody>
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1/7/2016 psychologycoding.com
Diagnosing

• Limited Formulary Often Offered by Third Parties
• Multiple Diagnoses May be of Value
• Psychiatric
  – DSM
    • The problem with DSM and neuropsych testing of developmentally-related neurological problems
• Neurological & Non-Neurological Medical
  – ICD – 9 CM (physical diagnosis coding)
  – www.cdc.gov/nchs/about/otheract/icd9
  – www.eicd.com/eicd.main.htm

(Note: Always consult LCD information to determine formulary)
Diagnosing (cont.)

- **Billing Diagnosis**
  - Based on the referral question
  - What was pursued as a function of the evaluation

- **Clinical Diagnosis**
  - What was concluded based on the results of the evaluation
  - May not be the same as the billing or original working diagnosis
International Classification of Diseases

• Present
  – ICD-9-CM (Clinical Modification)
  – Since 1978

• Future
  – ICD-10-CM (Clinical Modification) *
  – ICD-10-PCS (Inpatient Procedures)
  – Start date – October 01, 2015

* CM is what is used for clinical activities
RBRVS: History

• 1992- Code 58345 introduced by three specialty societies
• 1997- First Five Year Review
• 2004- Formation of Practice Expense Advisory Committee (PEAC)
• 2009- Relative Assessment Workgroup begins examining 1,700 codes
RVU: Components

- **Physician Work Resource Value**
- **Practice Expense Resource Value**
- Malpractice
- Geographic (sometimes referred as the GPCI); urban higher than rural
- Conversion Factor (2015 = $35.9335)
RVU: Components Percentages

- Physician Work = 50.9%
- Practice Expense = 44.8%
- Liability = 4.3%

- 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
Conversion Factor

- RVU X Conversion Factor = Reimbursement
- Conversion Factor is set by Congress
- Conversion Factor = 2015 is $35.9335
Misvalued Services

• Medicare Payment Advisory Commission (MedPac)
• Each code will be undergo a Five Year review Identification Workgroup analysis
• 1,800 identified
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
Misvalued Services

- Codes under review = 130, 7%
- Deleted = 305, 17%
- Decreased = 731, 40%
- Increased = 151, 8%
- Reaffirmed = 508, 28%

(From: American Medical Association, RUC Committee, 2015)
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
The Present & Future of CPT

- Applied Behavior Analysis (2014)
- PQRS (add on) (2014)
- Expanded Evaluation & Management - Prolonged Service (2014)
- Redoing H & B Codes (2015)
- Redoing Testing Codes (2016)
- Integrative Healthcare codes (2016)
- Prevention or G Codes (2016?)
Health Care Bill: How Health Care Will Be Revolutionized by 2018

Bill:
http://thomas.loc.gov/cgi-bin/bdquery/z?d111:H.R.4872

Timetable:
http://www.commonwealthfund.org/Content/Publications/Other/2010/Timeline-for-Health-Care-Reform-Implementation.aspx#2010
(also, www.healthcare.gov)
Accountable Care Organization

- Expand Medicaid Eligibility
- Provider Based
- Competency Based
- Approximately 15% of the US population signed up
- Expected to save Medicare up to $1 billion in first 5 years

(Kaiser Health News, 04.15.2014)
Alternative Payment Models

(ALL SLIDES ON APM ARE DERIVED FROM AN AMA RUC PRESENTATION BY HAROLD MILLER ON 10.02.15)

• To be initiated 2018 and applied 2019-2024 with an increase in 2025
• Engagement in “more than a nominal financial risk”
  – The greater the risk the greater the reward or loss
  – For procedures and conditions
Alternative Payment Models

• Delivery of Healthcare:
  – Currently = fee for service (FFS)
  – By 2018/2020 = fee for documentation (MIPS)
  – By 2019 = fee for performance (MACRA)

• Costs of Healthcare:
  – Inpatient hospitalization
  – Qualified Health Providers (16%)
  – Prescription Drugs

GOAL = REDISTRIBUTE ABOVE COSTS BY CHANGING THE DELIVERY MODEL
## Merit Based Incentive Systems

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEASURED QUALITY</td>
<td>30%</td>
</tr>
<tr>
<td>RESOURCE USE</td>
<td>30%</td>
</tr>
<tr>
<td>MEANINGFUL USE</td>
<td>25%</td>
</tr>
<tr>
<td>CLINICAL IMPROVEMENT</td>
<td>15%</td>
</tr>
</tbody>
</table>
Alternative Payment Models

EXAMPLES OF HOW TO DECREASE COSTS

• Avoidable Admissions and Tests
• Unnecessary/duplicative tests
• Use of Lower-Cost Procedures/Treatment
• Health care management vs. intense therapy
• More Efficient Delivery of treatments
• Lower-cost supplies/less wastage/better coordination
• Use of Lower-Cost Providers
• Ambulatory Surgery Centers
• Home-based post-acute care
• Preventable Complications
Alternative Payment Models

• Traditional Approaches to APMs
  – Medical Homes
  – Hospital-Based Episodes
  – Accountable Care Organizations
Alternative Payment Models

SPECIFIC APPROACHES TO REDUCE COSTS

1. Payment for Specific Services That Reduce Avoidable Spending
2. Condition-Based Payment for Alternative Less Expensive Treatment by Qualified Health Provider (QHP)
3. Bundled Payment to QHP and Hospital or Other Facility
4. Bundled Payment for Multiple Choices of Services and Providers
5. Warrantied Payment for Planned Services
Tsunami Explained: Future Paradigms

• Traditional Paradigms
  – Yearly reduction of 1-5% for foreseeable future
  – Unsustainable by 2020

• New Paradigms
  – Boutique services
  – Volume
  – Prevention
  – Integrative & multi-disciplinary (geographic or virtual)
  – Interface with other industries (e.g., legal, industrial, sports)
Bottom Line

1. Who gets paid?
   » Bundled (e.g., ACA, hospitals, etc.)
   » Individual (i.e., Qualified Health Provider)

2. How do they get paid?
   » RVBRS
   » Performance based