0:00
<Dr. Puente> Good afternoon.

Welcome.

I'm Tony Puente, president-elect for both the American Psychological Association and the APA Practice Organization. I will be joined later in our presentation today by Dr. Lynn Bufka for questions and answers.

0:17
This webinar is hosted by the APA Practice Organization which is a legally separate companion organization to the American Psychological Association. The Practice Organization works on, among other things, reimbursement issues for psychologists.

0:33
Because of APA's tax status as a charitable organization, APA cannot legally engage in work on reimbursement issues. That is one reason of the many why the Practice Organization exists. So, let's get started!

0:49
This webinar is geared to help psychologists in focusing on not the F codes; specifically we're interested in this particular presentation on the G and R codes. Our goal would be to help you understand better how is it that these codes can be applied.

1:11
We've heard from many psychologists about the importance of G and R Codes and their difficulties in understanding them and working with them. That's why we decided to specifically address these codes. So today's presentation is only on how to use this particular set of codes from the ICD-10.

1:30
We'll have time for questions during the hour. Many thanks to those of you who submitted questions already. We have received a large number of them and cannot answer them all - at least today - but we will do so and will post them on a Q & A section at a later time.

1:50
All right - so today's presentation really focuses on trying to answer some basic questions as you see on this particular slide. "How do I code for dementia?" What do I use for the old DSM 294.10- and of course the typical question, "How do I capture memory deficits or challenges?" We cannot cover all coding possibilities relevant to neurocognitive disorders and we have decided to focus today primarily on G and R codes because those are the questions that generate most interest among folks out in the practice world. It seems to us that individuals are having good success with the F codes, or if you call it "the typical 'mental health' codes", although future seminars will focus on other areas including testing conditions such as ADHD, autism or learning disorders. We do have more to say on this topic, but not necessarily today. So let's go with the next slide.

2:53
Psychologists are familiar with the DSM and I want to make sure that people understand that the codes in the DSM have corresponded to the codes in the earlier version of ICD; however, many psychologists were not aware of that "DSM codes" are not really DSM codes - they're actually ICD. You're encouraged to look at the structure of the ICD and see the range of chapters - ranging all the way from infections to pregnancy to injury. These are all kinds of health problems that individuals experience. You might want to check the APA PO website and psychologycoding.com websites for additional information. But let me emphasize: the DSM is essentially a descriptive system for mental health diagnoses or what is referred to as the F codes in the ICD world and there's very little information on other things like D and R where the ICD-10-CM or critical modification is what is universally used system for healthcare professionals and covers everything including the F or mental health codes. Let's continue with the next slide, please.

4:17
One of the things that we have a major challenge in the switch from the DSM or ICD-9 world to the ICD-10 and subsequently the ICD-11 world at the end of this calendar year or thereabouts is the fact that ICD-10 requires that one record as many diagnoses as necessary to cover the entire clinical presentation. You begin with what we might call a primary or main diagnosis and you continue with additional secondary or less important diagnoses. The most relevant diagnosis relevant to this particular point - that is, the point that you're pursuing - is what goes first. Subsequent diagnoses go later. I realize that this is not typical for most of us, but it's important that we appreciate that this is what other health providers do. Let's continue with the next slide, please.

5:15
If you have a doubt, list all the diagnoses that appear in the order they appear in the ICD system. I think it's a good idea, although not typically considered the case, to use F codes as well as the G and R codes. The next couple of points are critical. List all diagnoses found in the health record in the diagnostic section of the report. Towards the end of the report (or the beginning if you so choose), you have a section called "Diagnoses". The different diagnoses need to be inserted. If it's in the existing health record and you have had opportunity to review it, those diagnoses need to be included in that part. however, the patient self-report, even if behavioral signs support the report, does not meet the sufficient criteria for a medical or, if you will, healthcare diagnosis. This should be provided in the health record... excuse me, in the history section of the report and not in the diagnosis. Let me emphasize: record all previously found diagnoses in the order of importance of the consultation ahead. It could be, for example, that a tumor is really important but not necessarily for this situation, or diabetes. So start with the primary diagnosis and work down with the ones you are going after, maybe the ones you've discovered, as well as the ones in the health record. Let's go onto the next slide, please.

7:10
If you want to do this right, here's how you get everything correct: get the three volumes available - volume 1, 2, and 3 - from the World Health Organization and you can study them. I will tell you that some of them are in American English and others are in English English and they are a bear to use. Here's an alternative: find a browser that you might like to make the crosswalk occur for you. And specifically here's what I suggest: that you use your records to indicate what are the top five or ten diagnoses that you have historically used - say for the last few months or years - and then translate those, crosswalk those over with the specific browser. One that I have used with some degree of success is the icd10data.com - icd10data.com. There are others, such as the WHO, the Center for Disease Control, and several more and those you can find at the psychologycoding.com website, but the one that I have used with a fair degree of success is icd10data.com. Now let's get into the business of how this works specifically, so let's move onto the next slide and now we're going to tackle the actual diseases themselves. So what we're going to focus on is the diagnostic classification.

8:43
Now here's a probable condition which could be found in the health record what you were referred the patient for, the patient was referred to address memory disorders regarding, for example, Alzheimer's disease, and just for the record, let me read some of the more common ones. Alzheimer's disease now becomes G30.9; frontotemporal, G31.09, Lewy body, G31.83; Parkinson's, G20. If there's a possible major neurocognitive disorder due to Alzheimer's disease, it's G31.9, and the one many of us use in neuropsychology mild neurocognitive disorder due to Alzheimer's disease or some variation, G31.84. Now before I move on, let me emphasize that these are the diagnoses and very often the patient will come to you with this kind of information, but it may not be what you end up with so let's go onto step two which is found on the next slide.

9:47
In this step two, this is basically your involvement, so what you might have is not necessarily what you were sent for. For example, you were sent for maybe Lewy Body, but it turns out that you have dementia in other diseases classified elsewhere, without behavioral disturbance, (F02.81 and F02.80). Now, keep in mind that the last set of slides... the last slide, excuse me... was actually a set of G codes; these are now F codes. As I'll say a few times today, some of these insurance carriers may not allow you to use a G code, so you may end up having to work in the F world. If that's the case, these might be viable ones, If you have some flexibility, the most appropriate thing would be to go with the G and R codes because that's what you're going after. Let's continue with the next slide which depicts, if you will, variations of the theme.

10:49
In this case, what I have provided is some more typical disorders such as TBI (S06.2X9) and by the way, I could see in the future, that we might have a seventh level which is the location of the injury. That does not seem to be very often required by carriers, but I could see in a TBI that this nay be required, but right now I think this is as much as you need to go. Other diseases like HIV, Prion disease, and Huntington's disease are found. Let me alert you to the last two portions of this particular slide because it's a bit complicated. Major Neurocognitive disorder due to another medical condition - so in other words, you have a dementia. For example, it could be an F Code, but it's a medical condition for example, like diabetes. So, your first diagnosis would be diabetes and your second diagnosis would be the F code. For example, again here's another way to look at it: that the parent code, or the original code, is the original medical condition whereas the subsequent problem that you're experiencing with the patient - for example, dementia - would be the subsequent, or secondary, diagnosis. If you have multiple etiologies, you have to code all the etiologies before you
put your own in the order of importance to the condition that you're currently evaluating. This is all true, except for vascular disease, which I'll explain in a couple of slides. Let's continue, please.

12:34
Here is an example of some F codes and, for that matter, the mild cognitive impairment code that many individuals use in your psychology: G31.84. I think at this particular juncture we could get away with five levels; it could be in the not-too-far future the specificity and granularity of the ICD system will require it, but I think at this particular juncture, probably five levels are all that is necessary. So you see the F codes in the first two and then the G code. Again, code the most appropriate code relative to your condition assuming the insurance carrier accepts that. Next slide, please.

13:21
Now here's the vascular dementia. In probable major vascular neurocognitive disorder, there is no additional medical code for vascular disease. So if there is a vascular problem, you do not need to have a parent condition; or, in other words, you don't have to emphasize certain vascular disease and then F01.51 or G31.9 - that is enough. So, in other words, unlike some of the other disorders - for example, diabetes producing dementia - in this particular case, you do not have to have a parent diagnosis. You can get by... or you should not get by; you should just give a singular diagnosis if that's all that's applicable and that is the diagnosis that you're working with. Next slide.

14:14
And, of course, here's the unspecified neurocognitive disorder, R 41.9. Here's my own interpretation; I'm not sure there's anything to support it, but my own interpretation having worked with insurance carriers for a number of years and that is that the system is moving to a very granular system. Unspecified disorders are not often viewed favorably by carriers for reimbursement purposes, so all things being equal, go as deep, as careful, as thoughtful, as accurate as you can with your diagnosis. As I've said before, I think at this point four or five levels is all you need, but try to avoid unspecified and I wonder when it is going to be the day when we're going to have to go to all seven levels. But at this point, avoid unspecified and go as far as you need to. Now, having said that, let me give you a different issue. In some ways, granularity is where we need to go, where the system goes, where you ought to go as a diagnostician. Having said that, however, keep in mind the more granular you go, the further away from some of the formulary systems that insurance carriers have produced you may go. So we'll address this in a couple of slides. So, next slide, please.

15:41
All right, one of the things that people ask me well how does a DSM vs ICD-9 or ICD-10. Here's a generic slide that provides some idea of how it works. Some things are pretty straightforward like generalized anxiety disorders and others, like dementia of the Alzheimer's type (290.10), become a bit more complicated with a G30 code as well as an F code. So, in this case, some things are pretty straightforward and I will tell you - and this is my own personal impression - that the basic mental health codes or the F codes are pretty, pretty easy to go from DSM to ICD-10. It's not point-to-point, but in the ballpark; but when you're starting to use ICD-9 outside the DSM or mental health codes, that point-to-point correspondence becones a bit more complicated. Next slide, please.

16:41
Many of us have lived in the world where we typically diagnose one thing or maybe two. When is the last time you saw a health record with only one or two diagnoses? In fact it is very common for me to see up to ten. So we now have to get into a different mindset and that mindset essentially emphasizes that we have to include a series - not one, but a series

of diagnoses. First of all, you start with the primary: what's most important for what you're doing. Second, what's next most important. Third, what's third and so forth. Now let's talk about the total number of diagnoses. You diagnose, as I mentioned before, all conditions present, including those diagnosed by you and those diagnosed by other qualified health providers, and where you have documentation that diagnosis has actually occurred. if it's in the record, you have to report it. Again, do not include self-reported diagnosis from the client in the diagnostic section of the report. Place that in the history section. So the days of singular or just two diagnoses have come and gone. The ICD world now basically encourages us to do more and, as I'll say several times today, it encourages you not only to do more but to live outside the F world which is basically what we're discussing today. Next slide, please.

18:23
Bill for the diagnosis that you are pursuing on the claim form. This is a question that people have on a regular basis. Hold on a second - I'm going after dementia, but I discover depression and you have discovered that after an entire set of tests six hours, eight hours, whatever. So you basically put down, "I went after dementia"; that is what you put on the claims form. That may not be what you put on the eventual final diagnosis in your report, so the initial working diagnosis establishes a medical necessity for subsequent assessments and intervention. In essence, the diagnosis that you are putting down at the end of the event that you are pursuing sets the foundation for medical necessity and that medical necessity is the foundation for or link to the next activity. So an interview links to the testing; the testing leads to the intervention or to the referral. It is the new diagnosis that is used that is essentially is what you go after. This is a critical point. Think of each diagnosis as setting the foundation for the later work as well as medical necessity. However, what the literature says is medical necessity, what you think, how you were trained may or may not match the carrier's interpretation of medical necessity. Each carrier, each plan has a different formulary which we will discuss and this is the crux of the problem with using these G and R codes. Next, please.

20:14
The formulary that is really the Holy Grail for us is essentially what CPT codes - in other words, what procedural codes - one is to use with what diagnostic codes. For example, essentially it makes sense that you would do neuropsych testing for, oh let's say, dementia. Or you might do health psych testing for, say, diabetes and chronic pain. How about this idea? How about depression? Refractory depression - why not pursue a neuropsych evaluation? Well, most carriers will not allow a CPT code, for example - testing, with an ICD code, example - depression. That formulary is atypical; the combination is very unusual. The challenge is that Medicare will establish - that is each carrier will establish - and publish this formulary on their website. it may be dug very deep in the website, but it's there. if not, you can certainly find it from the medical provider office. However, private payors do not, in spite of establishing these formularies, do not publish this information and therefore you have to discover this on your own. You may have to study your own EOBs, possibly talk to your peers, but essentially this is a discovery mission that is not easily formulated. And it is my impression, by the way, that for the first six months from the transition from DSM or ICD-9 to ICD-10, most carriers accepted almost all formulary interpretations. They just went ahead and reimbursed you regardless of what the diagnosis was or what the CPT code was. However, I believe that those formularies have now been established and are ready to be applied; hence, many of us are starting to get denied simply because we don't have an appropriate matching of a CPT code to the ICD. And your job is to find out for each company and each plan what the formulary might be in an effort to make sure that you get reimbursed for the services you're providing. Let's pursue slide 19.

22:48
Now, in terms of assessment, you basically put the primary diagnosis that was discovered and the secondary and so forth as we discussed. In other words, you go after dementia; you've discovered this is now depression. You went after chronic pain, but you discover it's depression - whatever the case may be. That's what you link as a foundation for the treatment. In other words, we now move into a new phase of our engagement with the client and that is the treatment. Now the diagnosis must match the treatment. The primary diagnosis in each case - in other words, when you finish - the primary diagnosis will determine whether you are going to the bin, if allowable, of medical or behavioral. A couple of points: remember earlier I mentioned that we are now living in a world with multiple diagnoses? Imagine that we have diabetes and depression, or dementia and depression. This allows you to live in the neuropsych or health psych world, the rehab world as well as, if you will, the mental health world. So today I might be doing cognitive rehabilitation or biofeedback for chronic pain or adjusting to the illness depression, so what we need to be able to do is move back and forth as the intervention requires. Now the question you might have is, "What if it's 50/50?" Well, in the ICD world. or for that matter the CPT world, it has to be at least 51, so you end up coding what is most appropriate in terms of determining what is the

diagnosis that you're using. But doing psychotherapy on schizophrenia or, for example, dementia may not be reimbursable by some carriers. Although one could argue that it should be, it may not be so you may have to, for example, deal with depression and psychotherapy, otherwise you'll have a mismatch between the two. If you do mental health treatment, an F code is required in your original findings, so it's critical that all your original findings that you were exhaustive as possible in an effort to provide the client and, for that matter, yourself the greatest range of interventions possible. If you do not find any kind of mental health problems - for example, an F code like a depression code - then it's going to be hard to establish why you're doing psychotherapy. Nothing was originally liked to the original findings because the findings just say, for example, dementia or chronic pain. It is critical that you link one activity to the other by establishing a foundational code that allows you to move in a number of directions. Let's move on to slide number 20, please.

25:48
Now you're saying, "OK, how does it work? Where do I find this?". I've given you three examples of carriers that have that information, Now, of course, these are Medicare plans, but not necessarily all applicable. For example, in Aetna, you may have multiple different plans and it's encumbered on you to discover which plan your client has and how do you make sure whether that activity is actually being covered. In most neuropsych testing, as far as I can tell, F and G codes are very commonly, very commonly reimbursed. I'm starting to see more and more for R codes and, to a lesser degree, S. But as far as I can determine, when it's all said and done and everything... the dust settles, I believe that individuals in health, neuro, and rehab - for example - will be able to do F, G, I, Q, R, and S codes. Now here's my goal: there's 21 chapters; I believe we should work in all 21 worlds. So I hope that one day that we as psychologists with appropriate training and scope of licensing being within limits, that we will have access to all the chapters, all the, if you will, seven thousand different codes that we could use, but in this particular case, we have to live in the F, G, I, Q, R, and S worlds. At the beginning... see, here's some caveats. UBH is using DSM as a foundation for major crosswalk; UHC has posted their own tool for a crosswalk. The overall take-home message is that you need to find a tool that gives you the equivalent diagnosis you were historically using for that client or that type of condition and here's my suggestion: if you got reimbursed for it, you need to continue having that be your diagnosis. Each carrier and each plan will have different interpretations of what is acceptable. It's important to know - as I've said several times - it's not what you think; it's not what you should do per se; it's what the carrier's willing to pay. Now this is a very, very delicate balancing act because our goal is to be as ethical, as clinically appropriate as possible, as scientifically rigorous, but sometimes that doesn't match the insurance carrier. Your job is to figure that out and do your very best and balance that act in the most efficient and ethical way possible. Let's move onto slide 21.

28:45
OK, now what's the bottom line? Well, you've got to put this in the HCFA form. We now have the number of diagnostic places has gone from six to twelve. You can use a primary code and, if necessary, a parent code following. Now this is a little different than what I said earlier; in the actual report, you might want to put the parent code first and the code that applies to the evaluation second. In this case, it kinda goes backwards, but imagine this scenario: that the carrier pays for F codes, but not for G codes - what do you do? You put the G code; it will be denied. So it's important to note that you've got to understand the system that you're working with. The ICD indicator is an actual field 21, so as much as possible, make sure that not only do you do a good job in the report for the patient, the client, but also that you make sure you put the correct information in HCFA. You don't have to put all the diagnoses in the HCFA form; in the Health Care Finance Administration, there's really only a certain number of spaces, so at this particular juncture, I think it's probably a fair thing that we limit ourselves to the primary and secondary diagnoses; that should take care of this this. Let's continue with slide 22, please.

30:08
Now, for those of us that work in other areas or want to get more into details, here's some examples of the G codes that could be useful. For example, let's take G35 through 37. This may very applicable to, for example, an individual that has multiple sclerosis. In essence, these are very standard though I want to emphasize something I said earlier: try and shy away as much as you can from the unspecified or other disorder sections of most of these activities. So the G89, G99 may be less likely to be reimbursed than the prior ones simply because they are much more granular, much more specific, and that's what the ICD system is looking for. It's avoiding or moving away from unspecified disorders and getting into specific and granular situations. [Slide] 23 also has a couple of other examples. Next slide, please.

31:18
Here we have some specific examples: the infectious and parasitic diseases are the A ones; complications of pregnancy are the O ones; injury, poisoning, and so forth are the S ones; and as I mentioned earlier, I hope that one day we will have access to all these different codes, but at the present time, they are very infrequently reimbursed by individuals doing the kinds of things that many of us are doing. It just seems like a mismatch at this point; I hope that our scope of practice, that our science, as well as our profession moves to cover all of ICD. Certainly healthcare is in need of us to increase its efficiency and to reduce its costs, but right now we have to be realistic and live within the system that we're working under. Let's go to slide 24, please.

32:13
Now I know that many of you want to get more information and many of you maybe even have insomnia - we have a solution for you. Take a look at some of these, especially Psycoding... Psychology Coding website. It has a ICD presentation, about 200 slides and a CPT one about 500, 600 slides - that will certainly cure your insomnia. And so will the ICD one: it will tell you all the different numbers that are available to you, which include about seventy thousand or so, but if you want to get down to the business of how you make this happen, check out APA Practice Central. These are great sources of information and, of course as I mentioned I think two other times, ICD10 data dot com and many others are good examples of how you can do the crosswalk. As I said before, find five or ten diagnoses that you commonly use. crosswalk them, double-check with your EOBs, make sure you're on the right track, change and, as appropriate, educate. Let's move onto slide 25.

33:24
Oh, who are those people? That's Dr. Bufka who's going to take all your questions and actually she has some questions that you have mentioned or have sent in and we'll have her read those and we'll try to answer them for you, but before we go further, let's go to the next slide. Oh, no - let's stay with the question and answer period. So how about at this particular juncture, let's go back to the photos... right there, thank you. Let's go ahead and stick with that and let's turn it over to Dr. Lynn Bufka who's going to read some of these questions before we have our parting comments. We have approximately twenty minutes and what we're going to do is we're going to take some questions that have been submitted to us and then as time permits, we will also accept questions through the chat box. realizing that there's many of you and we may not have time to answer those questions, but we will do a question and answer and put it on the APA Practice Central website in the near future. For now, let's turn it over to Dr. Bufka.

34:34
<Dr. Bufka> Hello, everyone - I'm so glad so many of you joined us today for this webinar and I'm also very appreciative of the many people who sent in questions in advance; so we got well over one hundred or more questions in advance, some of which we'll get to today, some of which we probably will be able to answer with a Q and A information down the road. And then we've also gotten questions from participants, so I will try to address the questions from participants on the line first and then move onto questions from... that we received in advance from people registered. So the first question that I'm seeing is "If you're working in outpatient," the person is asking, "we are not supposed to use 'suspected', 'probable', or 'rule out'; instead we're supposed to use 'symptoms'." Is that something you can comment on, Dr. Puente?

35:31
<Dr. Puente> Yes, if you read carefully what the DSM... excuse me, the ICD descriptive information regarding how to go ahead and diagnose, "Symptoms" is what you should really be going at; as a matter of fact, if you really want to get down to business, ICD isn't really an international classification of diseases - it's actually an international classification of symptoms. So, in many ways, what we're doing is we're looking at the symptoms, so you're supposed to do that. A more interesting question is the following, or at least one aspect of that question and that is "What is it that... I can't go after a problem; well, what am I supposed to do?" So here's an example that I think might be useful in explaining all this. Imagine... imagine how many MRIs are done every year and how many are positive. So, are you supposed to put down "headache" for an MRI because that's just not going to be reimbursed. So you go for what you search for; then afterwards you come up with the right diagnosis which may be the same one and then go from there. But at this particular point, you do go after the symptoms. You're correct on that.

36:48
<Dr. Bufka> I think you've sort of answered this next question with that example, but the person was wondering, "What if the referral diagnosis - for example, autism spectrum disorder - is considered medically necessary, but the evaluation reveals the client only has a diagnosis that is not considered a medically necessary reason for neuropsych testing - for example, attention deficit disorder." The person wants to know do we bill under referral diagnosis so insurance will cover it or under the truer diagnosis that the evaluation reveals? In the latter case, of course, the family may be responsible for quite a balance, but if I'm understanding you correctly, what you would say is at the time you started the testing, you were evaluating for whether or not autism was present; so when you start the evaluation, is that what you are saying? that you would do the initial bill, but subsequent interventions with the... with the child would be for the diagnosis that was actually found? Is that what you were suggesting a person handle that sort of situation?

37:51
<Dr. Puente> That is correct, Dr. Bufka, and that means that essentially in terms of the bottom line, the insurance will cover the evaluation, but the insurance will not cover subsequent interventions. So let's imagine that we go after autism and we find a learning disorder; that's even easier. And the learning disorder obviously is not going to be covered by insurance carriers, so what do we do? Well, you didn't discover autism, so that's good news as far as the client; it's also good news in the sense it provides, you know, a reasonable code that should be reimbursed. Now let's say the parent wants to come in and say, talk to you about what this means: "How does... how do I set up an IEP?" and "How do I work with the child at home and homework?"; well, that is outside the health carrier's policy and that becomes out-of-pocket expense.

38:48
<Dr. Bufka> So the... so the next question that somebody asked about was, "Could you address the use of modifier 59?" and they were wondering about this specifically in regards to Medicare, but also third-party payors as well. Is that something you are able to address?

39:07
<Dr. Puente> Yes, that's a little outside of the scope of our presentation this afternoon, but I will address modifier 59 and that is an unusual service. That essentially comes from the December 2006 transmittal from CMS that basically says that base... they basically say that you can not do one... one one eight and one one nine together which is... essentially means you can't do a professional activity and a technical activity in the same event. Well, there's several ways to do that. One of them is a) do one eight and one nine on different days. Another one is do a modifier and here's a problem: the question is do you put it on a one eight or a one nine and I tend to suggest that you might want to do one eight, but then becomes a problem because they may think it should go on one nine. And then the other possibility is you actually do some of the testing yourself. the Psychology Coding website has about twenty or thirty slides on that particular topic. But this is a major issue that we're trying to resolve; the work of Randy Phelps and his group, APA is going full steam ahead. I'm trying to make sure that in the future we do not have to worry about modifiers. A quick comment regarding modifiers: that's not a typical thing for most healthcare professionals, but it's not also an abnormal one. Hence, you may have to consider that this may be a... a standard activity for many of the services that you do that would be unusual. Modifiers are basically a qualifier that says, "I did something unusual." For example, you could have a modifier in a psychotherapy session where you simply... the patient walks out halfway through. You may say you have a 45-minute activity, but then you say a terminated session because the patient lost their cool; a modifier would be appropriate. But that's for CPT and maybe another presentation in the future. Thank you.

41:11
<Dr. Bufka> One thing I'll add to that for those of you who are members of the Practice Organization, we have a section on the APA Practice Central web pages related to reimbursement and one specifically on the National Correct Coding Initiative that provides a little more information about modi... modifier 59 as well as we often get asked questions about "why can't I bill for this code and this code on the same day?" and there's an article on the website that provides a bit more explanation of that situation along with some very specific resources from Medicare. So I would encourage you, those of you who have questions about that, to look at the resources available on the Practice Central website as well and we'll make sure to try and point you in the right direction with some of our resources later on after the webinar.

42:04
<Dr. Puente> Dr. Bufka, let me just add a comment to this. It used to be in the sort of pre-ICD-10 world that wall we had to worry were... about was basically all about CPT codes. As long as we knew what codes were accepted, there were applicable, how to use them, then we're in good shape. Effective of October of last year, we just added a new... a new variable to the equation and that is the ICD. And, of course, you know now we have CPT and ICD. This presentation talks not only about that, but also goes one step further. I think for many insurance carriers, they'd love if we just lived in the F world. And for many of us, especially, if you will, clinical psychologists doing more traditional kinds of mental health work, that's enough. But many of us - neuro, health, rehab - we... we've actually pushed the boundaries of the standard mental health paradigm for psychology and this is where the challenges come in. I think the system really doesn't want us to move outside the traditional mental health paradigm; we're pushing it to make sure that our patients are taken care of within the scope of our practice, our training, and their needs. Keep... keep this in mind that essentially mental health represents two or three percent of the healthcare dollar - what about the other ninety-six percent that we're just simply not tapping? That's where these codes get us to: a new world where all of healthcare becomes part of our... our realm.

43:41
<Dr. Bufka> The... the next question, or point, sort of gets at a little bit of what you were talking about. You mentioned earlier in the presentation that someone should list all the conditions the patient has, but then the question... the person... the attendee is also noting, "From a coding standpoint, should you list only the conditions that you address in your notes?" and I think one of your points that you were making earlier on is that your medical record - the record that you have on an individual - should contain information about all the conditions the person has been diagnosed with, but then from a billing point of view, there might be some differences in terms of what conditions you reference and perhaps you want to come back to that point to clarify for the person who was raising a question about that.

44:24
<Dr. Puente> Yeah, let's do. Let's emphasize what you bill is what you go after. However, what you discover is what sets the foundation for the next activity, the next intervention, or the next referral, if you will. So it's critical that we consider the billing diagnosis and the, if you will, final diagnosis as two separate... although they could be the same. It just depends. Our goal is to then link the final diagnosis to the next activity whatever that may be.

44:57
<Dr. Bufka> So another question that has come in is "Can we use behavioral diagnostic codes if we are credentialed on a medical panel only?"

45:07
<Dr. Puente> Aha! Well, it used to be in the old days that we were credentialed only in the behavioral world and then we went to be credentialed in the medical world. For many of us, we're there, but here's the challenge: we need to be credentialed in both worlds because, for all practical purposes, it's really not common to see a patient with a non-F primary diagnosis that does not have an F diagnosis. So we want to be ready to take care of all the patients, not just the help side of things. And that becomes a real problem. So many of us left the F world, if you will, and... and in some ways what I'm recommending is that we might want to return. We have to have one foot in one world - the F world - and another foot in the other twenty chapters of the ICD. Maybe one day we'll find ourselves in the situation where we... we're comfortable, not only in terms of our practices and our science, but also in our relationship with carriers: that they understand that we just don't treat the mind, but we also treat the body. We have a ways to go, however.

46:20
<Dr. Bufka> Another question that an attendee has asked is "May I still use the old 3.16 diagnosis?" This would be from the ICD-9-CM and the 3.16 has to do with psychological and behavioral factors associated with... just with medical conditions and there is a comparable F code called F54: psychological and behavioral factors associated with disorders or diseases classified elsewhere in the ICD-10-CM, but it might be useful to hear from you, Dr. Puente, about any concerns people have about how best to use that or anything that you've encountered in terms of your work

47:02
<Dr. Puente> Oh, my own particular work is I used to use the 3.16 code regularly and I think that the new proposed code that the... that this individual suggested seems right on target. However, I also encourage - can they go deeper? Dan they get more granular? Can they get more specific? So, if you can, go for it; if you can't, then stick to your old trusted friend 364.00 and then the F code that you suggested.

47:34
<Dr. Bufka> And one more question that has come in on the webinar and I'll read it as it is and... and hopefully it will... you'll understand what the person is asking about: if Medicare uses HCFA billing information to assign value to our work, would it not make sense to include all diagnoses to demonstrate the complexities of our patients?

47:57
<Dr. Puente> Aha! Now... now you're talking. Whoever asked that question has read my mind. Here's how it works: most physicians work with E & M codes or evaluation and manager codes. They... those codes go for level one to level five with the average one being three. I think there's a folklore - may be some truth to it - that the more diagnoses that you put in the work-up, the more likely you can go up the ladder of "you know". So one or two diagnoses might be a drive-by evaluation or treatment and that may require a level one. If you have five or ten or fifteen, could that be a level three or level four? I think that is how we think of E and M codes. Now the problem is, how does that transfer into our world? Our world is... is a bit more complicated in the sense that outside of psychotherapy, we don't have difficulties in terms of difficulty driving the type of code or, for that matter, the reimbursement rate. So I think at this particular juncture it's just good clinical practice; it's required by the ICD and may only be useful in the psychotherapy world where there's different levels of psychotherapy where you might be moving, for example, from a simple psychotherapy to an interactive one or some variation of the theme. But for most of us that are working in the rehab, neuro, and health world, this would be not applicable and, for that matter, wouldn't even apply to the H and B codes - health and behavior codes. Good idea where we should go, but we're not there - not sure we'll get there in the very near future, but I really appreciate the question.

49:48
<Dr. Bufka> Some questions that came in when people registered - we'll try to address a few of them. Keep in mind I have seventeen pages of questions so we won't get through all of them because we have less than ten minutes in the webinar, but one person... well, several people actually... were wondering if you had some suggestions for what... what codes seem to work best when you're evaluating someone with questions related to a traumatic brain injury, TBI?

50:13
<Dr. Puente> Well, I gave you one in the slide set that was contained that.. that might be applicable. I... I don't know. Here's... here's the question I have back for that person: how low do you need to go? Because at this point, I think you might be able to get with five levels and I've given you a specific example in the slide set of one of those - the one I think is very typical, especially without loss of consciousness, and... and the question is: do... will we have to, sooner or later, go to level five where we have to address issues such as location of the injury? I don't think so at this point, but maybe stick with what I suggested. Now here's another thing that I... I tell people: I... I love to use as many diagnostic codes as possible, but the reality of life, especially with these complex formularies that are are often not available to us, you might find what typical codes you think are appropriate to your client population and what codes are typically reimbursed by the carrier and trying to stick with those. The more granular, the more away from the standard codes, I think, the more challenging it might be to be reimbursed.

51:36
<Dr. Bufka> We have received many, many questions in advance of the webinar on topics such as online interventions, online testing, use of specific CPT codes such as 961.16 which is Neurobehavioral Status Exam, or questions regarding billing for multiple codes in the same day, and challenges that individuals have had with that. So, those are things that certainly require a more complicated response to that; what we will do... the best we can with this... is try to put together more information about these kind of questions because clearly it's of importance to many people who signed on for the webinar. We have a few more questions... a few more minutes and a question came in that i know Dr. Puente is passionate about responding to, so I want to make sure I give him that opportunity, but before I do that, I would like to ask people if they could please stay online after the webinar has ended because there will be a quick survey about the webinar and we would really love to get your feedback because we like to know what works and what doesn't work and

how we can provide webinars in the future that are going to be of interest and useful to all of the psychologists who are responding to our invitation to participate. But here's a question that I know Dr. Puente's very passionate about: what's the status of including psychologist and neuropsychologist under the definition of physician?

53:06
<Dr. Puente> Well, obviously I am very passionate about that making that central focus for my year as president of APA. I will tell you that I'm really delighted and super enthusiastic about what's happening with Murphy's bill. I think that we may be in a position to really get some leverage in Congress at this particular time and I encourage everybody to consider that particular bill and I know APAPO has... has pushed that. I think that's the foundation for the next step; the next step is to move forward with the physician inclusion. Now, this is surprising to me that there are 13 doctor-level providers in... in the CMS system or Medicare system; we're the only health provider with a doctorate degree as a terminal degree that is not included that definition. We go back to 1965 to the advent of the Medicare where we failed to include ourselves; we did so again in 1989 with the revision of the Medicare Act and the... the Social Security. It's time... it's time Doug Walters and the folks at APA Practice are working very hard and we're lobbying and I think we're ready to... to move forward. We're looking forward to working with several folks in Congress and maybe we can add a very simple addition of a few words to the existing Social Security Act of 1989 to make sure that we are respected like everyone else. It's time - it's been too, too many years and we're... we're going to do it this next year with the help of APA and some influential members of Congress. We're... we're going to make it... make it happen.

54:56
<Dr. Bufka> That's going be all the questions and answers that we can address in the webinar right now; we encourage those of you who participated to stay tuned. We'll get you more information as we can; we... we see where questions are coming from - we'll do our best to try to help you with that. We also want to let you know that for those of you who are members of the Practice Organization, we work very closely in trying to identify what some of the problems are that our members face when it comes to billing whether it's the issue around the physician definition that Dr. Puente was talking about as well as sometimes our members have problems billing for health and behavior codes or with particular insurance carriers or managed care companies. And staff in our legal and regulatory affairs office at APA will... when they are aware that there are consistent problems with particular carriers, we try to work collaboratively with those insurers to smooth out some of the issues that our members are facing, but we don't know if they're issues unless you tell us. So when there are things like that that come up, we encourage you to contact the APA Practice Organization. You can use the email practice at APA dot org for those kinds of things. We also encourage you to work with your state psychological associations or specialty organizations because they too are going to be very focused on issues related to provision of care and reimbursement of care in your local jurisdiction or within your specialties such as neuropsychology.

56:27
<Dr. Puente> Could we have the next slide, please? Yeah, there we go. Don't forget APA; this is important. Don't forget your SPTAs as well. This is why the APAPO exists; we're here to advocate for psychologists. We're here to look out for your professional interests. This is what many people think APA is - it's not. This is what APA Practice Organization is. Let's go and end with our next slide

57:02
<Dr. Puente> So a copy of the recorded webinar will be mailed to all registrants and, in addition to that, we'll be in a position to... to continue working together for a stronger APA Practice Organization as well as do what you and I can do to provide for those we seek to serve and understand. Together we stand; divided we fall. Let's move forward to make APAPO strong and to serve those that make our day important each and every day. Thanks for participating in this webinar; have a great day. For those of you are still on, please stay on for a moment and you can help us out by filling out a short questionnaire in the interim. Thank you very much - appreciate you sharing an hour of your time with us. Look forward to doing something of this nature for you again in the future. Have a great day.