

Note, February 2006: This is time sensitive information. This document supersedes any previous reimbursement document(s) prepared by Pearson Assessments. Much of the information relied upon in the Q & A section is taken from the 2006 Testing Codes Toolkit from the APA Practice Organization, which is available at <http://www.apapractice.org/apo/toolkit.html#>. **Checking this web site to confirm that you have the latest interpretation is strongly advised.**

Pearson Assessments has compiled this information for your convenience. The information provided below is not intended as specific coding or legal advice. Healthcare practitioners who seek reimbursement for use of our tests should follow the direction of coding and legal experts familiar with the policies of the specific third party payer from whom they will seek the reimbursement. It is the healthcare practitioner's responsibility to document the medical necessity of services rendered. The following represents general guidance only.

INTRODUCTION: Pearson Assessments publishes and distributes the MMPI-2™, the MCMI-III™ and certain biopsychosocial diagnostic instruments, including the P-3®, the BBHI™ 2, the BHI™ 2, the MBMD™ and the BSI® 18 tests, that assist healthcare practitioners in the assessment of psychological factors that can affect the effective diagnosis and treatment of patients in general practice areas as well as certain specialized practice areas. For reporting and billing purposes, biopsychosocial tests may fall under different procedure codes depending on the following criteria: intent of test, if service meets the code description, the supporting documentation and provider qualifications. To facilitate reader understanding the following sections will address the criteria. A fourth section is dedicated Common Questions.

I. BILLING CODES

Submitting claims for payment requires, at a minimum, use of two coding systems. CPT codes are required for reporting the healthcare practitioner services. *The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)* diagnosis codes are required for all profession claims, e.g. physicians and non-physician practitioners; ambulance suppliers' claims are the only exception.¹

Central Nervous System Assessments/Tests

CPT Codes 96101-96103^{2*}

- 96101** Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI®, Rorschach®, WAIS®), 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.
- 96102** Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI, and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face.
- 96103** Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, e.g. MMPI), administered by a computer, with qualified health care professional interpretation and report.

*Effective January 1, 2006, 96100 was deleted for Medicare reimbursement. Other insurance carriers may adopt these policies.

INTENT: When biopsychosocial tests are used following a determination of the test's medical necessity for the specific patient, who has been diagnosed with a mental disorder previously, based on signs and symptoms (which may include, for example: anxiety, depression, somatization, non-specific pain, loss of function), qualified providers may consider CPT codes 96101–96103, for reporting services to Medicare or other third party payers.

DESCRIPTION DETAILS: CPT code 96101 is associated with 1-hour increments of psychologist/physician time including **face-to-face time with the patient and time interpreting test results and preparing the report**. CPT code 96102 is associated with 1-hour increments of technician time including **face-to-face time for administration**. CPT code 96103 is associated with a flat rate for **testing conducted by a computer**.

These codes specify who administers a test and how long it takes. Testing conducted by a psychologist/physician is billed in hourly units, based on the number of hours [they] spend administering a test and interpreting and reporting test results. Testing by a technician is based on the number of hours the technician spends administering a test. Testing conducted by computer is billed at a flat rate using a single code³.

The time spent should be combined and included when reporting the services and documented as such in the patient file. The payer may require that the 1-hour block of time occur in a single day. If the 1-hour block of service spans several days, the payer may permit the entire 1-hour block of time to be reimbursed if claimed on the last day that the testing service is provided.

Possible ICD-9-CM Diagnosis Codes⁴ used to support CPT codes 96101–96103 and medical necessity*:

290.0–299.91	Dementias through pervasive developmental disorders
300.00–319	Anxiety, dissociative and somatoform disorders through unspecified mental retardation
783.40	Lack of normal physiological development, unspecified
783.42	Delayed milestones

*The ICD-9-CM diagnosis codes listed have previously been reported with CPT Code 96100⁵, which has now been replaced with 96101–96103 codes.

Health and Behavioral Assessment/Intervention Codes (HBI)

CPT Codes 96150–96151

96150	Health and behavioral assessment (e.g., health-focused clinical interview, behavioral observations, psychophysical monitoring, health-oriented questionnaires), each 15 minute face-to-face with the patient; initial assessment
96151	Health and behavioral assessment (e.g., health-focused clinical interview, behavioral observations, psychophysical monitoring, health-oriented questionnaires), each 15 minute face-to-face with the patient; re-assessment

INTENT: If a patient has a physical condition, and one of the previously mentioned tests is administered to determine the biopsychosocial factors in relation to the treatment, or management of the physical health problems, and the provider’s scope of practice permits performance of the service and the requirements described by the CPT codes definitions are fulfilled, then the Health and Behavioral Assessment/Intervention (HBI) CPT codes 96150–96151 may apply.

DESCRIPTION DETAILS⁶: HBI codes report assessment of psychological, behavioral, emotional, cognitive, and relevant social factors that can help to prevent, treat, or manage physical health problems. The assessment must be associated with an acute or chronic illness, the prevention of a physical illness or disability, and the maintenance of health. The initial assessment (96150) and re-assessment (96151) apply to each 15-minute direct, face-to-face session with the patient. A reassessment (96151) is reported to obtain objective measures of goals formulated in the initial assessment and to modify plans as is indicated to support the goals.

ICD-9-CM Diagnosis Codes that have been reported with 96150–96151’:

- V15.81 Personal history of noncompliance with medical treatment, presenting hazards to health
- V62.89 Other psychological or physical stress, not elsewhere classified

II. DOCUMENTATION

Each third party payer may have its own requirements for patient file documentation related to biopsychosocial testing. The practitioner should request and follow specific requirements from the third party payer. In addition, local Medicare carriers may have their own requirements regarding documentation. It is always recommended to check with your local carrier for their specific requirements. Requirements can vary depending on the procedure done and the applicable codes. For reader convenience, specific suggested documentation required to support use of CPT code 96101–96103 is listed first followed by general patient file documentation.

Suspicion of Mental Illness Documentation Required to Support CPT Code 96101–96103:

The patient file must indicate the presence and diagnosis of mental illness or signs of mental illness for which psychological testing is indicated as an aid in the diagnosis and therapeutic planning. The patient file must show the tests performed, scoring and interpretation, as well as the time involved.

Establish the need for administering the test. As an example:

- Because the patient showed indications of depression, anxiety or anger
- Because the referring physician noted a suspicion of mental illness
- Because the patient’s symptoms are inconsistent with objective medical findings

Note what the test results suggested. After reviewing the report, note the information you find most relevant for the patient. As an example:

- The patient reported depression symptoms
- The patient reported a broad pattern of somatic complaints that are inconsistent with medical findings
- The patient reported suicidal ideation

Note the implications for treatment. As an example:

- The patient was referred for further psychological evaluation
- The patient was referred for chronic pain treatment
- The patient was started on a trial of antidepressant medication

General Patient Record Documentation Suggestions

At a minimum, it is suggested that the use of biopsychosocial testing should be documented to include the following information, including time documentation where appropriate.

- Patient was in the office
- Medical Necessity of test described. Medical necessity may also be established if a referring physician states suspicion of mental illness, saying, for example “the patient appears to be depressed, please evaluate.”
- Patient exhibited symptoms which resulted in a suspicion of mental illness (anxiety, depression, somatization, nonspecific pain, loss of function)
- Documentation of any physical condition that exists
- Appropriate test selected
- Who administered the test
- Length of time spent for face-to-face administration, and interpretation and reporting the test (if modifier is used, include explanation for reduced services)
- Scoring of test
- Interpretation of test (if by computer, with summary by physician to be added). Computer interpretive report to be maintained in patient file

- Time spent integrating the test interpretation and writing the comprehensive report based on the integrated data. Summarize tasks, which might include the practitioner’s interpretation of a test’s overall pattern of scores and the report in the context of:
 - Observed behavior/symptoms
 - Purpose of evaluation
 - Legal context
 - Primary, secondary or tertiary gain
 - Medical diagnosis
 - Medical history
 - Behavioral history
 - Social setting (work comp, etc.)
 - IQ
 - Literacy
 - Ethnicity
 - Gender
 - Clinical impressions
 - Results of other psychological or medical tests
 - Effect of prescribed or illegal drugs
- Treatment, including, if applicable, how test results affect the prescribed treatment
- Follow-up administration of test to measure efficacy of procedure
- Outcomes
- Recommendation for further testing

III. QUALIFIED PROVIDER

CPT code 96101–96103 is a Part B Mental Health Service. Providers of mental health services must be qualified to perform the specific mental health services that are billed to Medicare. Part B mental health services provider qualifications can be found in the Centers for Medicare and Medicaid Services (CMS) Program Memorandum Transmittal AB-03-037, March 28, 2003. See Appendix A for copy.

HBI codes are not considered Part B mental health services. To be qualified to provide HBI services the medical practitioner must be operating within the scope or his or her license as determined by the State in which the services are performed.⁸

IV. COMMON QUESTIONS

Note: Much of this information, as referenced, has been published by the APA (American Psychological Association) Practice Organization.

Q1. Who can bill using these revised codes?

A The definition of the 96101 code states “per hour of the psychologist’s or physician’s time”. As stated in the Introduction to the *CPT® Professional Edition–2006* book:

“It is important to recognize that the listing of a service or procedure and its code number in a specific section of this book does not restrict its use to a specific specialty group. Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician or other qualified health care professional.”⁹

Q2. If a patient is administered a test via a computer (e.g.: Q Local™ or PAD) with no face-to-face professional time and a psychologist/physician spends one hour integrating the test results and writing a comprehensive report based on the integrated data, how could this be billed?

A 96103 (which is a single, flat-payment rate that is not measured in units) and one unit of 96101 appear to be the most appropriate codes to bill. In this scenario, 96103 includes the test administration and the test results. 96101 includes the integration of test results and writing a comprehensive report based on the integrated data.

Q3. If a patient is administered a test via a computer (e.g.: Q Local or PAD) while the psychologist/physician is in the room and available for questions (face-to-face professional time) and a psychologist/physician spends time integrating the test results and writing a comprehensive report based on the integrated data, how should this be billed?

A When all aspects of the testing, interpretation and report are conducted by the psychologist, the psychologist code [96101] is used to account for all of the time¹⁰.

Q4. How do I handle billing for the interpretation and reporting of test results?

A Time that the psychologist spends conducting the **comprehensive interpretation and report based on the integrated data** is billable under the psychologist code [96101].

When interpretations of individual tests are combined with interpretations for other tests that are part of the evaluation, clinical interview information, prior historical information—including but not limited to educational, medical and psychological records and/or tests—as well as behavioral observations [see **General Patient Record Documentation Suggestions** section above for more examples], the psychologist's time spent on that portion of work is billed separately from the technician and computer codes.

When the testing is administered by a technician or a computer, the time that the psychologist spends interpreting and reporting on the individual tests is included in the [96102 and 96103] code payment [this appears to cover the initial reading and understanding of the test results].¹¹

Q5. If I spend less than an hour on interpretation and reporting the integrated data can I bill for a full hour?

A If you spend less than an hour—above and beyond the initial interpretation—to interpret and report on the aggregate data, then you may count that time as follows: If you spend 30 minutes or less, then you must bill the code using the -52 modifier which indicates a reduced service. If you spend more than 30 minutes then you may bill for the full hour. The same applies to billing the technician code if the technician spends less than one hour on testing.¹²

Q6. How do I bill for fractions of an hour beyond the first hour of service?

A If less than 30 minutes is spent on a service, that time cannot be billed. If 31 minutes or greater is spent, then you may round up to the next hour.¹³

Q7. Is the time spent scoring a test a billable activity?

A Scoring is not a billable activity unless [the scoring] is done while the professional or technician is face-to-face with the patient during the test administration.¹⁴

Q8. If a patient takes a paper-and-pencil administered test, what code should be used?

A It depends. If a psychologist is with the patient during the test, then that time is allocated to the psychologist code [96101]...If the patient is entirely on his or her own during the test, that time is not billable.¹⁵

Q9. When is the computer billing code used?

A The computer code is used when the patient takes a computer-based test and there is no involvement in the administration of the test by either a psychologist or a technician. Scoring by computer is not a billable activity.¹⁶

Q10. Can CPT codes 96101 and 96103 be used concurrently?

A It depends. It appears that these codes *can* be used together in these situations:

When a patient takes one or more tests via computer and another test is administered involving face-to-face time with a psychologist OR when a patient takes one or more tests via computer and the psychologist spends time—**above and beyond the initial interpretation**—to interpret and report on the aggregate data. Note the following example.

Billing example #5: A patient completes two hours of computerized testing, and the psychologist interprets and reports the outcomes. Then the psychologist conducts two hours of testing and the remaining interpretation and comprehensive report takes one hour. He or she would bill for the computer-based code [96103] (which is a single, flat-payment rate that is not measured in units) and three units of the psychologist-based code [96101].¹⁷

Q11. If I conduct an MMPI-2™ as part of neuropsychological testing, should I bill using the psychological testing code during that portion of the battery?

A No. Coding is not based on the tests that are conducted. It is based on the reason for testing. If you are testing a patient for neuropsychological functions, then the neuropsychological testing codes should be used no matter which tests are done.¹⁸

Q12. What is the definition of “technician” under the revised codes?

A The revised codes do not include a definition of a technician. The question of who can serve as a technician for purposes of psychological or neuropsychological testing may be determined by state law and/or coverage policies of third party payers. In addition, Division 40 of APA, the American Academy of Clinical Neuropsychology, and the National Academy of Neuropsychology all have policies on the use and training of technicians, and define administration and scoring as appropriate roles for them. (Copies of those policies are included in the 2006 Testing Codes Toolkit).¹⁹

Q13. Can students or other unlicensed individuals interpret and report test results?

A No. Only a licensed psychologist or other licensed health care professional may bill for time spent on interpretation and reporting psychological tests.²⁰

Q14. How can I facilitate prompt payment of my services?

A First make sure you have met intent, coding, documentation and provider qualification criteria addressed previously. For non-Medicare payers check to determine if the patient’s policy covers service and if prior authorization of services is required. Also check to see if service is considered a mental health service requiring claims submission to an address different from where medical claims are sent.

Q15. What if biopsychosocial testing is mandated by a third party payer?

A When a particular biopsychosocial test has been mandated by the third party payer, the addition of a modifier (for example modifier 32 mandated services) may need to be appended to the pertinent CPT code.

Q16. What other sources of information are available for CPT coding?

A *CPT® Professional Edition manual*. The new codes are published in the *CPT® 2006 Professional Edition manual*, which is available at AMA (American Medical Association) at 1.800.621.8335.

CPT® Information Services (CPTIS). This is a service offered by AMA. AMA members receive complimentary subscription to CPTIS, while for others, this is a fee-for service resource. The Coding Helpline is 1.800.634.6922.

2006 Testing Toolkit. The APA Practice Organization has published a toolkit which contains information and materials to help you learn about the proper use of the psychological CPT testing codes and payment for these codes. The toolkit can be found at <http://www.apapractice.org/apo/toolkit.html#>.

THE INFORMATION PROVIDED WITH THIS NOTICE IS GENERAL REIMBURSEMENT INFORMATION ONLY AS OF 2/1/06; IT IS NOT LEGAL ADVICE, NOR IS IT ADVICE ABOUT HOW TO CODE, COMPLETE OR SUBMIT ANY PARTICULAR CLAIM FOR PAYMENT. ALTHOUGH WE SUPPLY THIS INFORMATION TO THE BEST OF OUR CURRENT KNOWLEDGE IT IS ALWAYS THE PROVIDER’S RESPONSIBILITY TO DETERMINE AND SUBMIT APPROPRIATE CODES, CHARGES, MODIFIERS AND BILLS FOR THE SERVICES THAT WERE RENDERED. THIS INFORMATION IS PROVIDED AS OF THE DATE LISTED ABOVE, AND ALL CODING AND REIMBURSEMENT INFORMATION IS SUBJECT TO CHANGE WITHOUT NOTICE. PAYERS OR THEIR LOCAL BRANCHES MAY HAVE THEIR OWN CODING AND REIMBURSEMENT REQUIREMENTS AND POLICIES. BEFORE FILING ANY CLAIMS, PROVIDERS SHOULD VERIFY CURRENT REQUIREMENTS AND POLICIES WITH THE PAYER.

¹ DHHS, CMS Program Memorandum, Transmittal B-03-045, June 6, 2003.

² *Current Procedural Terminology* © 2005 American Medical Association. All Rights Reserved.

³ 10–20 2006 Testing Codes Toolkit. Retrieved February 20, 2006 from <http://www.apapractice.org/apo/toolkit.html#>.

⁴ *2006 Annual Hospital Version ICD-9-CM, 5th Edition*. Channel Publishing, Ltd. The circumstances of inpatient admission govern the selection of principal diagnosis.

Guidelines for selection of principle diagnosis can be found in *Coding Clinic for ICD-9-CM, 2Q*, 1990, pp. 3–16.

⁵ EncoderPro software © 2005 Ingenix, Inc.

⁶ Ibid.

⁷ Ibid.

⁸ Code of Federal Regulations, Title 42, Part 410, Section 20(b).

⁹ *Current Procedural Terminology* © 2005 American Medical Association. All Rights Reserved.