CNS Vital Signs®

In-Office Neurocognitive Testing Procedure
Objective I Valid I Reliable I Efficient

2016 Reimbursement Guide

Computerized Neurocognitive Testing Procedure
50+ Clinical & Quality Measure Instruments

Optimize Your Bottom Line Today…
Prepare Your Practice for the Future

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2016 Reimbursement Guide Contents

Overview: 3 common procedure codes 3
Central Nervous System NeuroPsych and Neurological Codes 4
Central Nervous System Psychological and Psychiatric Codes 5
Documentation Information 5
CNS VS Tools: Clinical and Quality Rating Instrument Coding 6
Documenting PQRS Quality Measures *a CNS Vital Signs Advantage* 7
Medical Necessity 10
Who can Perform and Bill the Assessments? 11
Billing on the same day as an office visit: What Modifiers? 11
Denial of Coverage 12
Additional Coding Information 13
Medicaid Coverage Example: North Carolina 14
ICD–9, 10, DSM Codes 15
About Reimbursement for Attention Deficit Testing 19
High Patient Deductibles: *The CNS Vital Signs Advantage* 20

Please refer to the 2016 CPT® Current Procedural Terminology Professional Edition, American Medical Association

CNS VS Billing & Coding Disclaimer

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Overview

CNS Vital Signs Billing, Coding & Reimbursement

CNS Vital Signs assessment platform (local software app, web –based app and tablet-based app) enables reimbursable clinic services. Generally, there are…

3 common procedure coding events

Neurocognitive Testing Procedures – The CNS Vital Signs computerized neuropsychological test measures brain or cognitive function under challenge (stress testing the brain). The reports provide a standardized and objective central nervous system assessment. CNS Vital Signs has 10 normed neurocognitive tests ages 8 to 89. Reimbursement is generated from…

1. Testing: ***Type of testing administration (clinician, technician, computer), interpretation, and reporting event.***
2. Results Integration: ***An 'additional professional code' for extra time a clinician takes*** INTEGRATING ***the test results into other sources of clinical data resulting in a report.***

The Central Nervous System Assessments (e.g., Neuro-Cognitive, Mental Status) billing and coding guidelines allow for billing both HOW (clinician, technician, computer) the test was administered and for INTEGRATING the testing results and interpretation and other test results into a report. "Integration" is the interpretation of neurocognitive testing in the context of other clinical assessments, tests and exams performed by a qualified healthcare professional. "*It would be unusual for neuropsychological testing to be conducted without prior clinical assessment and the integration of clinical and historical information. As a consequence, codes 96119 and 96120 may be reported in conjunction with 96118 so that information from these procedures is integrated with information obtained from other sources (e.g., a neurobehavioral exam, 96116) that will provide the foundation for a comprehensive report*." Source: AMA's CPT® Assistant

Patient and Informant Instrument Testing Procedures - important PQRS quality driven…

3. Clinical Measures ***of symptomology, behaviors, and comorbidities*** (rating instruments, health questionnaires, etc.) used to identify the psychological, behavioral, emotional, and social factors important to the prevention, treatment, or management of physical and mental health problems. CNS Vital Signs has 50+ evidence based rating instruments.

The value of Neurocognitive testing is well recognized. CMS has sent out several memos mandating coverage for these codes. ***Generally, there is widespread reimbursement and coverage by payers for the procedure codes used for CNS Vital Signs assessments.***

The CNS Vital Signs assessment platform has been reimbursed using PSYCH procedure codes 96101, 96102, and 96103 for psychological testing & 96101 for integrating results, NEURO procedure codes 96116, 96118, 96119, and 96120 for neuropsychological or neurocognitive testing & 96118 for integrating results, and 96111 for extended DEVELOPMENTAL testing. Generally, a minimum of 31 minutes must be provided to report any per hour code.

Clinical measures generated from patient and informant testing procedure codes are reimbursable by many public and private payers and combined with the neurocognitive testing can help document the complexity and higher reimbursement rate for the appropriate E&M (new 99201-99205 and established 99211-99215 patients) codes.

Central Nervous System Assessments / Tests
(e.g. Neuro-Cognitive)

CNS Vital Signs provides an OBJECTIVE, PRECISE, STANDARDIZED, and CORE set of neurocognitive or brain function clinical endpoints which supports the evaluation and management of many neuro-psych clinical conditions and enables clinical guidelines.

NeuroPsych and Neurological

		* Estimated National Average Practice Reimbursement
96118 Testing & Interpretation	Neuropsychological testing (e.g., Halstead - Reitan Neuropsychological Battery, Wechsler Memory Scales, and Wisconsin Card Sorting Test), per hour of the qualified healthcare professional time, both face-to-face time *administering tests to the patient and time interpreting these test results and preparing the report*.	**$98**
96118 Additional Professional	96118 is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously completed and reported technician- and computer-administered tests. ► (Do not report 96118 for the interpretation and report of 96119 or 96120) ◄	**$98**
96119 Testing & Interpretation	Neuropsychological testing (e.g. Halstead - Reitan Neuropsychological Battery, Wechsler Memory Scales, and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, *administered by technician*, per hour of technician time, face-to-face.	**$81**
96120 Testing & Interpretation	Neuropsychological testing (e.g. Wisconsin Card Sorting Test), *administered by a computer*, with qualified health care professional interpretation and report.	**$48**
96116 Testing & Interpretation	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem Striving, and visual spatial abilities), 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.	**$93**
96127	Brief emotional/behavioral assessment (e.g., limited (e.g., *Pediatric Symptom Checklist, Vanderbilt AD/HD, SCARED, PHQ-9*, depression inventory, ADHD attention-deficit/hyperactivity disorder scale), with scoring and documentation, per instrument	**$6**

This code should be used to report a brief assessment for ADHD, depression, suicidal risk, anxiety, substance abuse, eating disorders, etc. This code was created in response to the Affordable Care Act's federal mandate to include mental health services as part of the essential benefits that must be included in all insurance plans offered in individual and small group markets.

Developmental Testing

96111 Testing & Interpretation	Developmental testing *extended* (includes assessment of motor, language, social, adaptive and/or *cognitive functioning* by standardized developmental instruments with interpretation and report. http://www.cdc.gov/NCBDDD/autism/documents/AAP-Coding-Fact-Sheet-for-Primary-Care.pdf http://pediatrics.aappublications.org/content/118/1/405.full	**$129**
96110	Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	**$10**

** AMA cpt® Code/Relative Value Search National:* https://ocm.ama-assn.org/OCM/CPTRelativeValueSearch.do

Central Nervous System Assessments / Tests
(e.g. Neuro-Cognitive)

Psychological and Psychiatric

		* Estimated National Average Practice Reimbursement
96101 Testing & Interpretation	Psychological testing (includes psych assessment of emotionality, intellectual abilities, cognition, personality and psychopathology, e.g., MMPI, Rorschach, WAIS), per hour of the qualified healthcare professional time, both face-to-face time *administering tests to the patient and time interpreting these test results and preparing the report.*	**$80**
96101 Additional Professional	96101 is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously completed and reported technician and computer administered tests ► (Do not report 96101 for the interpretation and report of 95102, 96103) ◄	**$80**
96102 Testing & Interpretation	Psychological testing (includes psych assessment of emotionality, intellectual abilities, cognition, personality and psychopathology. e.g., MMPI, and WAISI), with qualified health care professional interpretation and report, *administered by technician*, per hour of technician time, face-to-face.	**$64**
96103 Testing & Interpretation	Psychological testing (includes psych assessment of emotionality, intellectual abilities, personality and psychopathology, e.g., MMPI), *administered by a computer*, with qualified health care professional interpretation and report.	**$28**
90791 Formerly 90801	Psychiatric evaluation exam (no medical services) for the elicitation of a complete medical and psychiatric history, a mental status examination, Integrated biopsychosocial assessment, and an evaluation of the patient's ability and capacity to respond to treatment on an initial plan of treatment. Non-Prescriber.	**$131**
90792 Formerly 90801	Psychiatric evaluation exam (no medical services) for the elicitation of a complete medical and psychiatric history, a mental status examination, Integrated biopsychosocial assessment, and an evaluation of the patient's ability and capacity to respond to treatment on an initial plan of treatment. Prescriber.	**$145**

Use 90785 in conjunction with 90791, 90792 when the evaluation includes interactive complexity services. Do not report 90791 or 90792 in conjunction with 99201, 99337, 99341-99350, 99366-99368, 99401-99444, 0368T, 0369T, 0370T, 0371T.

Documentation Information:

CMS (Recovery Audit Program) and other payers have active and ongoing audit programs to recover fraudulent claims. Clients have expressed the following tips to help a practice be prepared for an audit. ***The CNS Testing Platform Auto-Generates a testing audit trail.***

Technical Component – Label whether Tech admin or Computer admin, Number of Tests.

Professional Component – Label Activities: Testing by Professional, Interpretation, Report, or Integration of findings which may include history, prior records, interview(s), and compilation of tests.

KEY ADVANTAGE: Testing Time – CNS Vital Signs Time and Date stamps all assessments.
For Paper and Pencil testing minimum documentation should be: Date(s) & Total Time Elapsed, Maximum: Date(s) Start and Stop Times; Testing Time Backup - Scheduling System (e.g., schedule book; agenda, etc.), Testing Sheet with Lists of Tests with Start/Stop Times, Keep Time Information as long as records are kept. *Medical Necessity can vary by Payer.

CNS VS Tools: Clinical and Quality Rating Instrument Coding

PRO – patient reported outcomes, medical and mental health assessment instruments

Health and behavior assessment procedures are used to identify the psychological, behavioral, emotional, and social factors important to the prevention, treatment, or management of biopsychosocial factors important to physical health problems and treatments. The focus of the intervention is to improve the patient's health and well-being utilizing ***cognitive***, behavioral, social, and/or psychophysiological procedures designed to enhance the management of specific disease-related problems. Evaluation and Management services should not be reported on the same day. For patients that require psychiatric services (90785 - 90899) as well as health and behavior assessment intervention (96150-96151), report the predominant service performed. Do not report 96150-96151 in conjunction with 90785-90899 on the same date or in conjunction with 03641 03651 03661 03671 03731 0374T.

Health and Behavior Codes

When used as part of a complete assessment.

		* Estimated National Average Practice Reimbursement
96150	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; Initial Assessment.	**$21 per 15 min.**
96151	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; Re-Assessment.	

http://downloads.cms.gov/medicare-coverage-database/lcd_attachments/30514_1/L30514_031610_cbg.pdf

SBIRT – Substance Abuse (AUDIT & DAST)

Payer	Code	Description	Fee**
Commercial Insurance	**99408**	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	**$35**
	99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	**$69**
Medicare	**G0396**	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	**$29**
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	**$58**
Medicaid	**H0049**	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	**$24**
	H0050	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	**$48**

http://www.integration.samhsa.gov/sbirt/reimbursement_for_sbirt.pdf

**May vary by state or payer.

CNS VS Tools: Clinical and Quality Rating Instrument Coding

PRO – patient reported outcomes, medical and mental health assessment instruments

Health Risk / Depression		* Estimated National Average Practice Reimbursement
99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)	$11
99420 G0444	Annual Depression Screening, 15 minutes	$11
99420 G8433	Screening for Clinical Depression Using an Age Appropriate Standardized Tool Not Documented, Patient Not Eligible/Appropriate	$11

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-for-Depression-Booklet-ICN907799.pdf

Documenting PQRS Quality Measures a CNS Vital Signs Advantage

Preparing for Future Reimbursement

Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

"Our goal is to have *85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018*. Perhaps even more important, our target is to have *30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018*."

Sylvia M. Burwell, Secretary DHS; New England Medical Journal; January 26, 2015

As you map the future strategic direction of your practice CNS Vital Signs offers many products, features and benefits that can help you navigate, respond and profit from the changing healthcare environment.

The Affordable Care Act is driving payment change in two significant ways:

- ***A greater emphasis on quality activities e.g., PQRS***
- ***The requirement for patients to pay high deductibles***

PQRS Tools: The CNS Vital Signs Advantage

PQRS (Physician Quality Reporting System) is a reporting program from the federal Centers for Medicare & Medicaid Services (CMS) for physicians and other providers. Previously, it was known as the Physician Quality Reporting Initiative (PQRI). It uses a combination of financial incentive payments and payment adjustments to promote reporting of quality information by what CMS calls eligible professionals (EPs). ***The efficiency of the CNS Vital Signs Assessment Platform and the PQRS Tools iPad App e.g., auto-scored, auto-audit, export to EMR capabilities both neurocognitive testing and PRO – patient reported outcomes, medical and mental health assessment scales can be valuable practice asset when collecting the necessary clinical endpoints and data recommended by professional societies e.g., AAN, APA as part of their quality or PQRS measures.***

List of PQRS Measures Supported by CNS Vital Signs

2015 Physician Quality Reporting System (PQRS): Implementation Guide
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_ImplementationGuide.pdf

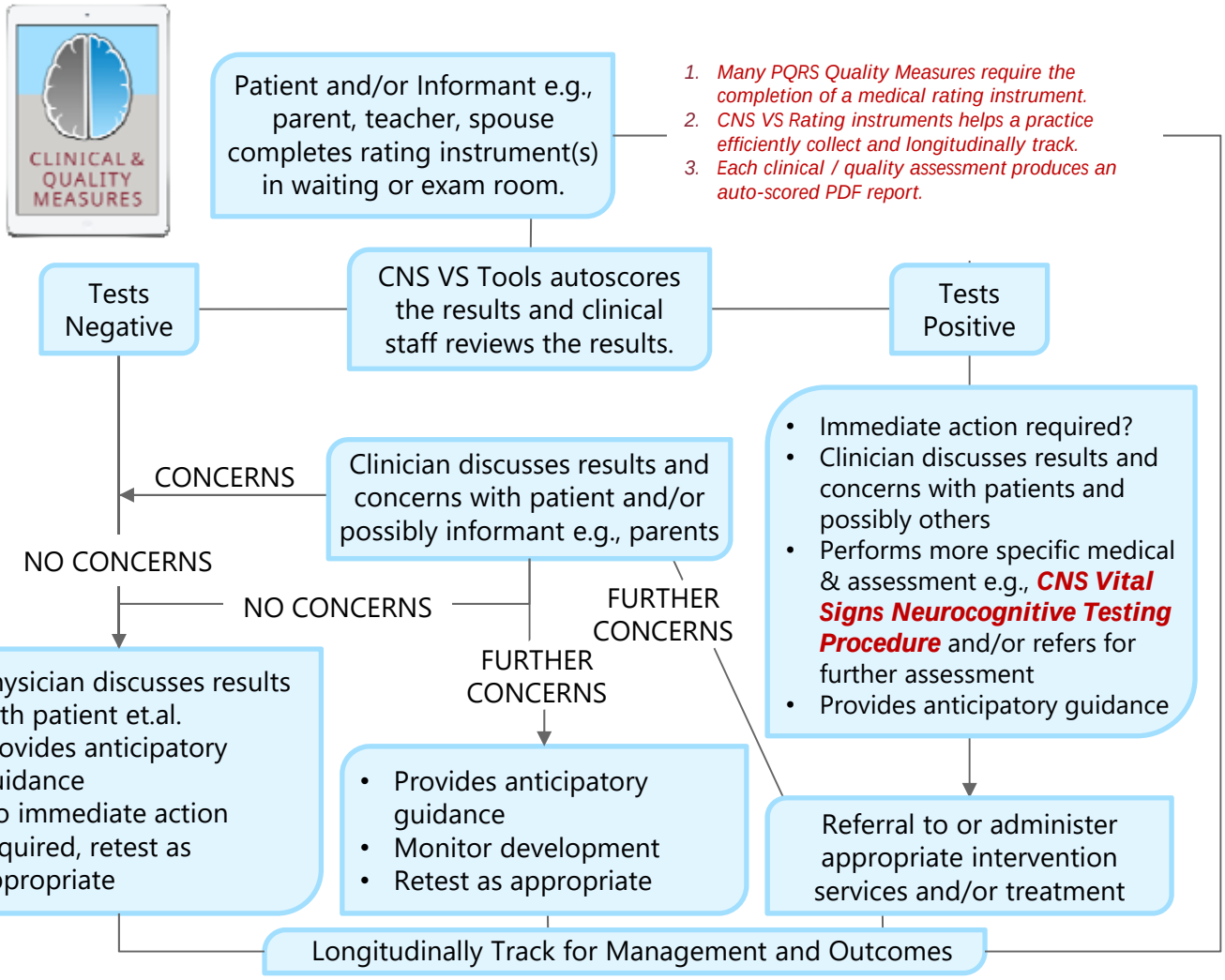
Measure Title	PQRS	Instrument	Measure Description
Preventive Care and Screening: Unhealthy Alcohol Use – Screening	173	AUDIT	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method**
Functional Outcome Assessment	182	MOS SF - 36	Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.
Sleep Apnea: Assessment of Sleep Symptoms	276	Epworth, Pittsburgh Sleep Quality Index	Percentage of visits for patients aged 18 years and older with a diagnosis of obstructive sleep apnea that includes documentation of an assessment of sleep symptoms, including presence or absence of snoring and daytime sleepiness
Sleep Apnea: Severity Assessment at Initial Diagnosis	277	Epworth, Pittsburgh Sleep Quality Index	Percentage of patients aged 18 years and older with a diagnosis of obstructive sleep apnea who had an apnea hypopnea index (AHI) or a respiratory disturbance index (RDI) measured at the time of initial diagnosis
Dementia: Staging of Dementia	280	*CNS Vital Sign Brief-Core Battery*	Percentage of patients, regardless of age, with a diagnosis of dementia whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period
Dementia: Cognitive Assessment	281	*CNS Vital Sign Brief-Core Battery*	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period
Dementia: Functional Status Assessment	282	MOS SF - 36	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period
Dementia: Neuropsychiatric Symptom Assessment	283	NPQ - 207 NPQ - 45	Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period
Dementia: Screening for Depressive Symptoms	285	PHQ - 9, Zung, GDS - 15 & 30	Percentage of patients, regardless of age, with a diagnosis of dementia who were screened for depressive symptoms within a 12 month period
Multiple Sclerosis: Disability Scale		Coming Soon	Percentage of patients with MS who have an MS disability scale score documented in the medical record in the past 12 months
Multiple Sclerosis: Fall Risk Screening		Coming Soon	Percentage of patients with MS who were screened for fall risk in the past 12 months
Multiple Sclerosis: Fatigue		Modified Fatigue Impact Scale	Percentage of patients with MS whose most recent score indicates results are maintained or improved on a validated fatigue rating instrument for patients with MS in the past 12 months
Multiple Sclerosis: Cognitive Testing		*CNS Vital Sign Brief-Core Battery*	Percentage of patients 18 years and older with MS who were tested for cognitive impairment in the past 12 months
Multiple Sclerosis: Depression Screening		PHQ - 9, Zung, CESD	Percentage of patients aged 12 years and older with MS who were screened for clinical depression using an age-appropriate standardized depression screening tool at least once in the past 12 months
Multiple Sclerosis: Depression Outcome		PHQ - 9, Zung, CESD	Percentage of patients aged 12 years and older with MS whose most recent score indicates results are maintained or improved on a validated depression screening instrument for patients with MS in the past 12 months
Multiple Sclerosis: Quality of Life		MOS SF - 36	Percentage of patients with MS whose most recent score indicates results are maintained or improved on an age-appropriate quality of life tool in the past 12 months
Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment	290	NPQ - 207 NPQ - 45	All patients with a diagnosis of Parkinson's disease who were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually
Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment	291	*CNS Vital Sign Brief-Core Battery*	All patients with a diagnosis of Parkinson's disease who were assessed for cognitive impairment or dysfunction at least annually
Parkinson's Disease: Querying about Sleep Disturbances	292	Epworth, Pittsburgh Sleep Quality Index	All patients with a diagnosis of Parkinson's disease (or caregivers, as appropriate) who were queried about sleep disturbances at least annually
Falls: Screening for Fall Risk	318	Dizziness Handicap Inventory	Percentage of patients 65 years of age and older who were screened for future fall risk at least once during the measurement period.
Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions	325	PHQ - 9 NPQ - 207 NPQ - 45	Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition
Depression Remission at Twelve Months	370	PHQ - 9, Zung, GDS - 15 & 30	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment
Depression Utilization of the PHQ-9 Tool	371	PHQ - 9	Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4 month period in which there was a qualifying visit.
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	382	PHQ - 9	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk

Clinical Instruments and Quality Measures Assessment Process Example

Clinical instruments and quality measure assessments are designed to identify patients, their level and type of impairment and who may need more intensive assessment or treatments. Early detection can result in a more timely initiation of appropriate interventions, which may improve clinical outcomes.

PQRS Measures Example: PHQ – 9

MEASURE #182 - Screening for Clinical Depression
Patient encounter during the reporting period (Billing Codes): 90791, 90792, 90832, 90834, 90837, 90839, 92557, 92567, 92568, 92625, 92626, 96116, 96118, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444



This is meant as a possible example. Adapted from: CDC

When clinical instrument testing is performed along with E/M services, Modier-25 may be required to be appended to the E/M code to show the service was distinct and necessary during the same visit. Generally, appropriate documentation, including showing the screening was given and action was taken, must be in the medical record if using this code. CNS Vital Signs supports your documentation needs by time and date stamping when the test was performed, identifying the test/tool used, autoscoring and presenting the testing results.

Medical Necessity

Neurocognitive / psychological testing is considered **medically necessary** generally**:**

- When there are mild or questionable deficits, and a more precise evaluation is needed to establish the presence of abnormalities or distinguish them from changes that may occur with normal aging or the expected progression of other disease processes e.g., neurodegenerative, MCI-Mild Cognitive Impairment (Healthy Aging/Prevention), Dementia, Parkinson's disease; HIV encephalopathy, Multiple Sclerosis, etc.
- When there is a need to objectively or in a standard way measure a patients mental or behavioral characteristics e.g., neuropsychiatric, developmental, AD/HD, Mental Health, Performance validity (feigning, malingering) of significant motivations and incentives like drug seeking, disability, accommodations, etc.
- When there is a need to quantify the deficits, particularly when the information will be useful in determining a prognosis e.g., Cerebrovascular disease or TBI (in the recovery/rehabilitation phase following significant clinical recovery when there is still evidence of cognitive impairment or as a guide to rehab and treatment planning, etc.
- When there is a need to evaluate, characterize and tailor medications and other treatment outcomes e.g., stimulants, PQRS quality measures, non-medication treatment effect, etc.
- When neuropsychological data can provide a more comprehensive profile of function that, when combined (integrated) with clinical, laboratory, and imaging data, may assist in evaluating and managing more complex neurological/psychiatric cases.

"Neuropsychological assessments provide measurements of brain function that are as objective, valid, and reliable as neuroimaging (Mattarazzo, 1990; Meyer, et al., 2001), and information from neuropsychological assessments directly impacts medical management of patients by providing information about diagnosis, prognosis, and treatment of disorders that are known to impact central nervous system (CNS) functioning... Indications for neuropsychological evaluations include a history of medical or neurological disorder compromising cognitive or behavioral functioning; congenital, genetic, or metabolic disorders known to be associated with impairments in cognitive or brain development; reported impairments in cognitive functioning; and evaluations of cognitive function as a part of the standard of care for treatment selection and treatment outcome evaluations (e.g., deep brain stimulators, epilepsy surgery). Neuropsychological assessments are not limited in relevance to patients with evidence of structural brain damage, and are frequently necessary to document impairments in patients with possible/probable neuropsychological and neurobehavioral disorders, and are the tool of choice whenever objective documentation of subjective cognitive complaints and validity testing are indicated. In children and adolescents, a significant inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional, or physical demands warrants a neuropsychological evaluation. Neuropsychological testing is not excluded from medical necessity based on diagnosis alone. Rather, indications for testing are based on whether there is known or suspected neurocognitive involvement or effects, or where neuropsychological testing will impact the management of the patient by confirmation or delineation of diagnosis, or otherwise providing substantive information regarding diagnosis, treatment planning, prognosis, or quality of life."
Adapted from: AACN NEUROPSYCHOLOGY MODEL LCD

Medical necessity may vary by payer so consultation with payers and carriers for definitive guidance on their policies is recommended.

Central Nervous System Assessments / Tests
(e.g. Neuro-Cognitive)

The AMA and the Center for Medical Services, or CMS, is the governing agency's that generally sets the procedure codes and how they are used. Regional or local insurance companies such as Medicare third party administrators, Blue Cross/Shield or large national carriers generally follow these rules but there can be regional differences or variances in both fees paid and utilization procedures. Even though the patient may not qualify for Medicare most payers design their benefit coverage rules according to CMS criteria

Who can Perform and Bill the Assessments?

With 10 Normed Neurocognitive tests and over 50 psychological, PRO, mental health and other rating scales there are many procedure codes that can be billed using the CNS Vital Signs testing platform technologies. For neurocognitive testing CMS guidance says quote *"…regulations allow a clinical psychologist (CP) or a physician to perform the general supervision assigned to …psychological and neuropsychological tests. In addition, nonphysician practitioners such as nurse practitioners (NPs), clinical nurse specialists (CNSs) and physician assistants (PAs) who personally perform …psychological and neuropsychological tests are excluded from having to perform these tests under the general supervision of a physician or a CP. Rather, NPs and CNSs must perform such tests under the requirements of their respective benefit instead of the requirements for psychological and neuropsychological tests. Accordingly, NPs and CNSs must perform tests in collaboration (as defined under Medicare law at section 1861(aa)(6) of the Act) with a physician. PAs perform tests under the general supervision of a physician as required for services furnished under the PA benefit. Furthermore, physical therapists (PTs), occupational therapists (OTs) and speech language pathologists (SLPs) are authorized to bill three test codes as "sometimes therapy" codes. Specifically, billing codes 96105, and 96111 may be performed by these therapists. However, when PTs, OTs and SLPs perform these tests, they must be performed under the general supervision of a physician or a CP." NOTE:* Each carrier/payer may have different testing and billing guidelines.

Billing on the same day as an office visit: What Modifiers?

Modifiers allow a clinician to indicate to a payer that there is something unusual about the way in which a particular service/procedure was provided e.g., billing for office visit and testing on the same day. *"The actual performance and/or interpretation of medically necessary tests ordered during a patient encounter are not included in the levels of E/M service. Physician performance of medically necessary tests for which specific CPT® codes are available may be reported separately, in addition to the appropriate E/M code."* Adapted from: AMA CPT® Manual

Modifiers 25, 59 and 52 are the most common modifiers used. The use and need of modifiers may vary so consultation with payers and carriers for definitive guidance on their policies is recommended. Carriers may determined that when psychological, neuropsychological or developmental testing and/or clinical and quality rating instrument coding is reported in conjunction with an assessment code e.g., 90791-90792 psychiatric evaluation exam, 96116 for neurobehavioral status exam or an E&M code, the time and effort to perform the testing itself is not counted toward the key components (history, physical exam and medical decision-making). Coding for the testing **administration / interpretation** and/or its **integration** into the overall patient evaluation are viewed by some payers as two separate and distinct services that are both above and beyond the office visit.

Modifier 59: Distinct procedural service code is used when procedures not usually reported together do occur appropriately on the same date of service. It indicates the procedure was distinct from the other procedures performed on that same date of service. For psychological and neurocognitive testing, modifier 59 (separate and distinct service) may be the most appropriate choice when billing the testing code combinations 96101 with 96102 and/or 96103, or 96118 with 96119 and/or 96120*. "Modifier 59 is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in time periods that are separate and distinct and not interspersed with each other (i.e., one service is completed before the subsequent service begins), modifier 59 may be used to identify the services."* Source: CMS Modifier 59. CMS provides a number of examples of correct and incorrect uses of 59, and then follows with examples for the new X [EPSU] modifiers. The new submodifiers XE (separate encounter), XP (separate practitioner), XS (separate structure) and XU (unusual non-overlapping service) or GT (telemedicine) may also be used and are generally for use only in the Medicare program.

Modifier 25: Significant, separately identifiable Evaluation and Management services by the same physician on the same day of service. Modifier 25 "a significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service. It may be necessary to indicate that on the day a procedure or service identified by a CPT® code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported." Modifier 25 may be the most appropriate choice when billing the Clinical and Quality Rating Instrument testing codes 96127 (PCS - Pediatric Symptom Checklist, Vanderbilt AD/HD, SCARED, Etc.), 96110, 99408 (Substance Abuse AUDIT & DAST), 99409, G0396, G0397, 99420 (Depression/Health Risk PHQ-9), G0444, G8433, etc. Modifier "25" signals that you have provided a separately identifiable E/M service.

Modifier 52: Reduced services. Some clinicians use this modifier with the integration code if the time to integrate the CNS Vital Signs test results (Neurocognitive testing, Clinical and Quality Rating Instruments) with information from other relevant clinical endpoints (Labs, MRI, Etc.) along with the clinical examination is 30 minutes or less. The use and need of modifiers may vary so consultation with payers and carriers for definitive guidance on their policies is recommended.

Denial of Coverage:

Most payers consider computerized neurocognitive assessment procedures medically necessary because the assessment procedure aids in the assessment of neurocognitive impairment due to medical or psychiatric conditions. Neurocognitive testing such as CNS Vital Signs helps clinicians better understand the nature of their patient's illness, in making recommendations regarding coping with and compensating for their neurocognitive difficulties, and encourages treatment adherence. Ultimately, the data accumulated from administering CNS Vital Signs can be used as an outcome measure or for generating clinical insights that improve current and future care strategies. If for some reason the carrier or plan denies coverage it is important to EDUCATE and INFORM the carrier or plan's personnel about the importance of covering the procedure. Example of denial letter exchange is available at the CNS Vital Signs website.

Central Nervous System Assessments / Tests
(e.g. Neuro-Cognitive)

Additional Coding Information:

About 96118 and 96101… These Codes are reported for psychological and neuropsychological test administration by the qualified health care professional with subsequent interpretation and report. It is also ***reported for the*** integration ***of information obtained from other sources which is then incorporated in the more comprehensive interpretation of the meaning the tests results in the context of all testing and assessments. The administration of the tests is completed for the purposes of a physical health evaluation and management.*** According to the AMA's CPT® Assistant: *"It would be unusual for neuropsychological testing to be conducted without prior clinical assessment and the integration of clinical and historical information. As a consequence, codes 96119 and 96120 may be reported in conjunction with 96118 so that information from these procedures is integrated with information obtained from other sources (e.g., a psychiatric interview, rating and PRO instruments, 96116) that will provide the foundation for a comprehensive report."* The potentially confusing aspect of this code is that when the qualified health care professional performs the tests personally, the test specific scoring and interpretation is counted as part of the time of 96101 and 96118. Adapted from: *AMA CPT® Assistant*, November, 2006.

About 96119 and 96102… *"The qualified health professional has previously gathered information from the patient about the nature of the complaint and the history of the presenting problems. Based on the clinical history, a final selection of tests to be administered is made. The procedures are explained to the patient, and the patient is introduced to the technicians, which administers the tests. During testing, the qualified health professional frequently checks with the technician to monitor the patient's performance and make any necessary modifications to the test battery or assessment plan. When all tests have been administered, the qualified health professional meets with the patient again to answer any questions."* Adapted from: *AMA CPT® Assistant*, November, 2006

About 96103 and 96120… These Codes are reported for the computer-administrated psychological and neuropsychological testing, with subsequent interpretation and report of the specific tests by a qualified health care professional. ***This should be reserved for situations where the computerized testing is unassisted by a provider or technician other than the installation of programs/test and checking to be sure that the patient is able to complete the tests.*** If greater levels of interaction are required, though the test may be computerized administer, then the appropriate physician/psychologist (96101/96118) or technician code (96102/96119) should be used.

"It is not unusual that the assessments may include testing by a technician and a computer with interpretation and report by the physician, psychologist or qualified health professional. Therefore, it is appropriate in such cases to report all 3 codes in the family of 96101-96103-or 96118-96120." Adapted from: *AMA CPT® Assistant*, November, 2006

About 96116… A neurobehavioral status exam is completed prior to the administration of neuropsychological testing. The status exam involves clinical assessment of the patient, collateral interviews (as appropriate and review of prior records. The interview ***would involved clinical assessment of several domains including but limited to; thinking, reasoning and judgment, e.g., acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities.*** The clinical assessment would determine the types of tests and how those tests should be administered. Adapted from: *AMA CPT® Assistant*, November, 2006 (NOTE: Some payers have recommended this code be used for CNS Vital Signs testing)

Code 96118 was revised in 2008 to clarify and differentiate appropriate reporting of services by the psychologist or physician from those testing services performed by the technician or computer administered tests (96119 and 96120). The revisions emphasize that the services reported with the time-based code (96118) are reported for clinician administered testing, interpretation of the results, report preparation, AND any additional necessary time for the ***integration*** of the test data acquired from the computer, technician testing or other data *(paper & pencil)* into the report. Modifier is not applicable if the professional provides the service. If the technician provides the service, it may be advisable to use the appropriate modifier. The modifier should be applied to any of the testing codes though probably best to attach to technician and/or computer codes (CMS, September, 2006).Simultaneous Use of Professional and Technical Codes Allowed by Medicare MLN Matters: MM5204 Revised, Effective December 28, 2006.

Medicaid Coverage Example: North Carolina

Outpatient Behavioral Health Services Clinical Coverage Policy No. 8-C Amended Date: August 1, 2014

Description of the Procedure, Product, or Service Outpatient behavioral health services include psychiatric and biopsychosocial assessment, individual, group, and family therapies, psychotherapy for crisis, and psychological testing for eligible NC Medicaid (Medicaid is NC Medicaid program, unless context clearly indicates otherwise) and NC Health Choice (NCHC is NC Health Choice program, unless context clearly indicates otherwise) beneficiaries… These services are intended to determine a beneficiary's treatment needs, and to provide the necessary treatment. Services focus on reducing psychiatric and behavioral symptoms in order to improve the beneficiary's functioning in familial, social, educational, or occupational life domains.

Outpatient behavioral health services are available to eligible beneficiaries and often involve the participation of family members, significant others, and legally responsible person(s) as applicable, unless contraindicated.

Based on collaboration between the practitioner and beneficiary, and others as needed, the beneficiary's needs and preferences determine the treatment goals, frequency and duration of services, as well as measurable and desirable outcomes.

1.1 Definitions 1.1.1 Psychological Testing Psychological testing involves the culturally and linguistically (CNSVS has 60 Languages) appropriate administration of standardized tests to assess a beneficiary's psychological or cognitive functioning. Testing results shall inform treatment selection and treatment planning. For Medicaid beneficiaries 21 and older and NCHC beneficiaries ages six to 18 years, Medicaid and NCHC cover one diagnostic assessment (90791 or 90792) and up to five units of one psychological testing assessment (96101, 96116, 96118) without a diagnosis of mental illness or a substance use disorder. This visit may be coded with a "V" diagnosis code. All other visits require an ICD-9-CM code between 290 and 319.

http://www2.ncdhhs.gov/dma/mp/8C.pdf

Psychiatric Evaluation… Psychological Testing Billing Codes

Code	Psychiatrist / MD	Psych NP	PA Incident to	LP/ LPA	Prior Authorization (PA) / Unmanaged Visit Limits
96101	X			X	BH visit limits/PA requirements apply; limit of five hours per date of service
96110	X	X	X	X	BH visit limits/PA requirements apply
96111	X			X	BH visit limits/PA requirements apply
96116	X			X	BH visit limits/PA requirements apply; limit of five hours per date of service
96118	X			X	BH visit limits/PA requirements apply; limit of five hours per date of service

Neuro / Cognitive / Psych Dysfunction ICD – 9, 10, DSM Codes

Carriers may have adopted Local Coverage Determination(s) (LCDs) which include a very specific list of ICD-10 Diagnosis Codes to be used for Neurological, Psychiatry and Psychological services which include CPT® Codes 96118, 96119, 96120 or 96101, 96102, 96103 and others. It is suggested that you check to see if your specific carrier has adopted such a policy. CNS Vital Signs can help report the patient's symptoms, behaviors, comorbidities and brain function. Use as many diagnosis codes as apply to help document the patient's E&M complexity.

ICD-10 and DSM-5 are described as being "companion publications". DSM-5 provides the most accurate and updated criteria for diagnosing mental disorders, making a common language for clinicians to communicate about their patients. ICD-10-CM contains code numbers found in DSM-5 to ensure proper insurance reimbursement and monitor health statistics by health agencies.

International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)-2015-WHO Version for ;2015

ICD - 9	Description ICD - 9	ICD-10, DSM	Description ICD - 10
F00–F99 – Mental and behavioral disorders			
		F00-F09	Organic, including symptomatic, mental disorders
294.10	Dementia in conditions classified elsewhere without behavioral disturbances code. First underlying condition	F02	**Dementia in other diseases classified elsewhere**
		F03	Unspecified dementia
		F04	Organic amnesic syndrome, not induced by alcohol and other psychoactive substances
		F06.7	**Mild cognitive disorder**
294.9	Cognitive Disorder NOS Not Otherwise Specified	F06.8	**Other specified mental disorders due to known physiological condition**
		F06.9	**Unspecified mental disorder due to brain damage and dysfunction and to physical disease**
		F07.0	Personality and behavioural disorders due to brain disease, damage and dysfunction; Organic personality disorder
		F07.2	**Postconcussional syndrome**
		F1.2	Dependence syndrome
		F1.6	**Amnesic syndrome**
		F1.7	Residual and late-onset psychotic disorder
		F01-1.9	Vascular dementia
		F10-F19	**Mental and behavioural disorders due to psychoactive substance use**

Neuro / Cognitive / Psych Dysfunction ICD – 9, 10, DSM Codes

ICD - 9	Description ICD - 9	ICD-10, DSM	Description ICD - 10
F00–F99 – Mental and behavioral disorders			
		F20-F29	Schizophrenia, schizotypal and delusional disorders
		F30-F39	Mood [affective] disorders
296.80	Bipolar disorder, unspecified	F31.9	**Bipolar disorder, unspecified**
311	Depressive disorder, not elsewhere classified	F32.9	**Major depressive disorder, single episode, unspecified**
296.32	Major depressive affective disorder, recurrent episode, moderate	F33.1	Major depressive affective disorder, recurrent episode, moderate
296.30	Major depressive affective disorder, recurrent episode, unspecified	F33.9	Major depressive affective disorder, recurrent episode, unspecified
296.33	Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior	F33.2	Major depressive disorder, recurrent severe without psychotic features
300.4	Dysthymic disorder	F34.1	Dysthymic disorder
		F40-F48	Neurotic, stress-related and somatoform disorders
300.00	Anxiety state, unspecified	F41.1	Generalized anxiety disorder
		F41.8	Other specified anxiety disorder
		F41.9	Anxiety state, unspecified
309.81	Posttraumatic stress disorder	F43.10	**Posttraumatic stress disorder, unspecified**
		F43.11	Posttraumatic stress disorder, acute
		F43.12	Posttraumatic stress disorder, chronic
309.0	Adjustment disorder with depressive mood	F43.21	Adjustment disorder with depressed mood
309.28	Adjustment disorder with mixed anxiety and depressed mood	F43.23	Adjustment disorder with mixed anxiety and depressed mood
		F44	**Dissociative [conversion] disorders**
		F50-F59	Behavioral syndromes associated with physiological disturbances and physical factors
		F50	Eating disorders
		F89	**Unspecified disorder of psychological development; Incl.: Developmental disorder NOS**
314.	ADHD of childhood	F90.0	**ADHD, predominantly inattentive type**
314.01	Attention deficit disorder with hyperactivity	F90.1	**Attention-deficit hyperactivity disorder, predominantly hyperactive type**
294.9	Cognitive Disorder Not Otherwise Specified	F99	**Mental disorder, not otherwise specified**

Neuro / Cognitive Dysfunction ICD – 9, 10, DSM Codes

Diseases of the Nervous System: Key updates to the Nervous System chapter include: *Classification improvements (significant changes to sleep disorders); Code expansions (Alzheimer's, headaches); Updates to medical terminology (epilepsy, seizures); Codes for TIA are now included; the sense organs (eye/adnexa and ear/mastoid processes) have their own chapters.* Brain and nervous system problems are common. Diseases of the nervous system include multiple sclerosis, Alzheimer's disease, Parkinson's disease, epilepsy, and stroke, and can affect neurocognitive function and the ability to perform daily activities.

ICD - 9	Description ICD - 9	ICD-10	Description ICD - 10
G00–G99 – Diseases of the nervous system			
		G10-G14	Systemic atrophies primarily affecting the central nervous system
		G10	Huntington disease
		G20-G26	Extrapyramidal and movement disorders
332.0 - 332.1	Parkinson's disease	**G20**	**Parkinson's disease**
		G30-G32	Other degenerative diseases of the nervous system
331.0	Alzheimer's disease	G30.0	Alzheimer's disease with early onset
		G30.9	Alzheimer's disease, unspecified
		G31.01 - G31.9	**Other degenerative diseases of nervous system, not elsewhere classified**
		G31.2	Degeneration of nervous system due to alcohol; encephalopathy
		G31.84	**Mild cognitive impairment, so stated**
		G31.9	Degenerative disease of nervous system, unspecified
		G35-G37	Demyelinating diseases of the central nervous system
340	Multiple sclerosis	**G35**	**Multiple sclerosis**
		G40-G47	Episodic and paroxysmal disorders
345.00 - 345.91	Epilepsy and recurrent seizures	G40	**Epilepsy**
		G43	Migraine
		G44	Other headache syndromes
		G47	**Sleep disorders**
327.20	Organic sleep apnea, unspecified	G47.30	Sleep apnea, unspecified
327.23	Obstructive sleep apnea (adult) (pediatric)	G47.33	**Obstructive sleep apnea (adult) (pediatric)**
		G47.9	**Sleep disorder, unspecified**

Neuro / Cognitive Dysfunction ICD – 9, 10, DSM Codes

ICD - 9	Description ICD - 9	ICD-10	Description ICD - 10
G00–G99 – Diseases of the nervous system			
		G90-G99	Other disorders of the nervous system
		G93.4	**Encephalopathy, unspecified**
		G93.9	**Disorder of brain, unspecified**
		G96.8	**Other specified disorders of central nervous system**
		G98	Other disorders of nervous system, not elsewhere classified
		G99	Other disorders of nervous system in diseases classified elsewhere
E00-E90 Endocrine, nutritional and metabolic diseases			
		E10-E14	Diabetes mellitus
		E14	Unspecified diabetes mellitus
		E14.4	**Unspecified diabetes mellitus with neurological complications**
		E14.7	With multiple complications
		E14.8	**With unspecified complications**
I00-I99 Diseases of the circulatory system			
		I60-I69	Cerebrovascular diseases
		I67.4	**Hypertensive encephalopathy**
437.9	Cerebrovascular insufficiency	I67.9	Cerebrovascular disease, unspecified
		I69.01 I69.11 I69.21 I69.31 I69.81 I69.91	**Cognitive deficits following cerebrovascular disease**
R00-R99 Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified			
		R40-R46	Symptoms and signs involving cognition, perception, emotional state and behaviour
		R41	**Other symptoms and signs involving cognitive functions and awareness**
		R41.1	Anterograde amnesia
		R41.2	Retrograde amnesia
780.93	Memory loss	R41.3	Other amnesia
Note that in ICD-10-CM, if the term ''memory loss'' is used in relation to brain injury instead of ''amnesia,'' the code becomes a nonspecific psychiatric code F06.8, Other specified mental disorders due to known physiological condition. Source: Continuum 2014;20(6):1692–1703			
799.55	Frontal lobe and executive function deficit	R41.844	**Frontal lobe and executive function deficit**

Neuro / Cognitive Dysfunction ICD – 9, 10, DSM Codes

ICD - 9	Description ICD - 9	ICD-10	Description ICD - 10
S00 - Injury and certain other consequences of external causes			
		S00-T98	Injury, poisoning and certain other consequences of external causes
		S00-S09	Injuries to the head
850	Concussion	S06	Concussion; Intracranial injury
		S06.2	Diffuse brain injury; contusion NOS
		S06.3	Focal brain injury contusion NOS
909.3	late effect of complications of surgical / medical care e.g., ChemoBrain	T50.9055	Adverse effect of unspecified drugs, medications, or biological substances, sequela.
About Reimbursement for Attention Deficit Testing			
314.	ADHD of childhood	F90.0	ADHD, predominantly inattentive type
314.01	Attention deficit disorder with hyperactivity	F90.1	Attention-deficit hyperactivity disorder, predominantly hyperactive type
		F90.2	Attention-deficit hyperactivity disorder, combined type
		F90.8	Attention-deficit hyperactivity disorder, other type
		F90.9	**Attention-deficit hyperactivity disorder, unspecified type**
799.55	Frontal lobe and executive function deficit	R41.844	**Frontal lobe and executive function deficit**

Neurocognitive assessments may be deemed medically un-necessary for uncomplicated (primary care, school psychologist) cases of attention deficit disorder with/without hyperactivity (ADHD). If a patient is clearly seeking the testing for educational reasons e.g., special accommodations such as extended time on testing or other special services in school, these services generally, are provided by school systems under applicable state and federal rules and generally are not reimbursed by insurance carriers. Most benefit plans exclude coverage of educational testing. Check the patients benefit plan as payment may need to be paid directly to the practice by the patient for the services. However, many employer based benefits have special set-aside health accounts that can be used for payment of neurocognitive assessments for AD/HD if the health plan deems the procedure medically unnecessary. Health plans may reimburse and consider the procedure medically necessary for the evaluation and management of complicated cases e.g. executive dysfunction, examining expanded developmental concerns, neurologically complicated cases of ADHD, e.g., post head trauma, seizures, or comprehensive bio-psychosocial treatment for these disorders in collaboration with primary care physicians and other specialists.

NOTE: Your state may have a special EPSDT Provision: "Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible."
Source NC Medicaid

High Patient Deductibles: The CNS Vital Signs Advantage

One of the biggest trends impacting healthcare today is a shift towards high deductible plans. While the shift to high deductible insurance plans started well before the Affordable Care Act (ACA), the government mandated health insurance and associated health insurance exchanges have accelerated the high deductible growth.

High deductible plans mean a major shift in who will be paying the bill. Practices will need to be effective at collecting from insurance companies and from patients as well. This movement to the empowered patient with a high deductible insurance plan is not likely to go away. The spread of consumer driven health plans could have a profound impact on how practices interact with patients. Marketing a practices services / procedures will be a key capability going forward.

"Here are the… insights attendees shared: ***Direct-to-patient marketing is rapidly becoming the new specialist growth strategy***… Our referral volumes from PCPs have gone down. If we're seeing any growth, it's from the direct patient shopper." Market consolidation and PCP employment by hospitals make it difficult for independent specialists to convince PCPs to redirect their referrals. Furthermore, with the ***upsurge in the number of patients with high deductible health plans***, even if PCPs direct their referrals to independent groups, specialists feel that "PCPs have less power than they used to" and "***patients are making their own care decisions, regardless of PCP referrals***." Which is why ***direct-to-patient marketing initiatives may become more effective than referring physician outreach in some markets***."

SOURCE: 2014 The Advisory Board Company Health Care Consulting National Summit

CNS Vital Signs has customizable tools and capabilities to assist in the marketing of Neurocognitive Care to HIGH DEDUCTIBLE patients.

Capabilities: Current guidelines and quality care measures reinforce the need for a longitudinal view of a patients cognitive and neuropsych function. The CNS Vital Signs assessment platform is designed to enable the longitudinal mapping of each patient which helps tie the patient to the practice.

Tools: Customizable Marketing Packages are freely available to client practices.

Advertising

Clinic Handouts

Patient Ed

Small Poster