Clinical Neuropsychology Practice and the Medicare Patient

8

Edward A. Peck III and Lucien W. Roberts III

In 1965, President Johnson signed HR 6675 to establish Medicare for the elderly in Missouri. President Truman was the first to enroll in Medicare [1].

Fast-forward a few years, the President of the United States, in his annual message to Congress, complained about the rising cost of health-care costs, the variations in access to health care, and the variation in the quality of health care across social and income groups. He recommended a more "level playing field" approach to national health-care reform that would rely on current market forces to bring change to the US health-care system. Congress voted to deny the President what he wanted. A familiar story? The President was Richard Nixon, and the date of the annual speech to Congress was 1972. The concern was how much the then current federal programs contributed to "this growing investment in health" as a portion of national expenditures [2].

Fast-forward to the early 1980s, at that time there were relatively few nationally identified federal health-care sponsors besides CHAMPUS and Medicare or multistate private insurance carriers such as Blue Cross/Blue Shield (aka Anthem/aka WellPoint). However, the mid- to late 1980s saw the first sparks leading to the now recognized baby boomer explosion of aging in the US population. Suddenly, mental health services were confronted with the expansion of the managed care system and the resulting attempts by employers to limit the costs of medical care, while simultaneously trying to continue to offer a comprehensive insurance plan to their employees. For a much more detailed review of this period of health-care change, the reader is directed to the Managed Care Museum website [3].

Health maintenance organizations (HMOs), the predominant managed care "cost control" strategy of the 1980s, offered an all-or-nothing option: typically, only care provided by providers in a network HMOs was covered. Through much of this period and even today, mental health has been something of an afterthought for insurance payors. HMOs evolved and preferred provider organizations (PPOs) were established to counter the "all-or-nothing" nature of restrictive HMO networks. These plans still had gatekeepers to access, but they also offered patients various financial and/or easier access to specified providers. In turn, these providers had to agree to work within the limitations in practice and the fees ordained by the PPO. Eventually, more costly point of service (POS) plans were developed to offer patients an opportunity to circumvent the more negative aspects of the gatekeeper provisions to their plans. In recent years, we have seen other efforts to control health-care costs by putting more of the responsibility for care on the

E. A. Peck III (✉) · L. W. Roberts III
Neuropsychological Services of Virginia, Inc, Richmond, VA, USA

L. D. Ravdin, H. L. Katzen (eds.), *Handbook on the Neuropsychology of Aging and Dementia*, Clinical Handbooks in Neuropsychology, https://doi.org/10.1007/978-3-319-93497-6_8

patient. Plans such as health savings accounts, flexible spending accounts, high-deductible health plans, and tiered-pricing formularies are all examples of this effort to control health-care costs by involving the patient in the responsibility for their care.

The federal and state governments have continued to attempt to control Medicare and Medicaid expenditures. None of these attempts at managing health-care costs have been particularly effective in tempering the rising costs of health care significantly. Nonetheless, we expect that there will continue to be a migration toward some form of managed care alternative to traditional Part B Medicare, combined with reduced payments, in Medicare. The clinical neuropsychologist cannot ignore Medicare HMOs and other limitations on Medicare and simply hope that they will go away. Many Medicare managed care plans generally pay close to standard Medicare but may present the patient and the provider with additional constraints (e.g., arduous preauthorization processes or fewer testing units permitted). It is incumbent upon each Medicare provider and/or professional practice group to understand the cost and hassle factor of doing business with each plan, so that they can make informed financial decisions with regard to participation in such plans.

Fast-forward to today, a hot July day in the summer of 2017, the efforts of new President Trump and the Republican Party to repeal and replace the Affordable Care Act of 2010 enacted by President Obama and the Democratic Party have failed. Trump and Republicans instead are attempting to repeal the Affordable Care Act (aka Obamacare) outright. It's a difficult time to write a chapter on the future of the business side of health care. Still, the core tenets of the business of neuropsychology remain. Without a margin, there can be no mission. We therefore review many of the tenets of a successful neuropsychology practice that we shared in the first edition of this book.

The same superlative factors remain in play: an unfettered federal deficit, an aging population, a large portion of the US population either uninsured or underinsured, health-care expenses as a percent of federal and state budgets continuing to grow (albeit at a slower rate), and no easy solutions. Both primary political parties have chosen the blame game rather than work together; this is not a political statement but a political reality. The US health-care system of today cannot be sustained, period, and the failures of the primary political parties to work together put more pressure on tomorrow's generations.

Relevance

Neuropsychology must remain relevant. We as individuals and as professionals must demonstrate that our work (1) impacts patient care, (2) improves quality, and (3) is a good business investment for health-care purchasers. We want to emphasize this point before we proceed. Psychologists and neuropsychologists are excluded from the first 2 years of the Merit-Based Incentive Payment System (MIPS), the quality/cost program promulgated in 2017 to replace Meaningful Use (MU), and the Physician Quality Reporting System (PQRS) [4]. Exclusion is a bad thing: if we are not at the table, we are on the menu. Funding decisions will be made in our collective absence, increasing the likelihood that neuropsychology will be further marginalized. Therefore, as you review the following primer on understanding your cost drivers, focus too on the value of what we do in bending the cost curve for Medicare and other payors.

Purpose of the Current Chapter

This chapter is designed to provide practical information concerning the business aspects of providing clinical neuropsychological care to Medicare patients under current (and projected) access and funding parameters. The specific focus is on Medicare reimbursement as it relates to practice management issues in clinical neuropsychology.

Medicare is not going away. It comprised about 15% of the population of our nation in 2011 and 17% in 2015. Medicare enrollment

grew nearly 19% between 2000 and 2010, from 39.6 million enrollees to 47.1 million enrollees; it surpassed 55 million in 2015. The first baby boomers (those born between 1946 and 1964) became Medicare eligible on January 1, 2011, and will contribute to an expected *doubling* of Medicare enrollment by 2030. The existing health-care infrastructure and Medicare reserves are not prepared. As a side note, Medicaid enrollment grew nearly 60% between 2000 and 2010, further stressing federal and state funding [5, 6].

There will be increasing pressure on providers to do more with less and to cope with increasing constraints on utilization and reimbursement. In response, it is incumbent upon every neuropsychological practice to understand its internal revenue and cost drivers and to be as efficient—with time and resources—as practically possible.

Good business is good business, and many of the matters we discuss in this chapter are applicable to your entire clinical practice and not just to your Medicare patient services. At the end of the work day, the difference between the dollars which your practice collects and what your practice pays out in expenses is critical. A practice cannot thrive—much less survive—if it focuses on revenues while ignoring expenses or vice versa. The successful neuropsychology practice must keep an eye on both revenues and expenses.

In this chapter, we emphasize a proactive response to the management of your professional practice, whether it is in a private or institutional setting. We believe that by being proactive in your business planning and management, you can avoid many patient- and insurance-related problems. This is far more reasonable than trying to resolve a situation which has already gotten out of control.

This chapter is comprised of three sections:

1. Understanding Your Cost of Practice and Living Within Your Means
2. Addressing Common Medicare Scenarios: Examples and Forms
3. Medicare and Neuropsychology: A Look Forward to the Abyss or to Eden? What Will Our Business Management Practices Look Like in the Future?

The first section offers insight into the business management of your practice. We urge our readers to use this section as a building block upon which to improve the financial operation of their practices.

Understanding Your Cost of Practice and Living Within Your Means

Let us start with a basic point for the private practitioner or institutional practitioner. For the private practitioner, the point is how much your practice brings in per month is not as important as how much you actually spend per month to pay all the bills. You need to know the extent of your financial overhead in order to meet your responsibilities. For the institutional provider, the point is to understand and appreciate what your administrator is setting as your minimum RVU or cost recovery value per time unit for a specific time period (quarterly, yearly, and so forth). You need to know to understand what you (or the institution) have to spend to keep your practice open.

Our goal is to help you calculate what it actually costs your practice to operate. Knowing this cost is essential to managing your expenses and improving your operating margins. The first thing you should do is to have your accountant or office manager develop a financial spreadsheet which lists all of the expense categories paid during each month and each year. Table 8.1 is an example of a practice income statement; it lists many of the cost categories which should be included in such a spreadsheet [7].

The sum of your expenses is your total cost of practice. To make a profit, you must recoup more than this amount. Once you have calculated the total expense for your office, you can calculate "what if" scenarios relating to profit and loss. It is also helpful to look at a 3-year period when possible to trend/forecast changes. You should plan to calculate cost escalations for each of these line items, e.g., salaries and fringe benefits, as part of projecting expenses for the coming 3 years.

Once you have an annual total cost of operation, you can calculate your average total cost per

Table 8.1 A sample financial report

		Sample financial report	
Revenues	Current month October	Current year to date 10 months	Prior year to date 10 months
Fees received	46484.87	350875.00	320897.50
Other income	2490.00	30115.00	18737.00
Interest earned	30.39	429.00	190.00
Total revenue	49005.26	381419.00	339824.50
Cost of practice			
Accounting	300.00	3000.00	2800.00
Advertising	50.00	500.00	425.00
Bank charges	17.81	581.79	500.00
Co. car loan	350.00	3500.00	0.00
Co. car expenses	65.00	650.00	639.00
Charity contributions	100.00	225.00	200.00
Continuing education	120.00	250.00	250.00
Dues and subscriptions	400.00	2805.00	3000.00
Employee benefits	660.00	6660.00	5000.00
Equipment—capital	0.00	2000.00	1000.00
Equipment—other	125.00	300.00	500.00
Insurance—malpractice	100.00	900.00	900.00
Insurance—Co. car	90.00	900.00	860.00
Insurance—other	140.00	1140.00	1000.00
Interest—loans	43.49	825.74	0.00
Legal fees	125.00	350.00	675.00
Licenses	100.00	450.00	450.00
Maintenance—equipment	475.00	2900.00	2500.00
Miscellaneous	50.00	2400.00	700.00
Office expense	239.00	3100.00	3000.00
Postage	135.00	1650.00	250.00
Refunds	50.50	1117.00	1750.00
Registrations—meeting	180.00	450.00	400.00
Rent—office	2000.00	20000.00	17000.00
Repairs	0.00	1000.00	800.00
Supplies—office	54.00	1334.75	1000.00
Supplies—test	125.25	375.00	350.00
Taxes—payroll	4800.00	48000.00	39000.00
Taxes—other	0.00	375.00	375.00
Telephone	210.24	2848.90	2500.00
Telephone ans. service	90.00	900.00	800.00
Travel	616.00	3300.00	1000.00
Meals and entertainment	75.00	590.00	200.00
Wages	8711.52	77810.64	74508.97
Total expenses	20597.81	193188.82	164332.97
Net income/loss	28407.45	188230.18	175491.53

Co. is company, *ans*. is answering

hour of practice. For example, an office which is open 8 h a day, 5 days a week, has 2080 operating hours per year, less holidays, vacations, bad weather closings, and the like. Dividing your annual total cost by your total operating hours will calculate your practice's average cost per hour of operation. Simply stated, if your practice is not bringing in at least this much per hour of operation (e.g., per week or per month), it is losing money.

It is possible to take a more detailed look at how much it costs you to provide an hour of testing or an hour of therapy. For example, you can set up a spreadsheet which incorporates cost items such as (1) technician salary and fringe benefits, (2) cost of test equipment, (3) cost of room space rent, (4) cost of front office (scheduling to billing), and (5) your salary and benefits. However, this is secondary to getting a solid handle on your overall average cost per hour of operation. Once you have a good feel for such data, you can dig deeper and look at individual financial facets of your practice.

This juncture is a good time to review your expenses at a "line item" basis. Be critical. We urge you to focus on expenses because a dollar saved is a dollar earned, whereas a dollar charged often results in receipts of less than half that.

Some axioms for consideration: A mere 30 min of overtime a day for a technician earning $20 an hour will cost your practice $3900 per year ($20/h times 0.50 h/day times 5 days/week times 52 weeks/year times, at time-and-a-half). Add in matching tax obligations of 7.65%, and your cost exceeds $4000 per year.

If you have a 5-year lease for 2500 square feet at $20 per square foot, a 4% escalation clause will cost you $5359 more than a 3% escalation clause over the term of the lease ($20/square foot times 2500 square feet is $50,000 in rent in year 1; in year 5, you will be paying $58,493 with a 4% escalation clause or $56,275 with a 3% escalation clause).

By avoiding the overtime and higher rent escalation in these two examples, you would save more than $26,000 over 5 years. Savings equals income.

Review annual service agreements for copiers, faxes, credit card processing, and postage meters. Ask your vendors for better deals if you will renew for 24 months instead of 12 months. Talk with other medical practices to ensure that your staff wages and annual increases are not too far above or below the average range for your geographic area. Ask the practices next door and across the hall if they would like to bid out janitorial or some other service together to get a better price.

The checklist provided as Table 8.2 offers a road map for managing your practice better.

Clearly, Table 8.2 goes into more detail than we can discuss in the space of this chapter. However, we felt its inclusion would provide readers a good checklist of areas where the cost of your practice operations might be improved. In this regard, while it is possible for your practice to take a more detailed look at how much it costs you to provide an hour of testing or an hour of therapy is only part of getting a solid handle on your total average cost per hour of business operation.

Having gotten a grasp on your expenses, you should develop a spreadsheet that lists the actual reimbursement amount paid by each insurance carrier, for each service you provide. Table 8.3 presents such a spreadsheet, and it lists (for the purposes of this chapter) sample allowed payment rates for CPT codes 96118 and 90806 (and its successor code, 90834) for Medicare Region 3 and for several other (unidentified) plans. For the record, the other insurance plans are not named due to confidentiality requirements. Many insurance plans have subplans or carve-outs to their plan, which may pay at different rates. This includes Medicare HMO and PPO plans. The spreadsheet that you develop should have the information organized so that each insurance plan can be viewed and compared for the CPT codes actually used in your office. Such a spreadsheet will serve several purposes, including allowing you to evaluate which insurance plans pay a better fee for a particular CPT code unit of service. Table 8.4 provides a comparison of CPT allowed payments from different insurer sources.

The following instances warrant consideration of contract termination or negotiation with the insurance company:

- If a payor pays relatively less than others or less than what it costs your practice to provide a service. As noted in the chart above, there is tremendous variation among payors even at the CPT code level.
- If you and your office staff consistently spend so much time getting testing units or evaluations preapproved, or after providing the ser-

Table 8.2 Practice operations checklist

	2014	2015	2016	2017	2018
Budgets					
Operating budget used to track performance?					
Operating budget includes prior year (PY) comparison?					
Capital budget established?					
Expenses compared to PY, budget, benchmarks?					
Retirement plans					
Service agreements (basis points) renegotiated?					
Expenses allocated to participants vs. borne by practice?					
Former employees removed if costing practice $$?					
Contributions balanced with operating cash?					
Timing/cost of plan valuations reviewed?					
Housekeeping					
Cost per square foot compared to other practices?					
Bid out or renegotiated alone or with other practices?					
Right sized frequency of service for satellite/nonclinical areas?					
Backed out square footage for space that will not be cleaned (e.g., samples closet, electrical/server closet, extra rooms)?					
Shredding					
Quarterly check of bins for nonpatient content?					
Bid out or renegotiated?					
Eliminated junk faxes?					
Checked for duplicate office notes, etc., and rooted out causes?					
Overtime/wage management					
Given wage increases only when warranted?					
Compared wages/benefits to those of other practices?					
Tracked overtime hours as a percent of worked hours?					
Reviewed schedules for smart scheduling?					
Tracked provider start time vs. scheduled start time?					
Avoided scheduling of “same sex” at end of day?					
Avoided scheduling of procedures at end of day?					
Ensured staff has exam rooms ready at start of day?					
Kept unwarranted overtime at a minimum?					
Employee retention					
Trended turnover rate vs. PY? By office/dept?					
Maintained undesired turnover at <5%?					
Engaged employees per the Gallup Q 12 Survey?					
Employees know what is expected of them?					
Employees have what they need to do their jobs?					
Employees have a chance to do their best everyday?					
Employees recognized/thanked every week?					
Employee development encouraged?					
Employee input requested and used?					
Equipment purchases and leases					
Obtained multiple bids?					
Bid out with other practices if buying common/same items?					
Asked finalists for better pricing/terms?					
Shopped for best interest rates?					
Negotiated caps or free years on equipment maintenance?					
For operating leases, defined “fair market value” before signing?					

(continued)

Table 8.2 (continued)

	2014	2015	2016	2017	2018
Locked in pricing on future purchases before signing?					
Looked for leases/loans with no personal guarantees?					
Negotiated supplies purchasing with future caps?					
Evaluated refinancing of existing leases?					
Credit card processing					
Obtained multiple bids? Compared all costs/rates?					
Considered Internet-based processing services?					
Considered dual purpose "swipe" readers?					
Copiers/printers/scanners/faxes					
Inventoried existing units/leases/maintenance agreements?					
Determined cost per copy of existing units?					
Bid out with other practices?					
Asked for free consolidation audits/bids from vendors?					
Reviewed ways to reduce unnecessary/duplicate copies?					
Eliminated high-cost and duplicative units?					
Reviewed processes for document retention (scan vs. print)?					
Copiers/printers/scanners/faxes					
Compared current pricing discounted plans?					
Compared current pricing to other professional organization vendors?					
Solicited others in local community or same specialty to join in group purchasing?					
When purchasing the following, look at volume buying with others					
Copiers/faxes					
Housekeeping					
Shredding					
Supplies/equipment					
Payroll/accounting					
Legal advice					
*Contract review					
Electronic medical records and practice management systems					
Employee benefits/insurance options					
Office supplies					
Kitchen/coffee service and supplies					
If you buy it, bid it…					
Revisit provider schedules					
Provider Time Off policies reviewed for impact on schedule?					
Provider Time Off policies reviewed for carryover limits?					
Provider Time Off truly and fairly tracked?					
Reviewed schedules to make sure schedulers are optimizing?					
Looked for possible scheduling inequities?					
Determine relative value unit (RVU)/hour worked for each doctor/office?					
Provider compensation agreements					
Reviewed compensation relative to collections and overhead?					
Incentives and formulas understood by providers?					
Buy-in from providers on incentives and formulas?					
At least 50% of compensation to production incentives?					
Communications					
Evaluated elimination of pagers via cell phone use?					
Considered foregoing insurance on units if pagers are retained?					
Reviewed monthly answering service invoices?					

(continued)

Table 8.2 (continued)

	2014	2015	2016	2017	2018
Negotiated better rates and eliminated extraneous charges?					
Considered group bidding?					
Reviewed existing cell phone agreements?					
Considered foregoing maintenance insurance?					
Bid out agreement?					
Evaluated "family" vs. "corporate" plans?					
Looked at size of bucket of minutes vs. usage?					
Looked at cost of data messaging options?					
Completion of patient forms					
Asked patients to fill in nonclinical parts before appt.?					
Had providers/support staff fill out remainder during appt.?					
Reviewed charge(s) for form completion?					
Increased charge for time-consuming forms?					
Ensured form collection fees are collected up front?					
Patient registration forms					
Posted online or e-mailing to reduce copying/postage expenses?					
If making copies, farmed out to minimize cost per copy?					
The rent					
Negotiated cap on common area maintenance increases?					
Negotiated annual rent increase limits?					
Obtained guaranteed construction timeline in writing?					
Analyzed financing options and rates?					
Locked in renewal terms, including $$$ for refurbishment?					
Included "no-trade" provisions in lease to protect against involuntary relocation?					
Asked landlord to pay for all construction, architectural, and space planning drawings?					
Refinanced existing loans?					
Insurance benefits					
Medical malpractice					
Right sized limits to state caps?					
Bid out to ensure rates are competitive?					
Secured "tail" coverage for retiring docs at no cost?					
Ensured provider employment agreements are clear on tail coverage?					
Health/dental/disability/Section 125					
Bid out to ensure rates are competitive?					
Ensured all alternatives considered have the key providers in network that your staff, your docs, and their families use?					
Considered alternatives along a continuum of co-pays, deductibles, and drug plans?					
Offered multiple options (PPO, HMO, HAS)?					
Set practice's contribution to employee premiums as a fixed dollar amount rather than a percentage?					
Evaluated a Section 125 plan for employee premiums?					
Asked for group billing discounts for individual long-term disability (LTD) policies?					
Looked to American Psychological Association (APA) and others for discounts?					
Updated asset schedules for tax and business insurance calculations?					
Deleted unused assets?					
Used good descriptions/serial numbers for new assets?					
Most costs are fixed, so…					
Evaluated adding one patient/provider/day or/half-day?					

(continued)

Table 8.2 (continued)

	2014	2015	2016	2017	2018
Evaluated scheduling for efficient filling of schedules?					
Evaluated scheduling for potential creation of overtime?					
Ensured electronic remittance is in place and working?					
Looked to limit your nonrevenue-producing task producers?					
Credentialing?					
Mail review (and other distractions)?					
Patient/family phone calls?					
Exam room turnover?					
Ensured exam/testing rooms are stocked and ready?					
Shared "best kept" secrets with referrers to help them?					
Evaluated/reduced avoidable "no shows"?					
Looked at space utilization/efficiency/alternative uses?					
Subleasing?					
Shared satellite offices?					
Optimized coding and documentation?					
Most costs are fixed, so…					
Bell curve analyses vs. national norms and PY?					
Audited coding and documentation for problems/opportunities?					
Reviewed denial rates and trends by payor?					
Payor contracts					
Calculated operating expense and total expense per RVU?					
Compared payments for top 15–20 high dollar and high-volume codes by payor to operating and total expense for same?					
Eliminated or renegotiated money-losing and marginal agreements?					
Actively managed "% of Medicare" contracts to ensure proper payment?					
Established base Medicare year for contracts to protect against cuts?					
Asked for annual fee schedule increases?					
Asked for relevant fee schedules (not sample fee schedule)?					
Completed a strengths, weaknesses/limitations, opportunities, and threats (SWOT) analysis to assess negotiating strategy?					
Asked your providers and staff to complete payor report cards?					
Asked for carve-outs for certain services or codes?					
Loaded updated fee schedules in practice management system?					
Audited payments on signed contracts?					
If giving notice, considered 45 + 45 strategy?					
Co-pays, deductibles					
Ensured patients know what they owe before visit?					
Offered multiple payment options?					
Tracked collection of co-pays, deducts by site, by employee?					
Reminded staff what it costs to collect a co-pay after the fact?					
Ensured eligibility and deductible status are being checked previsit?					
Reminded providers that downcoding for friends only helps the payor?					
No shows					
Tracked "no show" excuses for patterns, noncompliance?					
Established "no show" fees not to anger but to deter?					
Empowered your front office to make decisions on excuse validity?					
After the fact collections					
Using lockbox services?					
Wasting $$ by sending pre-explanation of benefit (EOB) patient statements?					

(continued)

Table 8.2 (continued)

	2014	2015	2016	2017	2018
Considering collections placement after two statements?					
After the fact collections					
Looked at service charges for second/third statements?					
Looked at service charges for statements for co-pays?					
Accounts payable					
Verifying all nonrecurring invoices?					
Reviewed renewing contracts for onerous "evergreen" clauses?					
Tracking and managing inventory?					
Considered online bill pay?					
Used a "rewards" credit card for paying bills where possible?					

Table 8.3 Comparison of Medicare allowed payments for CPT codes 96118 and 90806 (90834)

Year	CPT code	
	96118	90806/90834
2007	$111.79	$87.71 (90806)
2011	$95.74	$87.97 (90806)
2017	$97.92	$84.91 (90834)

vice, having to file and refile the claim for payment, that the cost of doing business with that company is not worth the payment received. Remember, this is an overhead expense. It may not be worth it to spend that time refiling the claim. It may be better that you terminate that contract.

- If the patients of a particular payor are more likely to miss appointments without sufficient notice (e.g., the "no show" or "late cancelation"), therefore leaving your schedule with holes where you are paying staff but not getting offsetting revenues.

While fee negotiation with Medicare is not possible, it is possible to negotiate with Medicare managed plans offered by regional and national payors. This is particularly true when they need your specialty services due to local service supply shortages. It is better to walk away from an agreement that costs you more to provide the service than to provide the service for that plan.

There are many good automated appointment reminder systems on the market. Such systems use e-mail and text messaging in addition to standard phone messages. Because reminders can be sent at any time and repeated (e.g., an e-mail reminder 4 days out and a text message the evening before an appointment), many practices have found them to be both effective and cost-effective.

This is also a time to review your commercial payor contracts and ensure you are being paid what you are due. Surprise, surprise, some payors have been known to pay less than what they have told you they will pay you! Medicare claims are generally paid accurately in terms of the number of units allowed and billed. However, you must stay current with what are the published approved/allowed payment rates. We advocate meeting or having periodic calls with your key payors, even if you are being paid correctly. These "touches" give you an opportunity to help payors understand what neuropsychology is and to discuss the value of neuropsychology in bending the cost curve. Again, it helps us remain relevant.

If your current approved/allowed fee schedules have not been loaded into your practice management software system, make this a priority. This should be carried out for each insurance company and plan you bill. Updated and current fee schedules in your practice management system are the *best way* of tracking whether your practice is being paid the correct amount per unit of each plan contract. Make sure your billing staff is cognizant of what you should be paid when they are posting payments. We cannot overemphasize this point. Your billing staff should know how much is paid per unit and when there is a deviation from the expected payment amount. They need to know that you want to know when problems in reimbursement arise.

Other spreadsheets can be prepared which calculate various ratios of actual payment versus the average length of time it takes to receive payment

Table 8.4 Comparison of CPT allowed payments from different insurer sources

		Ins 1	Ins 2	Ins 3	Ins 4	Ins 5	Ins 6	Ins 7	Ins 8	Ins 9	Ins 10
		HMO	PPO	Medicaid	Commercial	Commercial	Medicare	Medicare	Medicaid	Commercial	Medicare
				Commercial			Region 3	Commercial 1			Commercial 2
90791	DI Int	120.00	120.00	107.63	85.00	75.00	131.23	135.00	87.84	99.62	97.75
90834	Therapy	90.00	90.00	67.49	65.00	75.00	84.91	82.00	83.55	83.55	79.68
96101	Psy test	90.00.37	90.00	58.65	75.00	72.00	78.32	78.32	74.98	91.05	88.75
96102	PT	93.00	93.00	37.48	75.00	72.00	61.87	61.87	74.98	91.05	88.75
96118	Np test	98.00	98.00	71.14	75.00	127.85	78.32		123.96	123.96	121.80
96119	NT	81.37	81.45	47.94	75.00	62.88	61.87		61.13	61.13	122.98
96120	NT	81.37	81.45	51.52	75.00	62.88	61.87		0.00	46.13	88.75

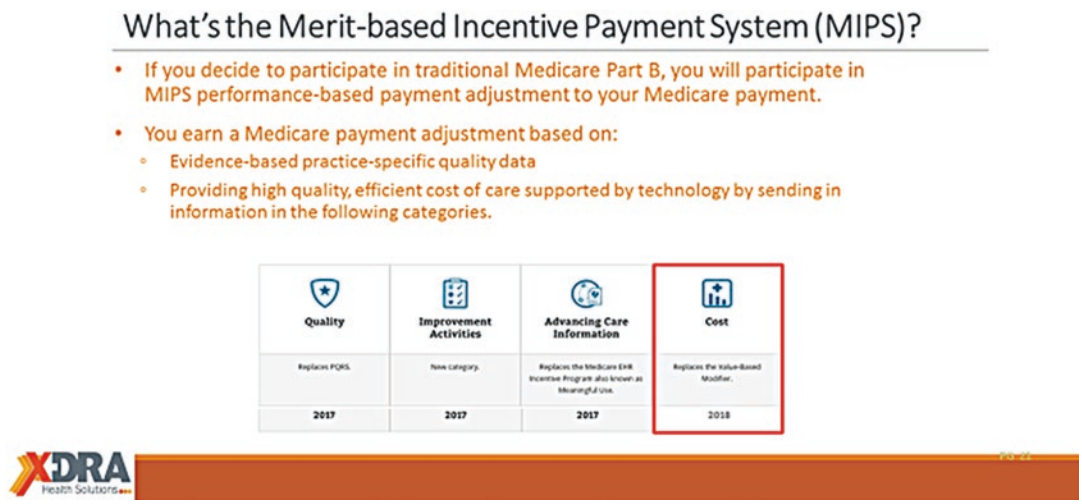
once your claim is submitted; number of first submissions (called "clean claims") leading to payment versus multiple submission/resubmissions of claims; and frequency of other problems leading to delay in payment and/or refusal of payment by the insurance company. Many of these spreadsheets are premade as part of commercial software billing programs.

Over time, you will determine that some insurance companies pay a lower fee per unit of service but that they actually cost less in terms of the actual cost to your practice. This is because they have a very high rate of clean claims, thereby lowering your claims processing costs. In turn, others may promise a high rate of payment but cost more to service the claim (or, as noted earlier, cost you so much more in staff and doctor time getting preauthorizations than your actual reimbursement per hour or per unit due to having to resubmit claims and so forth).

In the prior edition of this book, we discussed the sustainable growth rate (SGR), a formula used by the Center for Medicare and Medicaid Services (CMS) to attempt to control rising health-care expenditures. SGR was eliminated by the Medicare Access and Chip Reauthorization Act of 2015 (MACRA), the act that established the Merit-Based Incentive Payment System (MIPS). We do not discuss SGR in this update because it is no longer relevant [4].

Most of the above applies to Medicare as well as other federal, private, and commercial insurance plans. Earlier, we summarized key factors putting immense pressure on health-care costs. We mentioned MIPS, the payment system introduced in 2017 to combine prior payment systems.

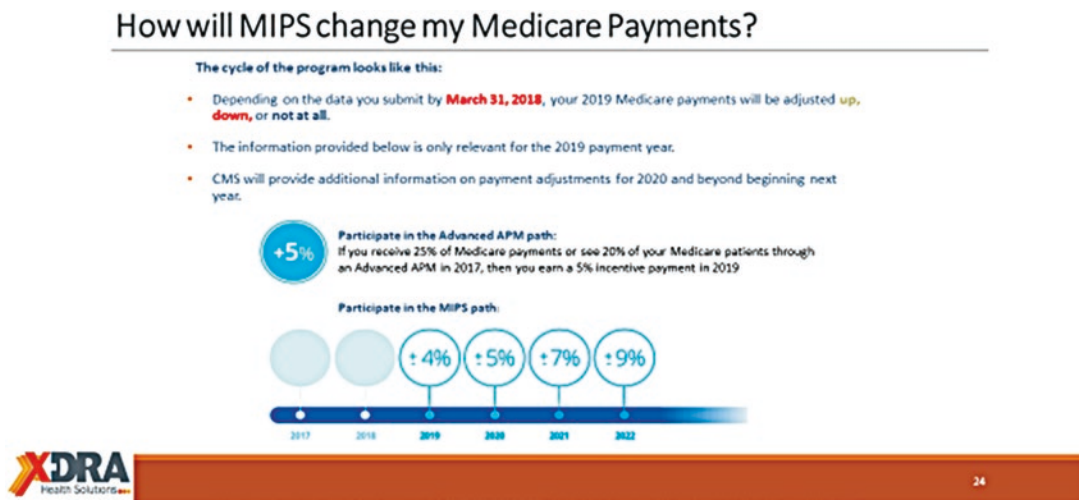
MIPS continues the trend established by Meaningful Use (MU) and the Physician Quality Reporting System (PQRS) of penalizing providers who do not participate. MIPS expands on this concept, though. It is a zero-sum program in which participants will be rewarded—or penalized—based upon their cost and quality performance. The following charts provide a good summary of MIPS.



Note the shift in MIPS toward demonstrating high-quality, cost-effective care. MIPS moves beyond its predecessors where the focus was on reporting data. MIPS also places an emphasis on technology, or more aptly, seamless and transparent cost and quality reporting.

MIPS is the payment system of Medicare's future, and other payors are following lockstep. We review it in this chapter because we believe neuropsychology *must* find a way to be part of MIPS. The risks of being marginalized by not participating are just too great.

MIPS payments are adjusted on a 2-year lag. Therefore, efforts in 2018 will result in either a payment increase or payment decrease in 2020. As noted in the following chart, the rewards and penalties increase significantly in the next few years.



As the chart shows, there will be a rapid escalation of opportunities to be paid significantly more—or less—than what one is paid today. Note: the Advanced APM path mentioned on the preceding chart is an option under MIPS for providers to accept downside risk in a specific model (e.g., comprehensive end-stage renal disease care) in exchange for the opportunity to make even more by meeting defined quality and cost performance metrics. Advanced APMs are not discussed further in this chapter.

So, why should you be concerned? All you want is to keep a full practice and pay your bills and earn your salary? Well, how are you going to know if your practice is going to (a) make a profit, (b) break even, or (c) operate at a loss on Medicare services such as psychotherapy or testing if you do not know what the amount of fee reimbursement is going to be a month, 3 months, or a year from today. You *have* to think about the basic cost of delivering your professional service to the public from a business management point of view.

Table 8.3 presents the hard reality of the decline in Medicare allowed payment (the actual amount you are paid) over the past 5 years. As you can see, the actual CPT 96118 fee in Region 3 has declined from a 2007 level of $111.79 to a 2017 level of 97.92 (12.4%). Without a doubt, your overhead has continued to increase during this time period. Can you afford to see Medicare patients for these rates? Where can you make up the difference in lost revenue?

At the institutional level, the same situation regarding Medicare reimbursement is going to direct how the institution will allocate resources for patient care and professional salaries. Most of us have heard the real stories from our peers who have been told bluntly by their hospital administrator to balance their department budget (including their continued salary and other overhead) by increasing actual cash receipts (not just billable hours to indigent patients) to a level which covers salary and other expenses, or their position would be canceled.

Here is a basic example using CPT 96118. If your office cost of service is $150.00 per hour and you currently receive $150.00 per unit of 96118, then you are breaking even, with no profit or loss. Now, if the amount you receive is the our current Medicare reimbursement rate of $97.92 for each unit of 96118 provided to a Medicare patient, that is a loss of 52.08 per unit. Thus, an 8-h service with 96118 leads to a loss of $416.64. Where will you make up this loss? Have you calculated the total number of Medicare-based CPT units of service billed by your practice in the past 12 months? Please take a minute or two and calculate this amount versus your actual overhead. Knowing your margins by payor and by service is critical. This is only one of the many reasons why large numbers of physicians and psycholo-

gists are considering whether they can afford to continue to provide services to Medicare patients.

Let us add an additional level of payment impediment to the above scenario. This example reflects a Virginia Medicare (primary insurer) patient with Standard Virginia Medicaid (secondary insurer). Using the per figure of $97.92 per unit of 96118, Medicare will pay 80% ($78.33) per unit, and the remaining 20% ($19.59) per unit is passed on to Medicaid for payment. However, Medicaid will not pay the remaining $19.59 per unit because Medicaid has determined that the amount by Medicare is greater than what Medicaid would pay—and so will pay $0.00. As a Medicare provider, you are not allowed to "balance bill" under most circumstances. As a Medicaid provider, you are not allowed to balance bill the Medicaid patient. If, for some reason, you are allowed to legally "balance bill" this Medicaid provider, do you really expect to collect that $19.59 per unit (or, $156.72 for 8 units) and recoup the cost of that collection as well—if you could balance bill the patient? Again, the greater the number of service units provided at a per unit loss, the greater the loss on your bottom line. Typically, working for only 80% of the Medicare rate will reflect a significant dollar loss per unit for your business. How do you balance appropriate professional service delivery versus being able to afford to stay in business to provide continued care?

How you spend your professional time is a decision based upon multiple issues. Having an accurate picture of your office's financial status and how it can be affected by seeing patients who lead to financial profit or loss for your practice is critical to your business decision-making. Once you actually analyze your costs for carrying out a neuropsychological evaluation to a patient with a specific insurance plan, is continued service to patients with that plan justified from a business perspective?

Another concern that drives up office costs is the matter of patient "no shows." These are the instances in which patients do not show for their scheduled appointments. "No shows" cost your practice money since they represent unproductive "no income" time in which you still have the cost associated with running a practice. Virtually all insurance companies (Medicaid is a notable exception in most states) permit neuropsychologists and other providers to charge patients who fail to show for their appointments. While "no show" charges do not offset all the lost revenue from a "no show," they can provide an incentive to patients to keep their appointments.

As of October 1, 2007, Medicare allows the clinical neuropsychologist to charge patients a "no show" fee, provided the following conditions are met [8]:

1. The "no show" charge must be applied consistently to all patient insurance groups (Medicaid being an allowed exception) and not just to Medicare patients.
2. Patients must be informed in advance of the "no show" charge (we recommend that you inform patients at the time appointments are made, at the time appointments are confirmed, and in your patient registration material).
3. The charge must be reasonable (there is no guideline for "reasonable," though we are aware of $25–50 being common for "no show" charges per hour in our community). A simple method to find out what is the common charge in your community is to call *your* personal physician's office and ask what they charge for a "no show." Just remember, most PCP visits are much shorter that the typically 1-h minimal unit of time you set aside for a patient.
4. "No show" charges are billed directly to patients as a "noncovered" service; they *cannot* be billed to Medicare or other insurance companies.

Medicare Participation Options

Neuropsychologists and other providers are not required to see Medicare patients. Three options exist for contracting with Medicare: (1) participating (PAR), (2) nonparticipating (NON-PAR), and (3) opting out/private contracting (OPT-OUT) [9].

As a general rule, Medicare contractors send letters to providers in mid-November of each year, informing them of the upcoming calendar year's payment rates and offering them an opportunity to change their participation status. Providers then have until December 31 of that year to make their participation decisions. Unless CMS reopens this "open enrollment period," participation is binding for the entire calendar year.

1. PAR: When a neuropsychologist agrees to "participate" in Medicare, they agree to accept Medicare's reimbursement rates as payment in full for the calendar year in question. Medicare reimburses participating providers at 100% of the approved payment rate and pays them more rapidly than nonparticipating providers. Generally speaking, 80% of the payment comes from Medicare, with the balance coming from the patient.
2. NON-PAR: If a neuropsychologist elects not to participate in Medicare, they have the option whether or not to "accept assignment." If the NON-PAR provider accepts assignment, Medicare pays claims at 95% of the participating provider amount, with 80% of that amount coming from the contractor and 20% from the patient. If the NON-PAR provider decides not to accept assignment, they must fill out a Medicare beneficiary's claim form and submit the claim directly to Medicare. Medicare then pays the patient directly, leaving the physician to bill the patient for services rendered. Physicians cannot charge Medicare patients for filing their claims, but by refusing assignment, NON-PAR providers can balance bill patients up to the "limiting charge" (federal law restricts Medicare nonparticipating providers from balance billing more than 115% of the Medicare nonparticipating reimbursement rate. This is called the "limiting charge." The potential reimbursement rate for NON-PAR providers is 115% of the Medicare NON-PAR reimbursement rate, which is 109.25% of the participating provider reimbursement rate). Of course, as a NON-PAR provider, the onus is on your practice to bill and collect from your patients. For many practices, the cost of billing Medicare on behalf of their patients, then billing the patients to collect what Medicare paid directly to them, and then attempting to collect from these patients is not worth it.
3. OPT-OUT: Neuropsychologists also may elect to opt out of the Medicare system entirely. To do so, one agrees to not participate in the Medicare program for 2 years and privately contracts with Medicare beneficiaries for services rendered. Neuropsychologists can then bill patients directly for their services at rates agreed to between the patient and neuropsychologist. To meet the legal requirements for the opt-out option, one must sign and file an affidavit in which they agree not to bill or receive payment from Medicare for at least 2 years.

The affidavit of participation status must be completed at least 30 days before the first day of the next calendar quarter; there is a 90-day window for rescinding the affidavit. The opted-out neuropsychologist and Medicare patient must sign a written contract *before* any service is rendered. The contract must clearly state that, by signing the contract, the patient (1) declines all Medicare payments for services rendered by the neuropsychologist, (2) is liable for all charges without Medicare balance billing limitations *or* assistance from Medigap or other supplemental insurance, and (3) acknowledges that the patient has the right to receive services from other medical providers.

Where a neuropsychologist opts out and is a member of a group practice or otherwise reassigns his or her rights to Medicare payment to an organization, the organization may no longer bill Medicare or be paid by Medicare for services that the neuropsychologist furnishes to Medicare beneficiaries. However, if the neuropsychologist continues to grant the organization the right to bill and be paid for the services he furnishes to patients, the organization may bill and be paid by the Medicare patient for the services that are provided under the private contract. The decision of an individual provider to opt out of Medicare does not affect the ability of the group practice or

organization to bill Medicare for the services of those and practitioners who continue in a participating or nonparticipating status with Medicare.

Some Common Medicare Patient Request Situations: What Is the Appropriate Response?

These responses are based upon a review of the current APA ethics code as well as our years of clinical and business-related experience. Our responses should be viewed as guidelines to be considered by the reader. You may develop other responses to these situations that are also appropriate or, perhaps, even more appropriate than what is noted below. The main thrust of each response deals with (a) making a priori service delivery decisions about the contractual arrangements you set up with the patient and (b) using your understanding of how the patient's insurance approval and reimbursement system works.

Situation A The patient who wants you to carry out a comprehensive, attorney-requested or court-ordered, forensic examination, which is to be billed in its entirety to Medicare. The purpose of this evaluation is for a forensic opinion(s) to be developed and used in a legal matter.

Response Do not accept the referral with the proviso of billing Medicare for a forensic (administrative) service. This is not a medically necessary service. You may be in violation of several ethical rules as well as run the risk of committing fraud in terms of your contractual relationship with the insurance payor. Ask yourself the question, "Is the referral question and the resultant testing medically necessary as they relate to the making of a diagnosis or alleviating a medical or mental problem? Would the testing be necessary if there was no active litigation?"

Medicare specifically states The services of CPs are not covered if the service is otherwise excluded from Medicare coverage even though a clinical psychologist is authorized by state law to perform them. For example, the Social Security Act (Section 1862(a)(1)(A)) excludes from coverage services that are not "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Therefore, even though the services are authorized by state law, the services of a CP that are determined to be not reasonable and necessary are not covered [10].

Situation B The patient has always wondered if they could have a learning disability, and now they want to be tested under Medicare for that service. They want educational testing to identify a diagnosis of a learning disability, and the patient wants you to bill the services to Medicare. They are not complaining of any other form of medical, neurological illness or injury or mental health problem that may be causally associated with such an educational condition.

Response It is our understanding that Medicare does not cover testing for educational purposes, such as to identify a learning disability, as it does not meet the criteria for medical necessity/covered service.

Situation C The patient asks or demands that you waive either their co-pay, their deductible, or both.

Response Do not waive the co-pay or deductible. Not only are you providing a service well below your cost basis, but you may find that you have violated the law! The Centers for Medicare and Medicaid Services (CMS) has mandated that physicians and other providers of health care *must* collect co-pays and deductibles [11].

The reasoning behind this is as follows: If you (the neuropsychologist) waive the co-pay or deductible, you are, in effect, giving the patient a discount. Therefore, if you are willing to "sell" your service to the patient at a discount, you should also give a discount to the insurer. A sec-

ond (and lesser) reason for requiring co-pays and deductibles is to cause the patient to have a share in the cost of their health care, thereby reducing unnecessary consumption of covered services.

A Review of Some Sample Forms for a Private Practice in Clinical Neuropsychology

The items that follow are examples of the types of forms that we have developed to address common situations which occur in management of our practice. Please feel free to adapt them to your presented elsewhere [7].

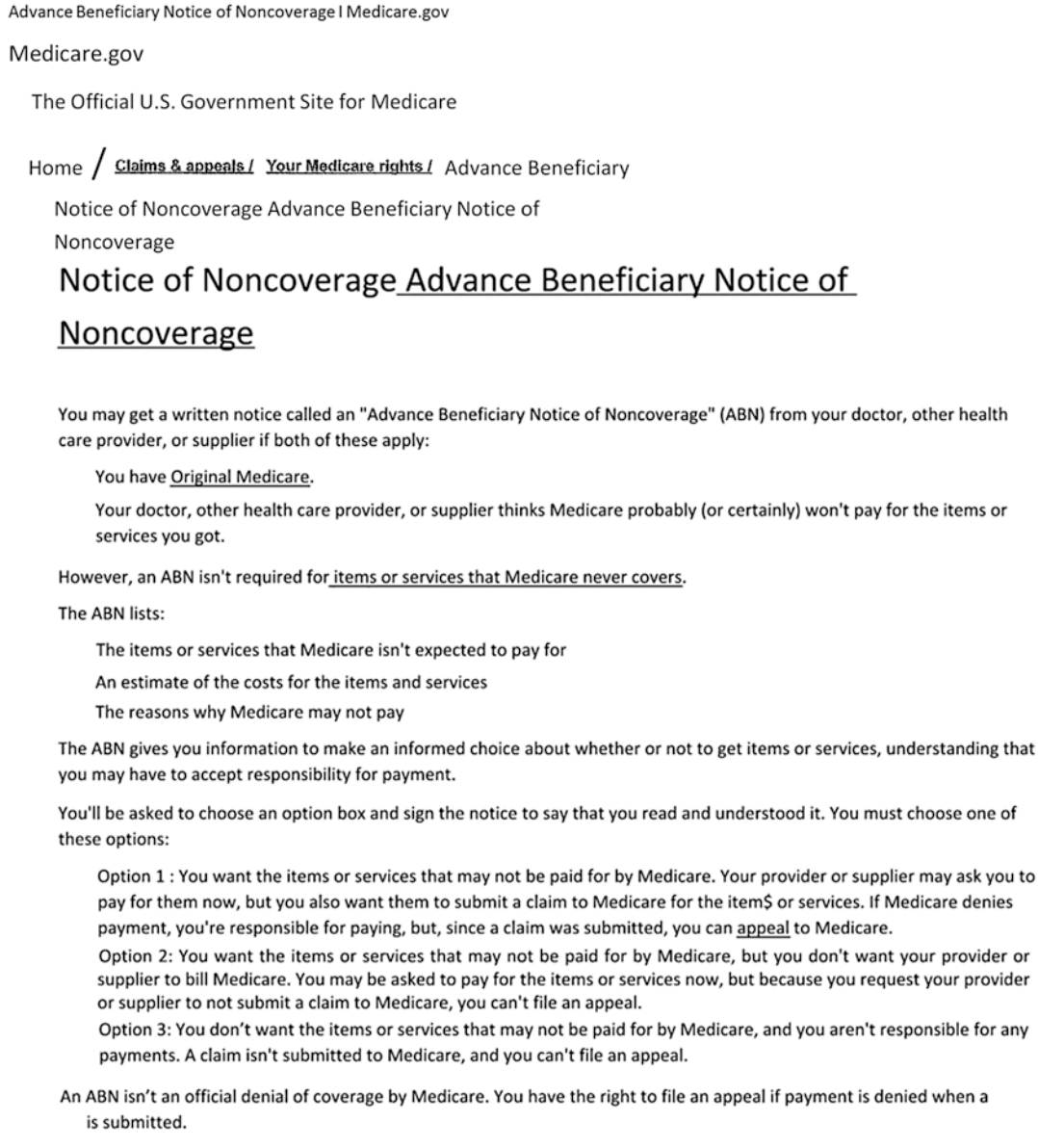
Please note the following caveats. Many of the forms have been reviewed by our company attorney for acceptable legal standards according to the laws of the Commonwealth of Virginia. You will need to determine whether the wording in these forms is legally valid in your jurisdiction. Also, we feel that these forms reflect an appropriate professional standard of practice according to current APA ethics standards. Please do not try to interpret these documents out of context. Our office will change these forms whenever it is deemed necessary so as to maintain acceptable legal and ethical standards. Finally, each of these forms is designed to be completed on an a priori service delivery basis. This issue is critical in many of the circumstances relevant to these forms.

(a) Referral form (Fig. 8.1): This intake form is typically completed as part of a telephone call from either the referral source or the patient/patient's family. Please note that it also prompts for secondary and tertiary insurance information. Some patients have Medicare plans that may require a preauthorization for services. You do not want to have to try to get a preauthorization, while the patient is waiting at the registration window and waiting for their appointment.
(b) Registration form (Fig. 8.2): Page 1 asks for the typical information. Page 2 addresses a number of specific issues. Without going into a line by line annotation, please note several items of particular interest: first, that the time for testing includes administration, scoring, and report preparation as well as report discussion and, second, that the cost of responding to medical legal matters requires time and that fees will be charged for these services; page 3 deals with documenting the Medicare no show policy and other general insurance matters.
(c) Waiver of insurance (Fig. 8.3): This form is a copy of the standard Medicare "Advance Notice for Medically Unnecessary Services—Waiver of Medical Necessity" form [12, 13]. This form should be used in those situations where you have a Medicare enrollee who is requesting services which, in their specific situation, are not likely to be deemed medically necessary by Medicare. In many situations, federal rules still require the provider to submit the claim, even though they have good reason to believe in advance that the service, e.g., forensic issues, is not going to meet the accepted standard of medical necessity. This signed waiver allows the provider to bill the enrollee for the service instead of having to write off the claim. For further information regarding this complex issue, please refer to the website of your state's Medicare Part B carrier.

This form is valid as of July 26, 2017, and the Medicare website states (taken verbatim as public information):

Medicare and Neuropsychology: A Look Forward to the Abyss or to Eden? What Will Our Business Management Practices Look Like in the Future?

(a) We see opportunities for reimbursement increases if our profession is successful in advocating for inclusion in MIPS and other quality/cost programs. However, we expect to see per unit reimbursement levels continue to decline over the next 10 years if our



Advance Beneficiary Notice of Noncoverage I Medicare.gov

Medicare.gov

The Official U.S. Government Site for Medicare

Home / Claims & appeals / Your Medicare rights / Advance Beneficiary

Notice of Noncoverage Advance Beneficiary Notice of Noncoverage

Notice of Noncoverage Advance Beneficiary Notice of Noncoverage

You may get a written notice called an "Advance Beneficiary Notice of Noncoverage" (ABN) from your doctor, other health care provider, or supplier if both of these apply:

You have Original Medicare.

Your doctor, other health care provider, or supplier thinks Medicare probably (or certainly) won't pay for the items or services you got.

However, an ABN isn't required for items or services that Medicare never covers.

The ABN lists:

The items or services that Medicare isn't expected to pay for

An estimate of the costs for the items and services

The reasons why Medicare may not pay

The ABN gives you information to make an informed choice about whether or not to get items or services, understanding that you may have to accept responsibility for payment.

You'll be asked to choose an option box and sign the notice to say that you read and understood it. You must choose one of these options:

Option 1 : You want the items or services that may not be paid for by Medicare. Your provider or supplier may ask you to pay for them now, but you also want them to submit a claim to Medicare for the item$ or services. If Medicare denies payment, you're responsible for paying, but, since a claim was submitted, you can appeal to Medicare.

Option 2: You want the items or services that may not be paid for by Medicare, but you don't want your provider or supplier to bill Medicare. You may be asked to pay for the items or services now, but because you request your provider or supplier to not submit a claim to Medicare, you can't file an appeal.

Option 3: You don't want the items or services that may not be paid for by Medicare, and you aren't responsible for any payments. A claim isn't submitted to Medicare, and you can't file an appeal.

An ABN isn't an official denial of coverage by Medicare. You have the right to file an appeal if payment is denied when a is submitted.

Fig. 8.1 Referral form

profession does not advocate effectively. We are moving away from per unit fees to global service fees. We still expect to see the upper limit of allowable testing units decline as Medicare and other payors increase the demand for computerized testing *and* decrease funding for our services.

(b) These changes will result in an even greater reliance on forensic and other professional services where fee structures are less regulated. This will also "make up" some of the lost revenue for those who continue to see Medicare patients.

(c) We also envision more neuropsychologists choosing to "opt out" of Medicare and work solely on a private contract arrangement with patients. The rise in "concierge neuropsychology" services is already a reality.

(d) Many of the "a la carte" options typically offered to patients for free, or little cost will

Neuropsychological Services Of Virginia
Intake Form

Referred To: _____ Referred By: _____ Date: _____

Referral Called In By: _____ Phone No: _____ Fax No: _____

Client Name: _____ DOB: _____ Age: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Phone: [Circle] Home - Work - Cell Email Address: _____

Responsible Party: _____ Relationship To Patient: _____

Responsible Party Contact Info: _____ Employer: _____

Reason For Referral: _____

_____

_____

_____

NT _____ PT _____ Therapy _____ EducT _____ DOA: _____ LOC [ ] Yes [ ] No

Outpatient: _____ Inpatient: _____ Room #: _____ Records Req?: [ ] Yes [ ] No

Accident?: [ ] Yes [ ] NO - DOI: _____ WC?: [ ] Yes [ ] NO - DOA: _____ Attorney: _____

Primary Insurance: _____ ID: _____ Phone #: _____

Address: _____ Contact: _____

Mental Health Carrier (If Different): _____ Phone#: _____

Mental Health Carrier Address: _____ Effective Date: _____

Policy Holder Name: _____ Rel to Pt: _____ Group#: _____

Policy Holder D. O. B. _____ Policy Holder Other Info _____

Deduct: _____ Met?: _____ Copay/Coinsurance.: _____ Preauth Req?: _____ OTR Req?: _____

Preauth # DI: _____ Preauth # Test: _____ Preauth # Therapy: _____

Notes: _____

_____

_____

Secondary Insurance: _____ ID: _____ Phone #: _____

Address: _____ Contact: _____

Mental Health Carrier (If Different): _____ Phone#: _____

Policy Holder Name: _____ Effective Date: _____

Deduct: _____ Met?: _____ Copay Visit/Unit: _____ PreAuth Req?: _____ OTR Req?: _____

Preauth # DI: _____ Preauth # Test: _____ Preauth # Ther.: _____

Appointment Date: _____ Confirmed Appt w/__ _____ on _____ by _____

Appointment Date: _____ Confirmed Appt w/_____ on _____ by _____

Appointment Date: _____ Confirmed Appt w/_____ on _____ by _____

Client Informed: Copay Amount: _____ 48-hr Notice: _____ Glasses/Med List: _____ D/E Q_____ Rev. 6/26/10

Fig. 8.1 (continued)

NEUROPSYCHOLOGICAL SERVICES OF VIRGINIA, INC.

PATIENT REGISTRATION

First Name:_____ **Middle:**_____ **Last Name:**_____

Address:_____ **City:**_____ **State:**_____ **ZIP:**_____

Home Phone: (_____**)**_____**-**_____ **SSN:**_____/_____/_____ **Sex: [ ] Male [ ] Female**

DOB:_____/_____/_____ **AGE:**_____ **Referred by:**_____

Were you injured while working? (Workers' Comp) [ ] NO [ ] YES-->Date of Injury: _____/_____/_____

Accident? [ ] NO [ ] YES-->Motor Vehicle? [ ] YES [ ] Other _____ **Date of Accident** _____/_____/_____

Are you represented by an attorney? [ ] NO [ ] YES-->Attorney Name _____

Have you been seen at NSV previously? [ ] YES [ ] NO Are you here on an emergency basis? [ ] YES [ ] NO

Are you covered by insurance health plan(s)? [ ] YES [ ] NO If YES, we need to make a copy of your insurance card(s).

Primary Ins. _____ **Secondary Ins.** _____

Vocational Status:

[ ] full-time student
[ ] part-time student
[ ] homemaker
[ ] retired
[ ] full-time employed
[ ] part-time employed
[ ] unemployed
[ ] disabled
[ ] other _____

Education:_____**Years Completed Degree:**_____

Handedness: [ ] right [ ] left [ ] ambidextrous

Occupation:_____
Employer:_____
Work Phone:_____
Cell Phone:_____

Marital Status: [ ] Single [ ] Separated [ ] Divorced [ ] Married [ ] Widowed

Medication	Dosage (mg)	# per day	Medication	Dosage (mg)	# per day
1)			4)		
2)			5)		
3)			6)		

Responsible Party, if other than patient: (who is responsible for payment of all costs incurred)

First Name:_____ **Middle:**_____ **Last Name:**_____

Address:_____ **City:**_____ **State:**_____ **ZIP:**_____

Home Phone: (_____**)**_____**-**_____
Employer:_____ **Work Phone: (**_____**)**_____**-**_____

Responsible party's relationship to patient: [ ] Spouse [ ] Child [ ] Parent Other _____

Note: Fees are posted at the receptionist's window.

Fig. 8.2 Patient registration form

need to become full fee expenses, so as to be able to operate at a profit vs. loss for the time, talent, and effort involved. These items include (1) forms that the patient wants completed and (2) letters to document some element of care or diagnosis, as well as other services which may not be billed to Medicare.

(e) Once Medicare and other insurance companies allow for services where the professional is not actually physically present on-site with the patient, the entire question of in-office testing will become moot. The patient will not have to come to the neuropsychologist's office if they can go to another site such as the PCP's office and be interviewed and then

Neuropsychological Services of Virginia, Inc.

GUARANTEE OF PAYMENT AND ASSIGNMENT OF INSURANCE BENEFITS: For value received, the undersigned guarantor and/or patient (hereinafter the "Responsible Party") promises to pay to Neuropsychological Services of Virginia, Inc. (hereinafter "NSV") all charges incurred for services rendered to the Responsible Party. The Responsible Party understands that NSV will process the paperwork to complete insurance claim(s) but only as a courtesy to the Responsible Party, and the Responsible Party authorizes NSV to release any and all medical information necessary to complete insurance claim(s) and assigns any monies due and owing under the insurance contract to NSV. **It is, however, understood and agreed that the Responsible Party is responsible for all monies due and owing for services rendered by NSV in the event insurance does not pay for these services.** It is acknowledged that the ultimate completing and following-up of any insurance claims is the responsibility of the Responsible Party. It is further agreed by the Responsible Party, that in the event any monies received by NSV from the insurance carrier which are at any time after their receipt withdrawn from NSV by the insurance carrier, the Responsible Party will be responsible for those monies then due and owing, and waives any defense for payment the Responsible Party may have against NSV. In the event this account is turned over to an attorney for collection, the Responsible Party hereby agrees to pay all costs of collection including, but not limited to, court costs and 33 1/3% attorney's fees. The Responsible Party authorizes use of this form on all insurance claim submissions. Release of records to referral sources is also authorized. The Responsible Party agrees to be bound by the terms and conditions of this account with NSV.

A minimum of 48 hours weekday / 2 business days notice is required for cancellation of appointments. If this notice is not received, the Responsible Party may be charged a fee for the amount of time which was reserved for the appointment at the rates posted in the offices of NSV. See page 3 for details. This also applies to Medicare patients. Insurance will not be billed for missed/canceled appointments. Your copay is expected at the time of service. We will file the Responsible Party's initial insurance claim(s) and provide documentation necessary for insurance reimbursement. We do not, however, guarantee that each service will be covered or what percentage will be covered. The Responsible Party may incur extra charges for refiling of insurance claims.

In the event that the Patient's/Responsible Party's insurance does not cover our services (or any portion thereof), NSV will work with the Responsible Party regarding payment (e.g., setting up a payment plan). NSV expects full payment within thirty (30) days of the date of service. **The Responsible Party hereby agrees that accounts not paid within thirty (30) days will be charged a late fee of $15.00 and will accrue interest at the rate of 1.5% per month (18% A.P.R. - a minimum of $1.00 will apply).** The Responsible Party bears ultimate financial responsibility for all services rendered to the Patient/Responsible Party, including workers' compensation claims and personal injury cases, regardless of the outcome of litigation. In the event that coverage is denied under workers' compensation, the Responsible Party will pay any unpaid balance, notwithstanding any appeal of such denial. With respect to personal injury cases, the Responsible Party is responsible for fees incurred, NSV may not be able to seek payment from third parties, and NSV cannot wait on the outcome of pending litigation for payments. NSV does not accept contingency fee arrangements. If there is any remaining balance(s) due at the time of settlement, the Responsible Party hereby authorizes their attorney to clear the Responsible Party's outstanding accounts. In the event the Responsible Party has **"medpay"** available and health insurance, NSV considers medpay to be the primary insurer. The Responsible Party's signature also constitutes the irrevocable agreement to a waiver permitting payment of medpay insurance claims directly to NSV prior to claimant receiving such funds.

Responding to Forensic/Medical Legal requests, conferences and telephone calls with attorneys involve additional time and record keeping. The Responsible Party is responsible for all direct costs and expenses associated with NSV and its attorney responding to discovery requests (including depositions and subpoena duces tecum time and labor costs) and with conferences including, but not limited to court appearances, preparation of reports, photocopying, faxes, long-distance telephone calls, out of office travel, overnight delivery and courier services. These expenses are billed to the Responsible Party and to the Patient's/Responsible Party's Attorney. The Responsible party, however, remains responsible for payment of these charges if not paid in full within sixty (60) days. The above noted direct cost and expenses are understood and accepted to be in addition to any published federal and/or state statutes which may otherwise apply.

NOTE: Testing includes time for (1) administering and (2) scoring the tests, and (3) preparing the report. In nonforensic/nonmedical-legal cases, this will typically add 1-3 hours to the actual testing time. Forensic/medical-legal cases typically require even more time and may include record review and consultation(s) with attorney(s), etc. In certain cases (such as, but not limited to, medical-legal cases), a more comprehensive and time-consuming assessment may be needed than what may be approved under your insurance plan [for example, when an insurance plan covers up to 3 hours of testing/report preparation but your clinician feels that your case requires additional hours of testing/record review/report preparation/etc]. The responsible party as noted below accepts responsibility for these charges.

If you have any questions, please speak with a member of our Management team. Your signature indicates that you have read the above and agree to the terms contained therein. These agreements are irrevocable.

Signature: _____ Responsible Party: _____

Date: _____ Date: _____

****If patient is a minor, are you her/his legal guardian?** [ ] YES [ ] NO If **NO**, please notify our Management team regarding this matter.

Rev. 4/12/2011

Fig. 8.2 (continued)

Neuropsychological Services of Virginia, Inc.

Insurance & Appointment No Show Information Notice

From: The Clinicians & Staff at NSV

It has come to our attention that, despite every reasonable effort undertaken by *you* and by our clinicians and highly trained office staff to obtain specific and accurate information/confirmation from your insurance company regarding:

1. Whether our clinicians and/or NSV is an approved provider of services under your health care plan;
2. What are the insurance approved services requested in your case;
3. What is the time limited extent of services which may be provided per appointment;
4. What is the insurance company stated allowed amount of patient copay and/or the allowed amount of insurance payment to be made to NSV;
5. The specific preauthorization and preauthorization number for the requested services;
6. Other information which documents the insurance company's responsibility to pay the patient's claim.

Unfortunately, some insurance companies may provide NSV with the information needed to appropriately process and reimburse NSV for professional services rendered, but then (after we perform the requested services) they inform us that the insurance information which they gave us is incorrect and/or incomplete. Your insurance company then may inform the clinicians and NSV that they are not responsible for payment for the otherwise agreed upon services. Your insurance company may delay and/or defer their reimbursement for previously authorized services. The clinicians and NSV thereby inform the responsible party noted below that: first, this type of situation may develop in your situation despite your/our best efforts to prevent such an event; second, that the responsible party assumes responsibility for making the insurance company take appropriate responsibility for their actions; third, that the responsible party agrees to pay NSV the appropriate payment which is otherwise due from the insurance company while the responsible party seeks to make the insurance company live up to their agreed upon financial obligations to the patient.

7. *Missed/Broken appointments:* A minimum of 48 hours weekday/business days advance notice is required for the cancellation of appointments without incurring a missed/broken appointment penalty. This is strictly enforced. If this notice is not received, the Responsible Party may be charged:
   (a) $75.00 for a missed 1 hour Psychotherapy and or Office Feedback appointment and
   (b) $75.00 *per hour* for a missed Testing appointment. This may involve 3 – 8 hours of lost time.
   (c) $15.00 for a missed 10 minute Telephone Feedback/Conference appointments.
   (d) Please see the 2011 rate schedule posted in the office of NSV for further information.

If you have any questions, please speak with a member of our Management team. Your signature indicates that you have read the above and agree to the terms contained therein.

Signature: _____ Date: _____

Fig. 8.2 (continued)

accessed via Internet-based video connection (e.g., Skype-type service). This is already happening.

(f) As Medicare moves toward its uncertain future, Congress will explore other mechanisms to rein in the costs of caring for a growing Medicare population. We, as a profession, must work together to create a qualitative and quantitative value proposition. Neuropsychology can and should play a key role in caring for Medicare patients. If they are unable to make a strong case for such, we run the risk of neuropsychology being pushed to the sidelines of patient care. We make this point a second time because we believe being at the table beats being on the menu for the future of our profession.

(g) Now that electronic medical records have become more widespread, private practice neuropsychologists will adopt such technology in greater numbers. There will be many reasons, but simply being able to maintain

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

  Note: If you choose Option **1** or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Fig. 8.3 Medicare noncovered service form

record access from referral sources and to provide quick transmission and access of our reports to other sources will become more critical. If we do not stay on an EMR technology par with our MD referral sources, then the MD will see the cost of their office having to copy or fax records to us as a financial disincentive for a referral. Active use of an EMR will be critical for involvement in MIPS and other payment incentive models.

It is therefore incumbent to focus on the "value" of the services we offer. Even as many of our tests become computerized, we must continue to demonstrate the value of the personal interaction between neuropsychologist and patient. We must be able to demonstrate how the information we provide is better and more accurate than "shortcut" software-based neuropsychological testing being sold to (and used by) other medical professions who do not have our training and expertise. We must be able to show how our care creates better patient outcomes. To the extent we can do this, our future is much brighter.

Clinical Pearls

- Know what constitutes a medically necessary service and agree to bill Medicare for such service—and bill the patient for services that are not medically necessary according to Medicare.
- Play a role in making sure payors understand what neuropsychologists do and how our efforts have a positive impact on both patient outcomes and the overall delivery of cost-effective health care.
- Do not hesitate to educate the patient as to what is a medically necessary service and what is not medically necessary. The patient should have a say in their health-care delivery choices. This includes accepting financial responsibility for nonmedically necessary services.
- Document time and service provided to the patient properly the first time, according to documentation standards, and you will reduce the risk of audit problems in the future.
- Know what your cost of practice is and use that information properly in your clinical care decisions. This includes understanding the cost of unfilled time on your schedule when you are not receiving offsetting revenue.
- Do not forget the rules you knew yesterday may have changed overnight. Health-care reimbursement, quality measurement, and delivery have changed significantly since the first edition of this book a mere 5 years ago. Be a student and remain a student.
- Be clear and consistent with patients about collecting co-pays and deductibles.
- One cannot provide "Luxury car quality care at used car rates of reimbursement." Also, plan for the autonomous driving vehicle and don't be left at the curb.
- We enjoy helping people or we would not work in this field. We feel that our professional time has value and that the business arrangements that we make are reasonable and appropriate to providing care to our patients. We cannot provide quality services if we cannot meet our financial obligations.
- The next time you visit your doctor, read the sign next to the receptionist's window. Typically, it will state that "Co-pays are expected at time of service" and that "the patient is responsible for obtaining pre-authorization for requested services." *Treat your patients appropriately and in the same manner you are treated when you are the patient at the receptionist window.*

References

1. http://www.kff.org/medicare/timeline/pf_intro.htm. Accessed 29 May 2011.
2. President Richard M. Nixon. Health care: requests for action on three programs (1972, March 2), message to Congress on Health Care, Congressional Quarterly Almanac 1972. Washington, DC: Congressional Quarterly Books; 1972. p. 43A.
3. http://www.managedcaremuseum.com. Accessed 25 May 2011.

4. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-MIPS-NPRM-Slides.pdf
5. Medicare and Medicaid statistical supplement (2010 Edition). Centers for Medicare and Medicaid Services; 2010.
6. www.kff.org/medicare/state-indicator/total -medicare beneficiaries. Accessed 28 July 2017.
7. Peck EA. Business aspects of private practice in clinical neuropsychology. In: Lamberty GJ, Courtney JC, Heilbronner RL, editors. The practice of clinical neuropsychology: a survey of practices and settings. Lisse: Swets & Zeitlinger; 2003.
8. Transmittal 1279. Change request 5613, Pub 100-04 for Medicare claims processing. Department of Health & Human Services, Centers for Medicare & Medicaid Services. http://www.cms.gov//transmittals/downloads/R1279CP.pdf. 29 June 2007.
9. Medicare participation options for physicians. The American Medical Association; 2010.
10. http://www.ssa.gov/OP_Home/ssact/title18/1862.htm. Accessed 25 May 2011.
11. http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html. Accessed 25 May 2011.
12. https://www.cms.gov/bni/. Accessed 25 May 2011.
13. https://www.medicare.gov/claims-and-appeals/medicarerights/abn/advance-notice-of-non-coverage.html. Accessed 28 July 2017.