

**APA DIVISION 38/
SOCIETY FOR HEALTH PSYCHOLOGY:
HEALTH REFORM TELECONFERENCE**

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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, and CPT Chairs (e.g., Ken Brill)
- **APA:** *Randy Phelps*, Katherine Nordal
 - (& APA Testing & Psychotherapy Groups)
- **NAN:** PAIC Former and Present Committees
- **National Psychologist:** Paula Hartman-Stein
- **Other:**, *Neil Pliskin*, *James Georgoulakis*, Pat DeLeon
- (*highly instrumental in recent CPT activities*)

Support Provided

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

Summary = AMA CPT includes travel/lodging support but no salary/stipend.

Any monies obtained, such as honoraria for presentations, are diverted to the UNCW Department of Psychology for graduate psychology student training. No funds are used to supplement the salary or income of AEP.

Personal Background (1988 – present)

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

Standards & Guidelines for the Practice of Psychology

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

Health Care Costs

(from the American Medical Association, 05.2016)

Year	Total	Out-of-Pocket Payments	Health Insurance		
			Total	Private Health Insurance	Medicare
Amount in Billions					
Historical Estimates					
2007	\$2,302.9	\$293.6	\$1,611.8	\$777.7	\$432.6
2008	2,411.7	300.7	1,703.2	807.8	467.9
2009	2,504.2	300.7	1,798.5	833.1	499.9
2010	2,599.0	305.6	1,873.9	859.6	520.2
2011	2,692.8	316.1	1,943.4	888.8	546.2
2012	2,793.4	328.2	2,014.4	917.0	572.5
Projected					
2013	2,894.7	338.6	2,094.1	947.5	591.2
2014	3,056.6	338.1	2,246.1	1,012.2	615.9
2015	3,207.3	345.7	2,372.5	1,082.4	632.7
2016	3,386.2	356.0	2,516.2	1,136.9	669.2
2017	3,579.0	372.1	2,662.2	1,191.3	714.7
2018	3,797.5	391.2	2,827.8	1,252.9	769.5
2019	4,042.5	413.5	3,015.2	1,330.4	825.3
2020	4,307.4	437.5	3,219.1	1,410.0	890.3
2021	4,577.8	461.1	3,427.5	1,489.3	958.9
2022	4,861.9	486.1	3,646.7	1,569.5	1,033.7
2023	5,158.8	512.2	3,875.9	1,653.2	1,111.5

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

Health and Behavior

- Psychiatric
- Neuropsychological

CPT: Health & Behavior Assessment & Management

(CPT Assistant, 03.04)

(CPT Assistant, 08.05, 15, #6, 10)

(CPT Assistant, August, 2009, Vol. 19, #8, pg. 11)

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

H & B: Rationale

- Acute or Chronic Health Illness
- Not Applicable to Psychiatric Illness
- However, Both Could be Treated Simultaneously But Not Within the Same Session

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

H & B: Assessment Explanation

- Identification of Psychological, Behavioral, Emotional, Cognitive and/or Social Factors
- In the Prevention, Treatment and/or Management of Physical Health Problems
- Focus on Biopsychosocial and not Mental Health Factors

H & B: Assessment Examples

- Health-Focused Clinical Interview
- Behavioral Observations
- Psychophysiological Monitoring
- Health-Oriented Questionnaires

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)

H & B: 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

H & B: Intervention Examples

- Cognitive
- Behavioral
- Social
- Psychophysiological

H & B: CORF

www.cms.hhs.gov/manuals/downloads/bp102c12.pdf

- 96152 is the only psychological code for both assessment and intervention (expect np testing) under which CORF psychological services can be billed.
- Such services may be provided by a non-doctoral service provider.
- Testing codes are not part of CORF.

(page 66299; Federal Register, Vol. 72, No. 227, November 27, 2007)

H & B: # of Hours

- Initial Assessment = 4 – 8 (?) units
- Re-assessment = 4 – 6 (?) units
- Group = 8 (?) units
- Intervention = 24 to 48 (?) units/day

H & B Limitations with Other Codes

- If a patient requires a psychiatric service (e.g., 90791) and a health & behavior service, the predominant service should be reported.
- In no case, should both sets of services be reported on the same day.
- Patient “has not been diagnosed with mental illness” (interpretation: not current)
- If service is not completed in one day, then the date of service coded should be the one in which the service was finalized.

Team Conference Codes

- Medical Team Conference with Interdisciplinary Team by Non-Physician
- Allows for Billing Professional Work in Interdisciplinary Team Activities Including Diagnostic and Rehabilitative Services
- No Time Allocated but “Team conferences of less than 30 minutes are not reported separately”
- Effective 01.01.08

Team Conference Codes (cont.)

- Codes
 - 99366 (direct contact)/ only one available for non-physician use
 - 99368 (without direct contact)
- Number of Participants Required
 - Minimum of 3 from different specialties
 - Must have performed an evaluation within 60 days
 - Patient/Family/Legal Guardian/Caregiver
- Typical Services Provided
 - Presentation of findings
 - Recommendations for treatment
 - Formulation of integrated care
 - Comprehensive and complex (Vs. standard interactions)

Team Conference Codes (cont.)

- Coding Rules
 - Documentation of their participation & information contributed
 - No more than one individual per specialty may report these codes
 - Professionals should not report these codes when they are contractually obligated by the facility where the team conference is provided
 - Conference starts when the team reviews the individual patient and ends at the conclusion of the team's review
 - Time is not used for record keeping and report generation is not used
 - Reporting participant shall be presented for all time reported
 - Time is broadly defined as all time used for diagnostic and treatment discussion

Education

- 98960
- Education and training for patient self-management by non-qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient

G & Related Codes: Health Behavior Screening

(psychologists are urged to use H & B codes)

- Tobacco Cessation
 - 99406 - 3-10 minutes
 - 99407 - greater than 10 minutes
 - G0137
 - Training and educational services related to the care and treatment of patient's disabling mental health problem, per session (45 or more minutes)
 - G0396 (99408)
 - Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, DAST) and brief intervention, 15-30 minutes
 - G0397 (99409)
 - Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, DAST) and brief intervention, greater than 30 minutes
- (NOTE: H & B codes should not be reported on the same day of service as these codes)

New Codes: Preventative Health (Healthier Life Steps)tm

(CPT Assistant, Vol. 19, #2, 2009)

- Preventative Medicine (group or individual counseling): 99401-404, 99411-12
- Behavior Change Interventions (individual): 99406-09 (tobacco & alcohol)

Modifier 33 and Prevention

(*CPT Assistant*, December 2010, pgs. 3-6, 19)

- Can Use Modifier 33 for:
 - Depression Screening- adolescents or adults
 - Health diet Counseling
 - Obesity counseling
 - Tobacco Cessation counseling
 - STI (sexually transmitted infection) counseling
 - No co-pay in some preventive care and screenings-
Bright Futures (children/women)

Modifier 33 Examples for Preventative Care

(CPT Assistant, 12.10, 20, #12)

- Alcohol Misuse Counseling (04.04)
- Depression Screening: Adolescents (03.09)
- Depression Screening: Adults (12.09)
- Health Diet Counseling (01.03)
- Obesity Screening/Counseling: Adults (12.03)
- Obesity Screening/Counseling: Children (01.10)
- STI Counseling (10.08)
- Tobacco Counseling/Prevention: Non-pregnant Adults (04.09)
- Tobacco Counseling/Prevention: Pregnant Women (04.09)

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

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

- Recent past
 - ICD-9-CM (Clinical Modification)
 - Since 1978
 - Present
 - ICD-10-CM (Clinical Modification) *
 - ICD-10-PCS (Inpatient Procedures)
 - Start date – October 1, 2015
- * CM is what is used for clinical activities

International Classification of Diseases

- Comparison
 - Diagnosis; 382.9 – B01.2
 - Procedure; 39.5 – 0DN90ZZ
- Timeline & Endorsements
 - World Health Organization
 - Developed 1989; released 1994
- Effective on 10.01.15
- Further Information
 - [www.cms.gov \(ICD10/01_Overlap.asp\)](http://www.cms.gov/ICD10/01_Overlap.asp)

ICD 10 System

- System
 - Level 1 = alpha
 - Level 2 = numeric
 - Level 3-7 = alpha or numeric (all letters apply except u; decimal after 3 characters)
 - E.g., = 0db588zx

Interpretations of ICD-10

- Uncertainty about applicability by carriers
- For further information about ICD 10 consult ~
200 slide set found at
www.psychologycoding.com

DSM V & ICD X-CM

- DSM IS A DESCRIPTIVE SYSTEM APPLIED TO PSYCHIATRIC CODES
- ICD IS THE DIAGNOSTIC SYSTEM

PROBLEMS?
CHAPTER 5
VS
OTHER CHAPTERS?

ICD: Diagnosing

(2009 ICD-9)

- Signs and Symptoms
 - If a diagnosis has not been established
 - Part of the disease process
- Late Effects
 - After injury or acute illness has finished
- Probable vs. Defined
- Code all Diagnoses That are Present

Medical Necessity

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

Medically Reasonable and Necessary

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

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

Simple Explanation of Medical Necessity and Eventual Coverage

Existence of Evidence for
Therapeutic Decision Making

(will it make a difference?)

Documentation: H & B Codes

- Must show evidence of coordination of care with the patient's primary medical care providers or medical provider for the medical management of the physical illness that the H & B activity was meant to address.

Documentation: H & B Assessment

- Onset and history of initial diagnosis of physical illness
- Clear rationale why the assessment is required
- Assessment outcome including mental status and ability to understand or respond meaningfully
- Measurable goals and expected duration of specific interventions

Documentation: H & B Intervention

- Evidence that the patient has capacity to understand or to respond meaningfully
- Clearly defined psychological intervention
- Measurable goals of the intervention stated clearly
- Documentation that the intervention is expected to improve compliance
- Response to intervention must be indicated
- Rationale for frequency and duration of service

Conversion Factor

- To be re-addressed in 2015
- Alternatives:
 - Proposed reduction is 20%
 - Longer period of suspension (e.g., 5 years)
 - Permanent (cost = over \$300 billion)
- Conversion Factor = 2015 is **\$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

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

Likely Winners in Payment Changes

- Alternative Payment Systems
- Focus on:
 - Chronic Diseases
 - Care Transition
 - Team & Interdisciplinary Care
 - Population Management

Medicare Payment Release

- Effective 2015, about 40% of Medicare payment is tied to value.
- AMA's Statement

<http://www.ama-assn.org/ama/pub/ama-wire/ama-wire.page?plckController=Blog&plckBlogPage=BlogViewPost&UID=e38cf47a-fc5f-473b-9234-c9e714c1c8f0&plckPostId=Blog%3ae38cf47a-fc5f-473b-9234-c9e714c1c8f0Post%3a8ef03d25-8c91-45bb-83ac-6849a6427a99&plckScript=blogScript&plckElementId=blogDest#.U0gsSvldV8E>

The Present & Future of CPT: Specifics

- Applied Behavior Analysis (2014)
- PQRS (add on) (2014)
- Expanded Evaluation & Management-
– Prolonged Service (2014)
- Redoing H & B Codes (2015-16)
- Redoing Testing Codes (2016)
- Integrative Healthcare codes (2016)
- Prevention or G Codes (2016?)

Affordable Care Act #s

- Qualified Health Providers: 9,737,842
- State X State: 30 ahead of projections, 12 behind
- Goal: to insure about 95% of the population
(and to decrease the budget deficit)

History of Health Care Reform

(New York Times, 08.19.09)

- 1912: Theodore Roosevelt proposes national health insurance
- 1929: First health insurance program- Baylor Hospital in Dallas, TX
- 1931: First HMO- Farmer's Union Cooperative Health Association
- 1932: Wilbur Commission recommends health insurance prepayment

History of Health Care Reform

(New York Times, 08.19.09)

- 1945: Harry Truman proposes compulsory health coverage
- 1965: Birth of Medicare & Medicaid (LBJ)
- 1968: Beginning of spiraling of health care
- 1971: Richard Nixon requires minimum health insurance by employers
- 1976: Jimmy Carter calls for universal and mandatory coverage
- 1993: Bill (Hilary) Clinton's managed competition

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)

Preventive Services: A New Frontier

- Annual wellness visits
- Prevention plan services
- Furnish personalized health advice to health education or prevention services
- Detect cognitive impairment

NOTE: Unclear application for psychologists

Prevention Services

- Removal of deductible and co-insurance
- Addition of annual wellness visits
- Addition of Health Risk Assessment

See ama-assn.org/go/medicare-prevention

Integrative Health Care: Engagement of Behavioral Health

- 75% are chronic illnesses
- 50% of mental health care is done by PCP
- 600,000 behavioral health professionals of which 100,000 are psychologists
- Current coding limited for physicians more limited for psychologists

Health Care Bill- Executive Summary

- Expand Affordable Health Insurance to Those Without Coverage
- Increase Affordability of Insurance for Those Who Have It
- Slow the Rise of Health Care Costs and Control National Deficit

Health Care Bill: Areas of Potential Interest

- Mental Health Parity (Section 214, pg. 100)
- Federally Qualified Behavioral Health Centers (Section 2513, pg. 1367)

Health Care Benefits Exchange

- States will create exchanges (or join federal government)
- Limited to citizens/residents who do not have employer based insurance
- Will provide standardize information
- Determine eligibility
- This is the present “battleground”

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)

Another Example

- Health Insurance Exchanges
 - Selection of beneficiaries
 - Large numbers and varied samples
 - Choice without complexity
 - Transparency and disclosure
 - Increased competition
 - Limit internal and external costs
 - Geographic limits(Regional/ State/National?)

(Jost, 2010)

Health Insurance Exchange

- Medicare “Light” or Expanded Medicaid Model
- Focus on Increasing Insurers AND Decreasing Costs
- Prevention & Integrative Care Will Be Central

(see apapracticecentral.org/update/2013/08-29/medicaid-hie.aspx)

Applications of Bill

- Development of Performance Metrics
- Increasing Transparency & Reporting
- Improving CMS Delivery

(Stremikis, Davis & Audet, The Commonwealth Fund, July, 2010)

Post-Health Care Health Bill

(Commonwealth 05.10.10)

- Defining “Medical”
- Medical Packages
 - From Bronze, 60%, to Platinum, 90%)
- Medicaid Expansion
 - Increase of 133% of the poverty level
- Independent Advisory Board
- Limit health Spending (to 6% from 6.6.%)

Present Trends at Federal Level

- GOAL OF LOWER COSTS
- INCREASED EFFICIENCY (E.G., DUPLICATION OF SERVICES, INNOVATION IN DELIVERY AND PAYMENT)
- INCREASING TRANSPARENCY/ACCOUNTABILITY (E.G., PQRS)

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

Alternative Payment Models- Medicare

(AMA 12.15.15)

- Medicare Access and CHIP Reauthorization Act (MACRA)
- If participating in MACRA-
 - 5% bonus payment
 - Exemption from Merit Based Incentive Payment System

Alternative Payment Models- Medicare Suggestions (AMA 12.15.15)

- Decreased cost of care
- Identify barriers to effective care
- Identify how to delete or control barriers
- Provide cost/benefit analyses
- Design payment models that:
 - Improve outcomes
 - Achieve savings

Alternative Payment Models- Medicare Suggestions (AMA 12.15.15)

- Reduce unnecessary testing, medications and procedures
- Reduce complications of treatment
- Reduce avoidable hospitalizations
- Prevent serious health problems

Alternative Payment Models

Medicare Examples (AMA 12.15.15)

- Examples-

Dementia- slow disease progression

Parkinson's- improve control of
symptoms

Depression- increase ability to work &
engage in activities

Merit Based Incentive Systems

VARIABLE	PERCENTAGE
MEASURED QUALITY	30%
RESOURCE USE	30%
MEANINGFUL USE	25%
CLINICAL IMPROVEMENT	15%

Alternative Payment Models

- Examples:
 - Reduces costs and distributing savings
 - Some costs are unavoidable (e.g., dementia)
 - Target costs that are changeable or unrelatable (e.g., RX)
 - Fee for service plus shared savings across
 - total spending
 - State/region
 - group
 - condition

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. Warranted Payment for Planned Services

MACRA & Patient Relationships

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was enacted on April 16, 2015.
- Section 101(f) amends section 1848 of the Social Security Act (the Act)
- Establishment and use of classification code sets: care episode and patient condition groups and codes¹, and patient relationship categories and codes.

Patient Relationships Defined

(CMS, 05.2016)

- (i) considers themselves to have the primary responsibility for the general and ongoing care for the patient over extended periods of time;
- (ii) considers themselves to be the lead physician or practitioner and who furnishes items and services and coordinates care furnished by other physicians or practitioners for the patient during an acute episode;
- (iii) furnishes items and services to the patient on a continuing basis during an acute episode of care, but in a supportive rather than a lead role;
- (iv) furnishes items and services to the patient on an occasional basis, usually at the request of another physician or practitioner; or
- (v) furnishes items and services only as ordered by another physician or practitioner.

Continuing Care Relationship

(CMS, 05.16)

- Clinician who is the primary health care provider responsible for providing or coordinating the ongoing care of the patient for chronic and acute care.
- **Examples include but are not limited to:** Primary care physician providing annual physical examination (outpatient); geriatrician caring for resident (Nursing Home); nurse practitioner - providing checkups to adult asthma patient (outpatient).
- Clinician who provides continuing specialized chronic care to the patient.
- **Examples include but are not limited to:** Endocrinologist (inpatient or outpatient) treating a diabetes patient; cardiologist for arrhythmia; oncologist (inpatient or outpatient) furnishing chemotherapy or radiation oncology.

Acute Care Relationship

(CMS, 05.16)

- (iii) Clinician who takes responsibility for providing or coordinating the overall health care of the patient during an acute episode.
- **Examples include but are not limited to:** Hospitalist caring for a stroke patient (inpatient); gastroenterologist performing a colonoscopy (outpatient ambulatory surgery); Orthopedist performing a hip replacement; urgent care practitioner caring for a patient with the flu (ambulatory); emergency room physician assistant treating a motor vehicle accident patient (outpatient), attending at a Long Term Care Hospital or Inpatient Rehabilitation Facility
- (iv) Clinician who is a consultant during the acute episode.
- **Examples include but are not limited to:** Infectious disease specialist treating a patient for sepsis or shingles; gastroenterologist performing an upper endoscopy on a hospitalized patient (inpatient); rheumatologist performing an evaluation of an acutely swollen joint upon referral by a primary care physician; dietician providing nutritional support to an Intensive Care Unit patient (inpatient).

Acute Care or Continuing Relationship (CMS, 05.16)

- (v) Clinician who furnishes care to the patient only as ordered by another clinician.
- **Examples:** Non-patient facing Clinicians such as pathologists, radiologist, and other practitioners who care for patient in specific situations ordered by a clinician but have very little or no relationship with a patient.

Emerging Initiatives: Integrative Care

- Comprehensive assessment
- Identification of health care home
- Comprehensive intervention
- Shared record, development and decision making to reduce duplication and enhance effectiveness
- Engagement of consumer in the preceding
Could be geographic or virtual

Mega Trends

(from : P. Hollman, 10.13.11; AMA CPT meeting)

- Unsustainable Cost Trends
- Increased Audits
- Electronic Health Records
- Health Care Homes
- Tele-health
- New Diagnostic Codes
- Chronic Care Model (and elderly patients)
- Redefinition of Diseases

Past & Future

Activity	Current	Future
Reimbursement Base	Service	Outcome
Reimbursement Direction	Singular	Bundled
Location of Service	Inpatient	Outpatient (e.g., home)
Provider Approach	Silo	Integrated
Numbers	Volume	Limited (& targeted)
Patient Approach	Standardized	Personalized
Foundation of Service	Experience based	Empirically based
Location of Patient	Independent <small>psychologycoding.com</small>	Health Care Home

Ongoing & Upcoming Activities

- Interpretation (e.g., Category 1?) of the Applied Behavior Analysis codes (2016)
- Development of New Codes (2016-17)
 - Testing (several);
 - Coordination of Care for Integrated Care (several)
- Revision of Existing Codes (2017?)
 - G or Prevention Codes
 - Health and Behavior (2017)
 - Possibly addressing non-face-to-face
 - Definitely re-surveying the existing codes

Economic & Political Outlook

- Estimated
 - For 2016, stabilization with decrease reimbursement based on state application of ACA
 - Affordable Care Act = Medicaid "light"
 - Approximately 15 million are insured
 - Shift in lowest common denominator from Medicare to Medicaid
 - Shifting from Service (2015) to Documentation (2016) to Performance (2017-18)

Continued Tsunami of a Change

- Expected to Change
 - Reimbursement System
 - “National” Health Care Policy
 - Diagnostic System
- Timetable of Change
 - New Codes next 5 years
 - New System thereafter

Tsunami Explained: Present Paradigms

- Comprehensive
- Uniformity
- Transparency
- Documentation
- Integrative
- Performance
- Large Data Sets

Tsunami Explained: Future Paradigms

- Traditional Paradigms
 - Yearly reduction of 1-5% for foreseeable future
 - Unsustainable by 2020
- New Paradigms
 - Boutique services
 - Volume & Population Statistics
 - Prevention
 - Integrative & multi-disciplinary (geographic or virtual)
 - Interface with other industries (e.g., legal, industrial, sports)

Emerging Patterns

- Shift from Pre to Post "Authorizations"
- Documentation is Support for Medical Necessity
- Medical Necessity is the Basis for the Service
- Integrative
- Health Care Delivery
- Shift of Focus from Federal to State
- Accuracy, Transparency and Utility
- Performance Based (but metrics being developed)
- Fast Moving, Major Paradigm Shifting

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

A Summary of Approximately 25 Years

- Expanded from a Approximately 3-4 Codes to Over Several Dozen Codes and Continuously Expanding
- Total Revision of all Diagnostic, Testing and Psychotherapy Codes and addition Health & Behavior
- Addition of Prescription Privilege Code
- Expanded from Psychiatric Only to All of Medicine
- Reimbursement Increases Has Outpaced Other Health Care Disciplines by a Significant Factor

Personal Involvement

- Professional Membership
 - Join APA, SPTA and your specialty association
 - Start a local/state specialty association (e.g., North Carolina NP Society)
 - Think nationally; act locally (e.g., state wide)
- Professional Participation
 - Join a organization committee, listserv
 - Join an insurance committee
 - Track insurance patterns in your state/area
 - Keep others informed and engaged
 - Take proactive and positive perspective
 - *Note: Listserv information is frequently incorrect*

And “I feel fine”

<http://www.apamonitor-digital.org/apamonitor/201212/?pg=70&pm=2&u1=friend>



Resources

- General Web Sites

- www.ama-assn.org/go/cpt (CPT)
- www.apa.org (general APA website)
- www.apapracticecentral.org (resources for practicing psychologists)
- www.nanonline.org/paio (practice patterns & information)
- www.apa.org/practice/cpt (APA's CPT information)
- www.cms.org (medicare/medicaid)
- www.hhs.org (health & human services)
- www.oig.hhs.gov (inspector general)
- www.ahrq.gov (agency for healthcare research)
- www.medpac.gov (medical payment advisory comm.)
- www.whitehouse.gov/fsbr/health (statistics)
- www.div40.org (clinical neuropsychology div of APA)
- www.napnet.org (national association of psychometrists)
- www.psychometristscertification.org (board of certified psychometrists)
- www.access.gpo.gov (federal statutes and regulations)
- www.healthcare.group.com (staff salaries)
- www.commonweath.com (health care policy)

Resources (continued)

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

Resources (continued)

- ICD
 - www.who.int/icd/vol1htm2003/fr-icd.htm (who)
 - www.cdc.gov/nchas/about/otheract/icd9/abtcd9.htm (ccd)
- PQRS
 - www.centerforhealthyaging.com
- Coding Web Sites
 - www.catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp (AMA CPT)
 - www.aapcnatl.org (academy of coders)
 - www.ntis.gov/product/correct-coding (coding edits)

Additional Sample Forms

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

AMA Contact Information

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

APA Contact Information

- American Psychological Association
 - Katherine Nordal, Ph.D.
Practice Directorate, Director
American Psychological Association
750 First Street, N.W.
Washington, D.C. 20002
- Association for the Advancement of Psychology
 - www.aapnet.org
 - P.O.Box 38129
 - Colorado Springs, Colorado 38129

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- Websites

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