Assessment in Primary Care

Melissa Baker, PhD, ABPP

January

Didactic

Hello.

- What do you want to be when you grow up?
  - I went to graduate school because I was inspired by Autism Assessments. I worked the front desk at the UW Autism Clinic and Child Development Clinic for 2 years, then worked behind the scenes doing intakes for assessments for another 2 years. I probably have seen thousands of ADOS… I was intrigued by the precision of testing and the impact I thought it could make
- Sometimes the path you think you are headed towards takes an unexpected (amazing) turn
  - I have worked at HealthPoint for 15 years, 5 years as Education Program Director, just over a year as BH Director
  - I am invested in PCBH, and believe PCBH needs to continue to adapt with the demands of healthcare BUT without losing the core of what PCBH is… GATHER
  - I hope today's lecture leaves you curious, asking questions, and likely still have questions unanswered.
  - My expertise is PCBH, not assessments.

What about you?

- What interest/experience do you have in assessments?
- What role do you see assessments playing in patient care? Diagnosis? Treatment Plans? Court?
- What are your thoughts about assessment in primary care?
  - Do assessments have a place in the PCBH model? Why or Why not? Or does it depend?
  - How would it help/hinder population-based care?
  - Ethical concerns?
  - Diversity concerns?

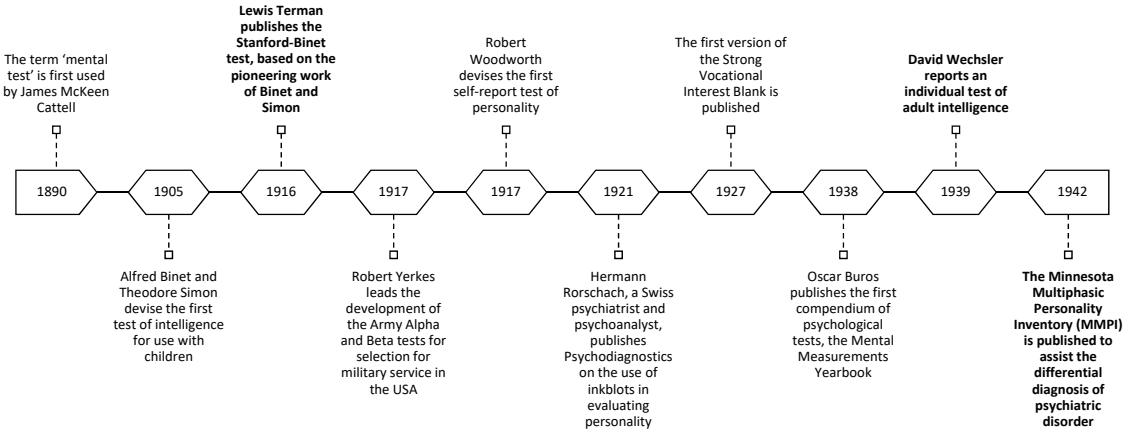
Goals for Today

- A brief history of testing (set the scene)
- Types of Tests and Assessments
- The State of Primary Care
- 3rd wave CBTs and Assessments: Friends or Foes?
- Billing for Assessments
- Pathway examples from primary care (ASD)

A Brief History (Review)

- The origins of psychological testing can be found in the public service examinations used by Chinese dynasties to select those who would work for them. These were large-scale exercises involving many applicants and several days of testing, and from the era of the Han dynasty involved written examinations (Bowman, 1989)
- Alfred Binet (1857–1911) was asked by the Office of Public Instruction in Paris to provide a method for objectively determining which children would benefit from special education. In responding to this request, Binet devised the first of the modern intelligence tests,
- The development and application of psychological tests is considered one of the major achievements of psychologists in the last century (Zimbardo, 2004).
- For the most part, tests are used to assist in making decisions or promoting self-understanding by providing more accurate information about human behavior than is available without them.

Timeline of major developments in the history of psychological Assessment



Timeline of major developments in the history of psychological Assessment

- 1948 Henry Murray and colleagues publish Assessment of Men and the term 'assessment' comes to replace mental testing as a description of work with psychological tests
- 1957 Raymond Cattell publishes on performance tests of motivation
- **1962 Computer interpretation of the MMPI is introduced**
- **1968 Walter Mischel publishes his widely cited critique of personality assessment**
- 1970 Computers are used for testing clients; computerized adaptive testing follows
- 1971 The Federal Court in the USA challenges testing for personnel selection
- 1985 Publication in the USA of the first edition of the Standards for Educational and Psychological Testing
- **1988 Jay Ziskin and David Faust challenge the use of psychological test results in court**
- 1993 The American Psychological Association publishes guidelines for computer-based testing and interpretation
- 1993 John Carroll publishes Human Cognitive Abilities: A Survey of Factor-Analytic Studies, in which he proposes his three-stratum theory of intelligence
- 1999 Publication of the second edition of the Standards for Educational and Psychological Testing
- **2001 Gregory Meyer and colleagues publish the results of a review of 125 earlier literature reviews indicating the value of psychological tests**

APA's WHY

- "Psychological testing may sound intimidating, but it's designed to help you. Psychologists use tests and other assessment tools to measure and observe a client's behavior to arrive at a diagnosis and guide treatment"
- For clinical psychologists, assessment is only second to psychotherapy in terms of its professional importance (per APA)
  - Some individuals believe a psychologist's ability to do assessments differentiate psychologists from the rest of the field? Do you agree/disagree?
- If a psychological test(s) can help with diagnosis and treatment plan, how come it is not a standard practice to do them for every patient seeking mental health care?

(APA website)

What is....

- What is a psychological test? This seems to be a difficult question to answer when one examines the plethora of published tests in the market and finds that they can differ in so many respects.
- While some psychological tests take only a few minutes to complete, others can take hours to administer.
- For some psychological tests:
  - a respondent is required to provide only a simple yes/no answer
  - Other tests are designed in such a way that a person must navigate and respond in a virtual reality environment.
  - Some psychological tests can be administered to hundreds of people at one time and scored and interpreted by a computer
  - Other tests require face-to-face administration and individual scoring and interpretation that require years of training and experience.

What is a test vs assessment

Basis of the Difference	**Psychological Testing**	**Psychological Assessment**
Degree of Complexity	Simpler, involve one uniform procedure, frequently unidimensional	More complex, each assessment involves various procedures (interviewing, testing, observation) and dimension
Duration	Shorter, lasting a few minutes to a few hours	Longer, lasting from a few hours to a few days or more
Sources of data	One person, the test taker	Often collateral sources, such as relatives or teachers are used in addition to the subject of the assessment
Focus	How one person or group compares with the others	The uniqueness of a given, individual, group or situation
Procedural basis	Objective required, quantitation is critical	Subjective, use clinical judgment
Purpose	Obtain data for use in making decisions	Arriving at decision concerning referral question or problem

What is….

- Despite the wide-ranging differences amongst tests, all psychological tests are considered to have one thing in common; that is, they are tools that psychologists use to collect data about people (Groth-Marnat, 2009)
- So, what kind of data do we collect?

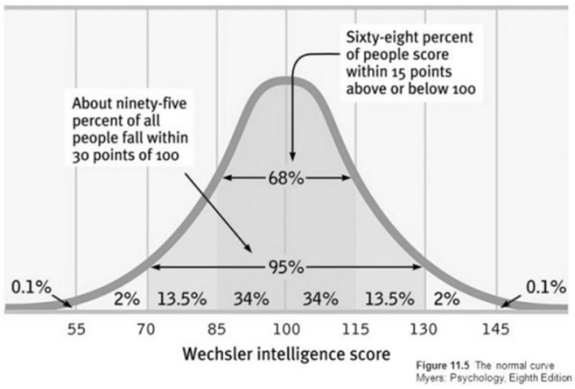


Figure 11.5 The normal curve
Myers: Psychology, Eighth Edition

Data might be driven by the type of test:

Psychological testing is divided into four primary types:

- Clinical Interview
- Assessment of Intellectual Functioning (IQ)
- Academic performance*
- Personality Assessment
- Behavioral Assessment

Clinical Interview

- What is in a clinical interview?
- During the clinical interview, a psychologist will gather information regarding a client's family history, social life, employment, financial situation, previous experience in mental health treatment and other factors that can impact mental health and well-being. The clinical interview can provide the psychologist a comprehensive picture of the client's life, which helps in determining the diagnosis and course of treatment
- What kind of data do you get from a clinical interview?
- What challenges have you encountered/think of in doing clinical interviews?

IQ testing

Intelligence, narrowly defined, can be measured by intelligence tests, also called intelligence quotient tests.

Such tests are among the most accurate, reliable, and valid psychological tests.

Such intelligence tests take many forms, but g theory proponents argue that the common tests and all measure the same dominant form of intelligence, *g* or "general intelligence".

(APA website)

IQ testing and data controversies

Gould (2008), "The Mismeasurement of Man" discusses:

- Is Intelligence even a "thing"
- Can Intelligence be captured in a single number (with a confidence interval)?
- Is Intelligence even measurable?
- Intelligence is innate
- Intelligence is heritable
- What is the relevance of psychometric intelligence to the common-sense understanding of the topic?
- Is IQ relevant in everyday life?

- What concerns do you have about IQ?
  - Diversity?
  - Gender?
  - Language?
  - Social Determinants?
- As a BHC, is IQ data something you wish you had access to in PCBH? Why or Why not?

Neuropsychological testing

- Assessment of a neurological deficit
  - Predicts the possibility organic psychopathology
  - Identification of intact neurological functioning
  - Help in the process of neuro-rehab
  - Evaluation of various treatment options and perceived efficacy
  - Progressive evaluation and formulation of differential diagnosis
  - Developmental progression of milestones
  - Tackling the mental developmental delay and taking necessary action on time

What goes into a neuropsychological assessment?

- History/Clinical Interview: Usually in-depth, takes at least 2 hours
- Laboratory Tests
- Neuroimaging Results
- Collateral information (spouse, friends, co-worker)
- Standard Neuropsychological tests (IQ, academic skills, attention, response inhibition, mental flexibility, reasoning, problem solving, language comprehension, receptive and expressive language/vocab, verbal fluency, visual and verbal memory, learning, recall, visuospatial abilities, visuomotor speed and integration, cognitive processing speed, motor skills, and emotional status

Neuropsychological testing challenges

- PA (will talk more about this later) required often for insurance to approve
- Lengthy
- Test costs (to purchase)
- Telehealth (COVID-19)
- Billing (Bill at final visit); so, documentation accumulates over time not billed each appointment
- Stressful
- Competency
  - Test batteries
  - Cultural/Diverse populations
  - Forensic

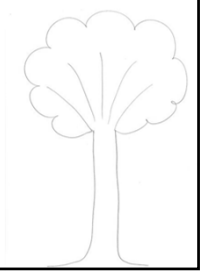
(Teng, 2005)

Neuropsychological testing challenges

- **Tests developed for members of the majority culture often are inappropriate for ethnic minorities, especially those who speak a different language, have little or no formal education, and grew up in vastly different circumstances.**
- **Researchers in the field have become increasingly concerned with the dearth of psychological measures available to evaluate ethnic minority individuals, and/or individuals who do not speak English (Nijdam-Jones & Rosenfeld, 2017; Melikyan et al., 2019)**
  - **Challenges of dialect**
  - **Translation challenges**
    - **MoCA example (Daisy and Spanish translation)**
    - **Psychological assessment measures, ideally, should not be translated by an interpreter**
    - **Gudmundsson (2009) describes that the ideal expertise of measure translation in general should include: a) language expertise, b) cultural expertise, and c) content knowledge relevant to the goals of the measure**
  - **Regarding tests word recognition and generation, some may have stimuli that an examinee from a different culture is unfamiliar with (e.g., the Comprehension subtest of the WAIS-IV, which asks specific questions related to United States history (Wechsler, 2008).**
- **Interpreter use in testing appointments:**
  - **Meet with the interpreter in advance of the evaluation in order to discuss the purpose and provide instruction for the interpreter to provide *verbatim* translations. (Challenges in PCBH setting?)**
  - **During evaluations involving an interpreter, meet with the interpreter in advance of the evaluation in order to discuss the purpose and provide instruction for the interpreter to provide verbatim translations (Shumate, 2020)**

Personality Test

- Structured Personality tests provides a statement, usually of the "self report" variety and require the subject to choose between two or more alternative responses such as "true or false"
- Projective Personality, either the stimulus (test material) or the required response are both ambiguous
- Personality tests are most used in court/legal related situations
- What are your thoughts about personality tests?



APA website

Assumptions of assessments

- Psychological constructs, states, and traits exist
- Psychological constructs, states, and traits can be quantified and measured
- Various approaches to measuring aspects of the same thing can be useful
- Assessments can provide answers to some of life's most momentous questions
- Various sources of error are part of the assessment process
- Test and measurement techniques have strengths and weaknesses
- Testing can be conducted in a fair and unbiased manner
- Testing and assessment can benefit society

Assessment outcomes

- For kids: a diagnosis could mean getting an IEP or academic support services
- Qualify for DD services
- SSDI qualifications
- Child Custody Cases
- Legal cases
- TBI Rehabilitation plan
- Earlier diagnosis of a cognitive condition like Dementia/Alzheimer
- Diagnostic clarity with treatment plan (?)
  - What's the research?

What else?

The current state of primary care

Screening in primary care

- Screening is the standard in primary care
- Screening typically involves self-report screeners that are:
  - Time sensitive
  - Can be administered anywhere/anytime
  - Free
  - Language
  - Literacy

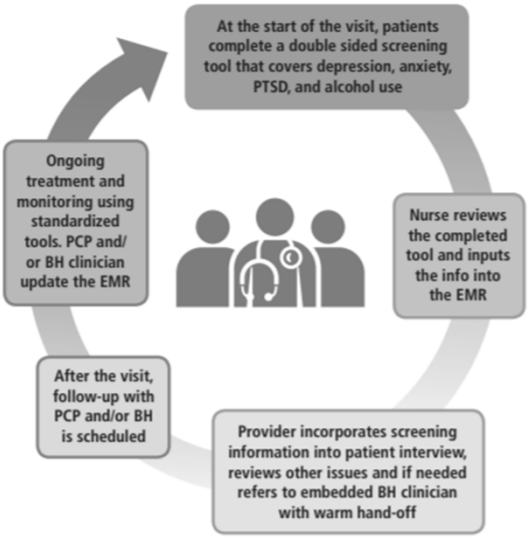
WORKFLOWS FOR BEHAVIORAL HEALTH SCREENING

First steps to identify the workflows….

- How are positive screens addressed?
- How are the results of the screen communicated/stored/monitored?
- Who is administering the tool?
- What tool(s) are being used?
- What is the current state of screening for behavioral health in your practice?

MASSACHUSETTS PCMHI Patient-Centered Medical Home Initiative

Behavioral Health Screening Workflow at Boston Community Health Center



MASSACHUSETTS PCMHI Patient-Centered Medical Home Initiative

Screeners

- Most BHCs use common screeners:
  - PHQ-9, PHQ-9A, Hamiliton Depression, GAD7, Hamiliton Anxiety, Moods and Feelings Questionnaire, SCARED, Geriatric Depression Scale
  - PC-PTSD, ACEs
  - SBIRT, CRAFT, AUDIT
  - EAT27
  - Fagerstrom
  - MDQ, CIDI
  - Vanderbilts, MCHAT
  - MoCA, Mini-Mental Status Exam
  - Duke health profile

	Over the past year: (place an X in the box)	Never	Seldom (1 × yr)	Sometimes (1–3 × mo)	Often (1–3 × wk)	Frequently (> 3 × wk)
1	It takes me 30 minutes or more to fall asleep.					
2	I am awake 30 minutes or more during the night.					
3	I am awake 30 minutes or more prior to my scheduled wake time or alarm.					
4	I am tired, fatigued or sleepy during the day.					
5	I sleep better if I go to bed before 9:00 pm and wake up before 5:30 am.					
6	I sleep better if I go to bed late (after 1:00 am) and wake up late (after 9:00 am).					
7	I fall asleep at inappropriate times or places.					
8	I have been told that I snore.					
9	I wake up during the night choking or gasping.					
10	I have been told I stop breathing when I sleep.					
11	I feel uncomfortable sensations in my legs, especially when sitting or lying down that are relieved by moving them.					
12	I have an urge to move my legs that is worse in the evenings and nights.					
13	I wake up frequently during the night for no reason.					
14	I have experienced sudden muscle weakness when laughing, joking, angry or during other intense emotions.					
15	I have been told that I walk, talk, eat or act strange or violent while sleeping.					
16	I have nightmares.					
17	For no reason, I awaken suddenly, startled, and feeling afraid.					

This is the SDS-CL-17 instrument that is printed on an 8.5 × 11″ sheet of paper. The text below shows how to score each item, and the subscale score above which a positive screen is indicated. Cut-point score determination is described in the methods and results sections, but are included here for completeness.

Item choice	Item score	Subscale	Items to sum for subscale score	Subscale score range	Cut-point score
Never	0	Insomnia	1, 2, 3, 4	0–12	5
Seldom	0	Circadian rhythm	5, 6	0–6	-
Sometimes	1	Narcolepsy	7, 14	0–6	1
Often	2	Obstructive sleep apnea	4, 8, 9, 10	0–12	3
Frequently	3	Restless legs syndrome	11, 12, 13	0–9	3
		Parasomnias	15, 16, 17	0–9	-

- Sleep Disorder Symptom Check-List (17 or 25 items)

Sleep

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel TIRED, fatigued, or sleepy during daytime?	Yes	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE?	Yes	No
BANG	Yes	No
BMI >35 kg/m^2?	Yes	No
Age > 50 y?	Yes	No
Neck circumference > 16 in. (40 cm)?	Yes	No
Gender = M?	Yes	No

Sleep Apnea

What screeners have you used?

- What types of screeners have you seen/used in your time in primary care (or healthcare)
- What did you like/dislike about the screener(s)?
- What advantages do you see in using screener(s)?
- What disadvantages do you see in using screener(s)?
- Would you prefer a test (instead of screener)?
  - Example patient scenarios?

Screeners

- PHQ-2 and GAD-2
  - https://www.annfammed.org/content/21/5/444
  - Looked at detection of anxiety and depression with these 2 screeners in an FQHC setting (diverse underserved population)
  - 90% detection rate (Arroll et al, 2010); this study found about a 60% detection rate
  - Limitations of study discussed:
    - Arroll study not done in an FQHC (but done in primary care)
    - PCP diagnosis used to confirm detection by screener
    - Screening in most primary care settings come with incentives (quality performance metrics) which can lead to multiple screenings

Screeners

- Routine screenings miss over 40% of patients with depression, anxiety | American Medical Association (ama-assn.org)
- Study looked at almost 3 million PHQ2 and GAD2s and compared to the validation studies of both metrics. Results:
  - They found that the tests had more than 90% sensitivity in published literature, compared with the less than 60% found in the EHR data in their study.
  - Discussed no recommended interval of when to give screeners, risk of over/under screening and the role of incentivized process (performance metrics)
- "Focusing on incentivized process measures like intake screening questionnaires leads to repetitive and, we hypothesize inaccurate completion"
- "The implementation of screening questionnaires during clinical encounters was done with good intentions, but in practice, clinicians don't often trust the results of the screens, and it takes up a lot of our limited cognitive bandwidth," said Chicago family physician Jeff Panzer, MD, MS, one of the study's authors. "We are so busy asking screening questions that there's not enough time to ask patients what they'd like to get out of their limited time in the office."
- Community Health Plan of WA has a quality metric for FQHCs in WA state for rate of PHQ2 screening. If we hit 70% of our population screened in a given year, we get $$$

But wait… what is the goal of screening?

- Is it diagnostic?
- Is it preventative?
- Is it a snapshot of symptoms? What about context?
- How often should/could they be used (if given more than once?)
- It is just because healthcare thinks it "has to" screen? Or is incentivized to screen?
- Does it influence questions you may ask?
- Do screeners influence your diagnosis or treatment plans?
- Do studies show screening reduces mortality and morbidity (think other screeners goals in healthcare)? The prior study suggested it wasn't convinced that PHQ2 and GAD2 screening achieved this common healthcare goal.

Primary Care Neuropsych Referrals

- In a 2002 study, primary care physicians were the most likely of health care subspecialists to have never referred a patient for neuropsychological assessment, citing lack of familiarity with services as the main reason (Michels et al., 2010)
- When asked, primary care providers commonly site these reasons they might request neuropsych assessment:
  - Decision-making capacity:
    - Such as health-care decision making
    - SSDI- managing own funds
  - Assessing a person's ability to drive (age)
  - Dementia and Cognitive Impairment
  - Concussion and TBI
- Despite these reasons, primary care providers were less likely to refer because:
  - Lack of resources (no one to refer to)
  - Prior Authorization: Primary Care billing department not set up to complete these type of PA
  - Prior referral with denials (so stopped referring)
  - HealthPoint example: Tried to refer a patient with suspected dementia, but the neuropsychologist only took referral from the healthcare system they work within (so patient must be a primary care patient of the healthcare system to see their specialist)

Using tests or doing assessments in PCBH

Is there an opportunity in primary care, PCBH, for BHCs to use a psychological test or complete a full assessment?

Let's go back to the beginning of this lecture and consider your thoughts

Do we have the time?

Do we have access? (Test batteries are not cheap)

Is there a need? (Challenges of referrals)

Is there a cost? (Do we bill? Is that possible in an FQHC setting?)

Does it impact our role? Or GATHER

Are we competent to do so?

Are there forensic implications? (Will any assessment be used in court or a legal setting?)

Is there enough supervision?

Do patients want/need/desire access to this?

Friends or Foes?

Hayes, S.C., Hofmann, S.G., Stanton, C.E., Carpenter, J.K., Sanford, B.T., Curtiss, J.E., & Ciarrochi, J. (2019). The role of the individual in the coming error of processed-based therapy. *Behaviour Research and Therapy*, 117(*1*), 40-53.

Hayes et, al (2019) describes important notions of the DSM-III and what the authors call "The Syndrome Era" of evidenced based therapy:

1. Notable and treatable human biopsychosocial problems reflect latent diseases (i.e. mental illnesses). Mental health is synonymous with or at least is based on the absence of mental illness.

2. While we do not yet know how many mental illnesses there are, they form a discrete and discoverable set.

3. To discover them, a good strategy is to gather together signs (features we can see) and symptoms (features of complaints) into syndromes and sub-syndromes and to use these identified clusters to guide a search for their underlying etiology, course, response to treatment, and mechanisms of pathology and response

Friends or foes?

Hayes, et al (2019) key points:

- DSM "lumping" of symptoms into syndromes has been problematic
- Mental health "treatment" has become more focused on medical approaches and viewing mental health as a "chronic condition"
- Gene research on "syndromes" has not yet provided results suspected
- An increase of diagnosis comorbidity has demonstrated lack of diagnostic specificity
- The DSM-V was met disinterest or controversary… not applause.

- A story of the APA Conference 2010; San Diego, CA.

- A speaker's story from the 2018 Preventing Overdiagnosis Conference (WHO); Copenhagen, Denmark

PCBH Pathways

- What kinds of PCBH pathways have you seen/experienced/participated in that involve(d) a psychologist test(s)?
  - Autism
  - ADHD
  - Cognitive impairment
- Observations around:
  - How long are each visit?
  - How many visits?
  - What can be done "outside" of the visit
    - Lobby
    - At home/prior to visit
  - Impact on (GATHER)?
  - How could the PCP still stay involved?
  - Who refers?
    - Patient self refer
    - PCP

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Autism Pathway

- Children with ASD from low income, minority families or those with limited English Proficiency are diagnosed at a later age, or not at all, compared to their more disadvantaged peers (Janvier, Y.M. et al., 2018)
  - Why?
  - Washington State: Long waitlists (UW, Marybridge, Children's); cost of traveling; scope/competency
- Washington State ranks 41st related to funding and access for patients with a developmental disability
- Children's and UW partnered in 2019 to do the SMART program: Reach rural areas by creating SMART teams to be trained to do ASD evaluations (schools, pediatrician, psychologist, RN, SLP)

Step One

- A center of excellence (COE) is any medical practice, psychology practice, or multidisciplinary team that receives COE training from the HCA to be qualified to write a prescription for ABA services
- For a child or youth to be eligible for ABA with Apple Health/Medicaid, a recognized COE must conduct a comprehensive evaluation.
- What that "comprehensive" evaluation includes is up to the provider
  - Conflicting opinions
  - DSM-V doesn't require a STAT, ADOS, CARS-2… yet… what is the standard of care?
    - Seattle Children's feedback

Step Two

- Train your team
  - Pediatricians and BHCs did the COE trainings
    - Review MCHAT workflow
    - Think about ages in need: Could we improve access for families in the early intervention range? Looked at ages 18 months to 36 months.
    - Wanted to focus on "easy to diagnosis" population; which was lower functioning (versus high functioning)
  - STAT certification ($2000 group training; $65 certify)
    - Full day training
    - Certification includes reviewing case examples and completing a STAT; submit to UW team for review
    - STAT kit $500
  - ADOS certification
    - $500-$1000 per provider
    - $2000 kit
  - Build a pathway: What's the role of the pediatrician? BHC?
  - Review financial
    - Cost of equipment
    - Billing/Revenue? (discussed later in this presentation)

HealthPoint ASD pathway

- Various a bit across clinics; goal is to standardize in 2024
- Focus age range is 18 months to 36 months; up to age 5
- Not all HealthPoint sites have a BHC-pediatrician combo
  - Can use BHC at the site and refer to an offsite pediatrician
  - OR refer patient and family to BHC-pediatrician site
- Family Medicine Provider/Pediatrician and BHC team approach
  - MCHAT
  - Birth to Three Program Records
  - Pediatric Visit
  - BHC initial visit
  - After this initial work is done then provider and BHC Consultation on ASD evaluation
- Autism Diagnostic Clinical Interview
  - Checklist of questions
  - Observations
  - Tele-ASD (telehealth)
  - STAT
- Final appointment give feedback
  - BHC and Pediatrician together

HealthPoint ASD pathway

- BHCs
  - Billing Developmental Codes 96112 and 96113
  - Molina is the only MCO that may require a PA
  - ## Units allowed up until age 18
  - BHC documents chart updates or X unbilled codes until final visit
  - Final Visit Documentation
    - Summary of all visits done during developmental assessment
    - Review of screeners and scores
    - Diagnosis
    - Treatment plan
    - Time for each component
      - Visits
      - Consultation(s)
      - Chart Review
      - Scoring
    - Bill for total time of all components. 96112 (first hour); 96113 additional 30 minutes (units)

HealthPoint ASD pathway: Success & Challenges

Successes

- Improved access to assessment and treatment (ABA) or school district programs, parent support, resources
- Pediatricians and BHCs positive experience

Challenges

- Billing: Initial had no billing code to use to capture an assessment
- Families coming to us for ASD eval (outside pediatrician)
- Age range
- Birth to 3 program evaluations
- Follow-up visits (no shows)
- Complexity: comorbidities, developmental history, cultural competency and contextual information
- Competence: ASD clinics see kids daily with possible ASD; one clinic at HealthPoint was doing 7 assessments a month
- Certification: BHCs in STAT
- Pediatrician and BHCs disagreeing on diagnosis
- What is ABA is needed?
  - CEO diagnosis is required by MCO plans to gain access to ABA
  - School districts don't require CEO designation; medical diagnosis

Billing Challenges with testing/assessments

- Comprehensive psychological testing, neuropsychological evaluations, and assessments for diagnostic purposes may need prior authorization. Insurance companies want to ensure these services are necessary and will contribute to the patient's treatment plan.
- Example PA form: unisonPTF.pdf (providerexpress.com)
- Example PA form: Microsoft Word - 224r - Psychologic Testing v4.docx (swhp.org)
- Psychological Testing Criteria and Codes - Community Health Plan of Washington - Medicare Advantage (chpw.org)

** PDEs: Psychiatric Diagnostic Eval

- Some psychologists use this billing code for an initial visit and do complete a test as apart of the PDE
- PDEs have no time limit, but can only use "once" a year

Psychotherapy Reimbursement (Medicare, 2020)

90791	$145.44	Psychiatric Diagnostic Evaluation (usually just one/client is covered)
90832	$71.10	Psychotherapy, 30 minutes (16-37 minutes).
90834	$94.55	Psychotherapy, 45 minutes (38-52 minutes).
90837	$141.47	Psychotherapy, 60 minutes (53 minutes and over).
90846	$103.58	Family or couples psychotherapy, without patient present.
90847	$107.19	Family or couples psychotherapy, with patient present.
90853	$28.15	Group Psychotherapy (not family).
90839	$147.61	Psychotherapy for crisis, 60 minutes (30-74 minutes).

Testing Codes (Medicare, 2020)

96112		$140.39	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory, and/ or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour
	96113	$62.80	Each additional 30 minutes (List separately in addition to code for primary procedure)
96130		$121.98	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
	96131	$93.83	Each additional hour (List separately in addition to code for primary procedure)
96132		$136.42	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
	96133	$102.49	Each additional hour (List separately in addition to code for primary procedure)

ASD pathway billing review

- **We used CPT codes 96112 (96113 additional units)**
- **Again, with this CPT code you add up all the time you provided**
  - **Visits (face to face)**
  - **Consults**
  - **Chart review**
  - **Research**
  - **Anything**
- **Average length of time billed was roughly 2 hours.**
- **Reimbursement is $260**
- **Not encounter rate eligible**
  - **FQHCs get negotiate rates with certain managed care plans to see patients assigned to them for primary care. To get this rate, you typically have to have two encounter rate eligible visits per year for a patient. If achieved, these visits are reimbursed $488.**
  - **PDE and psychotherapy visits are eligible for encounter rate eligibility (range is 16 minutes to ~60-minute visit)**
- **I am presenting to you this financial picture just to think about administrative leadership and how they may look at financial feasibility of testing/assessment codes, especially in an FHQC PCBH setting.**
- **Thankfully many FQHCs can also look for grants or other funding. We are blessed at HealthPoint to get a pediatric grant this year just for behavioral health work.**
- **But I also know colleagues in private practice that are frustrated by the reimbursed rate for testing or assessments.**

Billing Challenges and Implementation in PCBH

- Testing equipment is expensive plus the time (salary) of the psychologist per hour versus insurance reimbursement rate per hour for testing
  *Not talking about private practice
- Diagnostic code also influences billing outcome (denied or approved)
- Some payers also limit what tests you can/cannot do OR the context of request for the test (court)
- Billing challenges create revenue challenges which can impact sustainability
- What about patients with no insurance (sliding scale); especially in an FQHC setting?
  - Graduate school programs that offer sliding scale testing or assessments
  - Private practice sliding scale?
- Billing leadership knowledge of PA process, billing guidelines, etc.

A Challenging yet interesting topic in PCBH….. But I think even beyond PCBH settings.

Thoughts?
Questions?
Curiosity?

Thank You.

Wishing you an amazing second half of internship. Enjoy each and every moment. And thank you, each of you, for all you have done and continue to do for our patients, communities, healthcare teams, and our BH staff.