Cognitrax

Measure and Monitor Brain Performance

Reimbursement Guide

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A Product of CNS Vital Signs

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Cognitrax / CNS Vital Signs Billing & Coding Disclaimer

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Overview: Cognitrax Billing, Coding & Reimbursement

Central Nervous System Assessments / Tests (e.g., Neuro-Cognitive, Mental Status, Speech Testing): *"The following codes are used to report the services provided during testing of the central nervous system functions. The central nervous system include, but are not limited to, memory, language, visual motor responses, and abstract reasoning / problem-solving abilities. It is accomplished by the combination of several types of testing procedures. Testing procedures include the assessment of aphasia & **cognitive performance testing**, **developmental screening and behavioral assessments and testing**, **and neuropsychological and psychological testing**. The administration of these tests will generate material that will be formulated into a **report or an automated result.**"*

Source: 2020 AMA's CPT® | Changes an Insiders View https://commerce.ama-assn.org/store/

3 widely reimbursed procedure coding events…

Evaluate & Manage Cognitive Impairment

1 Test Administration Services

NEW 'Test Administration' codes provides reimbursement of a technician or qualified healthcare provider administration of the Cognitrax test battery. *"Testing: administered by a physician, qualified health professional and technician or completed by the patient. The mode of completion can be manual (e.g., paper and pencil) or via **automated means**. The results of these tests will generate material that will be formulated into a report or an **automated result**."*[1] Cognitrax administers Neuropsychological tests, Psychological tests, and Neurobehavioral Status tests. Cognitrax has custom configured test panels supporting complete test administration according to coding, clinical and quality measure guidelines e.g., Cognitive Impairment Assessment and Care Planning, Annual Wellness Visit, Etc.

2 Test Evaluation Services

NEW 'Test Evaluation' codes enables practices to bill professional activities e.g., Neurocognitive / Neuropsychological, Neurobehavioral, Developmental / Behavioral Testing Procedure(s). The auto-scored results are used in the Evaluation and Management of patient care. Cognitrax computerized neuropsychological tests measures millisecond brain or cognitive function under challenge (cognitive performance test). The reports provide a standardized and objective central nervous system assessment. Cognitrax 4 normed neurocognitive tests for ages 8 to 89 and guideline recommended coding, clinical and quality rating instruments.

and/or

3 E & M Billing Code: 99483 - Cognitive Impairment Assessment and Care Planning

Cognitrax capability allows each practice to set-up the neurocognitive testing and necessary rating instruments into an assessment that will most efficiently meet the Nine Billing Code Requirements. See pages 5 thru 8 of this guide.

(1) Source: 2020 AMA's CPT® | Changes an Insiders View https://commerce.ama-assn.org/store/

Central Nervous System Assessments / Tests (e.g., Neuro-Cognitive, Mental Status, Speech Testing)

1

Test Administration codes provides for the reimbursement of a technicians or qualified healthcare providers administration of the CNS Vital Signs test battery. ***"Testing: administered by a physician, qualified health professional and technician or completed by the patient. The mode of completion can be manual (e.g., paper and pencil) or via automated means. The results of these tests will generate material that will be formulated into a report or an automated result."***[1] CNS Vital Signs administers Neuropsychological tests, Psychological tests, Neurobehavioral Status tests, and Developmental/Behavioral tests. CNS Vital Signs has 10 standardized neurocognitive tests for ages 8 to 89 and 60+ evidence-based rating instruments that need to be custom configured (e.g., test panels) and documented according to coding, clinical and quality guidelines e.g., Cognitive Impairment Assessment and Care Planning, Multiple Sclerosis, Neurocognitive Disorder, Concussion, AD/HD, Etc.

Test Administration Services		RVU*	$*
96136	**Psychological or Neuropsychological** test administration and scoring ***by physician or other qualified health care professional***, two or more tests, any method, ***first 30 minutes***	1.30	$44.99
+96137	***Each additional 30 minutes*** (List separately in addition to code for primary procedure)	1.17	$40.49
96138	**Psychological or neuropsychological** test administration and scoring ***by technician***, two or more tests, any method; ***first 30 minutes***	1.02	$35.30
+96139	***Each additional 30 minutes*** (List separately in addition to code for primary procedure)	1.04	$35.99

2

Test Evaluation codes enables practices to bill professional activities e.g., Neurocognitive / Neuropsychological, Neurobehavioral, Developmental / Behavioral Testing Procedure(s). The auto-scored results are used in the Evaluation and Management of patient care. CNS Vital Signs computerized neuropsychological tests measures millisecond brain or cognitive function under challenge (cognitive performance test). The reports provide a standardized and objective central nervous system assessment.

Test Evaluation Services			
96130	**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***	3.51	$121.47
+96131	***Each additional hour*** (List separately in addition to code for primary procedure)	2.61	$90.32
96132	**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***	3.83	$132.54
+96133	***Each additional hour*** (List separately in addition to code for primary procedure)	2.97	$102.78

"+" Indicates an Add-On Code to be reported with another code; "*" Estimated national average payment. $309.06 non-facility price Limiting Charge. CMS Physician Fee Schedule 1/1/2022.

(1) Source: 2019 AMA's CPT® | Changes an Insiders View https://commerce.ama-assn.org/store/

3

Billing Code 99483 - Cognitive Impairment Assessment and Care Planning - $283.08 to 309.26*

Category I: Evaluation and Management ►Cognitive Assessment and Care Plan Services◄

99483 Code Description: *Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian e.g., spouse, informant. etc. in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: ***

CMS/Medicare Cognitive Assessment & Care Plan Services CPT Code 99483 Guidance: https://www.cms.gov/cognitive

99483 Clinic Procedure: Required Assessment Elements

- ***Cognition-focused evaluation*** including a pertinent history and exam; Use of standardized instrument for staging
- Medical decision making of moderate or high complexity;
- ***Functional assessment*** (e.g., basic and instrumental activities of daily living) including decision-making capacity;
- Medication reconciliation and review for high-risk medications;
- ***Evaluation for neuropsychiatric and behavioral symptoms,*** including depression, including use of standardized instrument(s).
- ***Evaluation of safety***, (e.g., home) including motor vehicle operation, if applicable.
- Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and willingness of caregiver to take on caregiving tasks;
- Development, updating or revision, or review of an Advanced Care Plan;
- Creation of a care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehab or support groups); care plan shared with the patient and /or caregiver with initial education and support.

Typically, 50 minutes (*Many of the required assessment elements can be completed by appropriately trained members of the clinical team working with the eligible provider)* are spent face to face with the patient and/or family or caregiver.***

Cognitrax Test Panel Solutions: Custom Configure to Your Needs

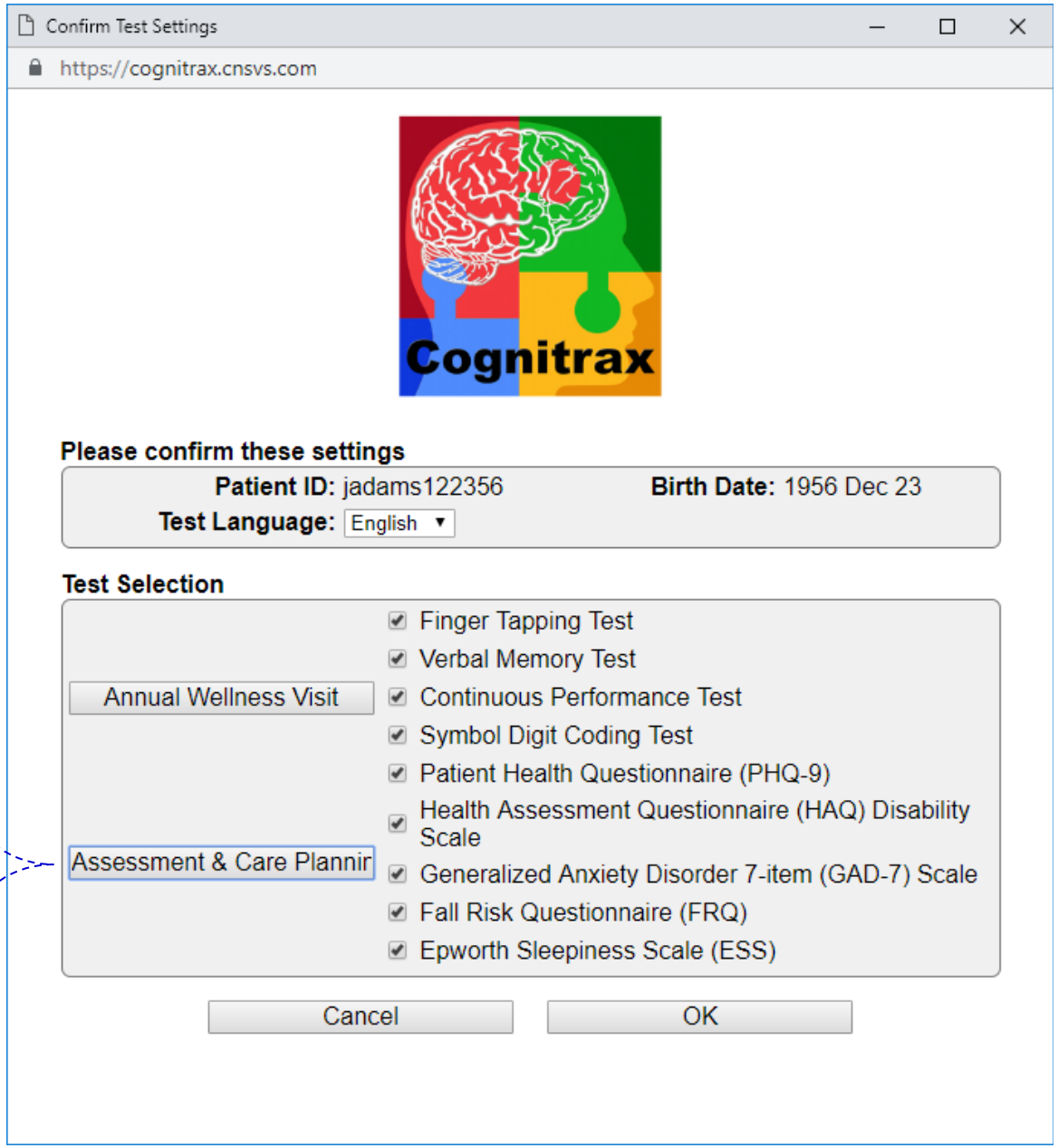
- ***Computerized Neurocognitive Testing***
- ***Functional Health Assessment Questionnaire (HAQ-8)***
- ***PHQ-9,GAD-7, Geriatric Depression, Epworth Sleepiness Scale***
- ***Fall Risk Scale, Computerized Neurocognitive Testing*** (Related to Safety Issues)

Blue lettered items are Rating Instruments that helps assess and satisfy the required elements. Testing is easily configured, auto-score and systematically documented.

* Estimated national average payment amount for 99483 at $282.63 non-facility price, $309.06 non-facility price Limiting Charge. CMS Physician Fee Schedule 1/1/2022.
** 2021 Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS); Federal Register / Vol. 85, No. 248 / Monday, December 28, 2020 / Rules and Regulations; https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf
*** Adapted from: Medicare's Cognitive Impairment Assessment and Care Planning Code: Alzheimer's Association Expert Task Force Recommendations and Tools for Implementation http://www.alz.org/careplanning/downloads/cms-consensus.pdf

3

Billing Code 99483 - Cognitive Impairment Assessment and Care Planning - $283.08 to 309.26*



Selecting the 'Assessment and Care Planning' button will assist the practice in the collection of the required elements for billing code 99483...

3

Billing Code 99483 - Cognitive Impairment Assessment and Care Planning - $283.08 to 309.26*

Category I: Evaluation and Management ►Cognitive Assessment and Care Plan Services◄

Who can provide this service? ***Any practitioner eligible to report E/M services can provide this service.*** Eligible providers include physicians (MD and DO), nurse practitioners, clinical nurse specialists, and physician assistants. Eligible practitioners must provide documentation that supports a moderate-to-high level of complexity in medical decision making, as defined by E/M guidelines (with application as appropriate of the usual "incident-to" rules, consistent with other E/M services) (Anonymous. Fed Register 2016). ***The provider must also document the detailed care plan*** developed as a result of each required element covered by 99483.***

When, where and by whom can the required elements be assessed? The nine assessment elements of 99483 can be evaluated within the care planning visit or in one or more visits that precede it, using appropriate billing codes (most often an E/M code). ***Patients with complex medical, behavioral, psychosocial and/or caregiving needs may require a series of assessment visits (e.g.,96138-39), while those with well-defined or less complex problems may be fully assessed during the care plan visit (e.g.,96138-39).*** Results of assessments ***(e.g., 96138-39)*** conducted prior to the care plan visit are allowed in care planning documentation provided they remain valid or are updated with any changes at the time of care planning. A single physician or other qualified health care professional should not report 99483 more than once every 180 days. ***Many of the required assessment elements can be completed by appropriately trained members of the clinical team working with the eligible provider.*** Assessments that require the direct participation of a knowledgeable care partner or caregiver, such as a structured assessment of the patient's functioning at home or a caregiver stress measure, ***may be completed prior to the clinical visit (e.g., CNS Vital Signs remote testing) and provided to the clinician for inclusion in care planning.*** Care planning visits can be conducted in the office or other outpatient, home, domiciliary or rest home setting.***

What measurement tools should be used to support the care planning process and its documentation? ***Standardized, validated tools are preferred*** whenever possible and are required for some elements. Such tools offer a basic framework on which to build a nuanced clinical understanding of care needs through ongoing clinical contact with the patient and caregiver. Though all required elements must be represented, the choice of assessment tools should be customized for differing clinician styles and practice composition, workflows and overall clinical goals. For example, primary care providers and specialists may prefer different tools.***

How does 99483 relate to Chronic Care Management (CPT 99490)? CPT code 99490 is an appropriate service to use for monthly care management of a patient with dementia plus at least one other chronic condition, after a cognitive impairment care plan has been developed and documented. ***

Identifying proper coding? CPT code 99483 was developed to provide reimbursement for comprehensive evaluation of a new or existing patient, who exhibits signs and/or symptoms of cognitive impairment, is required to establish or confirm a diagnosis, etiology and severity for the condition. This service includes a thorough evaluation of medical and psychosocial factors, potentially contributing to increased morbidity. Do not report cognitive assessment and care plan services if any of the required elements are not performed or are deemed unnecessary for the patient's condition. For these services, see the appropriate evaluation and management code.***

Estimated national average payment amount for 99483 at $ 282.63
** 2021 Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS); Federal Register / Vol. 85, No. 248 / Monday, December 28, 2020 / Rules and Regulations; https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf
*** Adapted from: Medicare's Cognitive Impairment Assessment and Care Planning Code: Alzheimer's Association Expert Task Force Recommendations and Tools for Implementation http://www.alz.org/careplanning/downloads/cms-consensus.pdf
(1) Source: 2019 AMA's CPT® | Changes an Insiders View https://commerce.ama-assn.org/store/

"*" Estimated national average payment amount for 99483 at $282.63 non-facility price, $309.06 non-facility price Limiting Charge.

3

Billing Code 99483 - Cognitive Impairment Assessment and Care Planning - $283.08 to 309.26*

Category I: Evaluation and Management ►Cognitive Assessment and Care Plan Services◄

What about the written care plan?

Preparing the plan

The care plan should reflect a synthesis of the information acquired as part of the assessment. It should be written in language that is easily understood, indicate who has responsibility for carrying out each recommended action step and specify an initial follow-up schedule.
Some clinicians find it useful to organize the care plan into broad components, such as:

- Specific characteristics of the cognitive disorder (e.g., type and severity of cognitive impairment; special hazards such as falls or orthostatic hypotension in Lewy body dementia; or referral to a dementia specialist for further diagnostic assessment or complex management).
- Management of any neuropsychiatric symptoms, including referrals for caregiver stress and behavior management training or psychiatric care for the patient as indicated.
- Comorbid medical conditions and safety management, including any changes needed to accommodate the effects of cognitive impairment.
- Caregiver stress and support needs, including primary care counseling and as indicated, referrals to community-based education and support, specialized individual or family counseling, or in-home care, legal or financial assistance.

Documenting and sharing the plan

Though not required by 99483, a standardized care plan template customized to the provider or health care system simplifies communication and tracking of patient care and outcomes over time. The written plan must be discussed with and given to the patient and and/or family or caregiver; this face-to-face conversation must be documented in the clinical note for all encounters reported using 99483. The care plan must be filed in the patient's medical record where it can be easily retrieved and updated. Sharing the plan with other providers caring for the patient, including clinicians, care managers, caseworkers, and others who assist the patient and caregiver, both within and outside the primary care environment will help ensure continuity and coordination of care. When such sharing requires explicit consent of the patient, family caregiver or legally designated decision-maker (DPOA holder), that permission should be sought and documented. ***

Additional Guidelines:

- 99483 can only be used twice in one-year[1]
- Eligible providers include physicians, nurse practitioners, clinical nurse specialists, and physician assistants.***
- Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
- Many of the required assessment elements can be completed by appropriately trained members of the clinical team working with the eligible provider.***
- ►(Do not report 99483 in conjunction with E/M services [99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215,99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99366, 99367, 99368, 99497, 99498]; psychiatric diagnostic procedures [90785, 90791, 90792]; brief emotional / behavioral assessment [96127]; health risk assessment administration [96160, 96161]; medication therapy management services [99605, 99606, 99607])◄**
- Do not report Cognitive Assessment and Care Plan services if anyone of the required elements are not performed or are deemed unnecessary for the patient's conditions. For these services, see the appropriate Evaluation and Management code.[1]

Estimated national average payment amount for 99483 at $ 282.63
** 2021 Centers for Medicare & Medicaid Services (CMS), Health and Human Services (HHS); Federal Register / Vol. 85, No. 248 / Monday, December 28, 2020 / Rules and Regulations; https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf
*** Adapted from: Medicare's Cognitive Impairment Assessment and Care Planning Code: Alzheimer's Association Expert Task Force Recommendations and Tools for Implementation http://www.alz.org/careplanning/downloads/cms-consensus.pdf
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"*" Estimated national average payment amount for 99483 at $282.63 non-facility price, $309.06 non-facility price Limiting Charge.

Billing & Coding

As you map the future strategic direction of your there will be an increased emphasis on outcomes rather than procedures. How will your practice navigate and to respond to the challenge of optimizing care by efficiently providing the necessary in-office procedures while preparing your practice for collecting and documenting outcomes?

Cognitrax provides an objective assessment of Neurocognition and collects additional important neuropsychiatric patient reported clinical endpoints. The Cognitrax assessment platform technologies are straightforward to implement and intuitive to use making for simple adoption into your clinical practice operations.

Procedure Codes for Neurocognitive Testing

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 (see billing rate differences below). Even though the patient may not qualify for Medicare most payers design their coverage rules according to CMS criteria. The value of Neurocognitive testing is well recognized as CMS has sent out several memos mandating coverage for these codes. Generally, there is widespread reimbursement or coverage for these procedure codes used for Cognitrax assessments.

Many patients that are not covered for cognitive testing e.g., Medicare, Private Carriers will pay out-of-pocket to have their neurocognitive function measured. Patients that have a family history of cognitive impairment e.g., dementia, Alzheimer's, etc. will be candidates for this clinical service.

Matching CPT Codes with ICD or DSM Codes

Coverage for neurocognitive procedures can vary by payer. The CPT procedure code and ICD -DSM codes need to "match" according to each payers' requirements. Contacting the payers provider representative(s) can assist in the appropriate or correct coding. ICD and DSM Code coverage can vary from plan to plan. Clinicians should consult with their office's coding and billing staff to determine the combination of codes that will work best for testing services.

Reimbursement

Reimbursement is determined at a "local or regional plan" determination and often without a consistent pattern. Federal law states that all carriers must acknowledge these codes. Whether an insurance company includes the billing code in their policy/benefit is a different matter. **CMS has mandated the coverage of the codes generally used to bill for the Cognitrax procedure.** Commercial payments are generally higher than Medicare and Medicaid is generally lower.

Billing & Coding

Documentation:

CMS (Recovery Audit Program) and other payers have active and ongoing audit programs to recover fraudulent claims. Coding experts have expressed the following tips to help a practice be prepared for an audit. KEY ADVANTAGE: Cognitrax has an audit tracking and testing history function for the account administrator.

Technical Component –Label which Tech or Admin, Computer admin, Number of Tests, etc. KEY ADVANTAGE: Cognitrax Admin stamps all assessments.

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.

Testing Time – 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. KEY ADVANTAGE: Cognitrax Time and Date stamps all assessments.

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 Cognitrax 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. 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.

Modifiers

Test administration and scoring services -By Professional: CPT codes 96136/96137-By Technician: CPT codes 96138/96139-If professional and technician perform on the same date of service, 96136 and 96138 must be billed with an appropriate modifier-Modifier 59 –"Distinct Procedural Service" OR-Modifier XE –"Separate encounter"^^

See Page I-17 **'Modifier 59'** https://www.cms.gov/files/document/chapter1generalcorrectcodingpoliciesfinal11.pdf
"Modifier 59: Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

See Page I-20 **'Modifier XE'** https://www.cms.gov/files/document/chapter1generalcorrectcodingpoliciesfinal11.pdf
Modifier XE is a Separate encounter, A service that is distinct because it occurred during a separate encounter" This modifier should only be used to describe separate encounters on the same date of service. "**Modifiers XE,** …These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be used in lieu of modifier 59 whenever possible. The modifiers are defined as follows: **XE** – "Separate Encounter, A service that is distinct because it occurred during a separate encounter." This modifier shall only be used to describe separate encounters on the same date of service."

See Page I-16 **'Modifier 25'** https://www.cms.gov/files/document/chapter1generalcorrectcodingpoliciesfinal11.pdf
Modifier 25 is a Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the other service. "The "CPT Manual" defines modifier 25 as a "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service." Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s).

When clinical and/or quality 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.***

^^APA Modifier Information: https://www.apaservices.org/practice/reimbursement/health-codes/health-behavior-assessment
^Adapted from: APA Services, Inc. webinar on the Psychological and Neuropsychological testing codes that went into effect on January 1, 2019.
https://www.apaservices.org/practice/reimbursement/health-codes/testing/webinar-testing-codes