creyos

REIMBURSEMENT PROTOCOL:

Primary Care

A comprehensive guide to essential coding for cognitive assessments and screenings using Creyos Health

Reimbursement Strategies for Primary Care Services

Reimbursement for primary care services can be a complex process, but understanding the key elements of coding and documentation is essential for successful claims. This guide is designed to provide clarity on the essential codes used for cognitive and mental health assessments and screenings.

By exploring the various coding guidance—including testing evaluation, administration, screening, preventative, and care planning services—providers can ensure that they are maximizing reimbursement opportunities while adhering to payer-specific requirements. **Understanding the nuances of these codes and the associated reimbursement considerations is crucial** to delivering high-quality care while ensuring financial sustainability for primary care services.

Table of Contents

Cognitive Assessment & Care Planning Services

Cognitive assessment and care planning services focus on evaluating and managing cognitive impairment through a comprehensive approach. These services involve assessing cognitive function, identifying safety concerns, reviewing medications, and addressing neuropsychiatric symptoms. The goal is to develop a personalized care plan that supports the patient's needs, enhances daily functioning, and connects them with appropriate resources for ongoing management.

Cognitive Assessment & Care Planning - 99483

Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements:

- Cognition-focused evaluation with history, examination, and moderate/high complexity decision-making
- Functional assessment (ADLs, decision-making capacity)
- Dementia staging (e.g., FAST, CDR)
- Medication review for high-risk drugs
- Neuropsychiatric and behavioral evaluation (e.g., depression screening)
- Safety assessment (home, driving); caregiver evaluation (knowledge, needs, support)
- Advance care planning
- Written care plan addressing symptoms, limitations, and referrals to community resources.

Reimbursement Considerations:

- Cognitive assessment and care planning services under code 99483 encompass a comprehensive evaluation and the development or modification of a care plan. These components may be completed over multiple encounters and involve collaboration with an independent historian, such as a caregiver or family member, to ensure a thorough assessment and effective care planning.
- Total time requires 50-60 minutes for face-to-face patient services and includes informant(s). The patient must be present for all or a majority of the service.
- Should not be reported on the same date as testing services codes (e.g., 96130-96146) and E/M services (e.g., 99202-99215).
- Can be reported in conjunction with an annual wellness visit (G0438 or G0439) or a preventative visit (99381-99396), as appropriate.
- Frequency limits apply, typically allowed every 180 days as medically necessary.

Test Evaluation Codes

Selection between **96130** (psychological evaluation) and **96132** (neuropsychological evaluation) is payer-specific and depends on factors such as the type of test performed, the primary condition being assessed, and the provider's specialization. It is essential to review individual payer policies to ensure appropriate code selection.

Psychological Evaluation

- **96130** – Psychological testing evaluation services by provider or QHP, first hour
- **+96131** – Each additional hour

Typically used for evaluating conditions primarily affecting emotional, behavioral, or cognitive functioning without significant neurological involvement.

Common examples include:

- Functional neurological symptom disorder (conversion disorder)
- Psychogenic non-epileptic seizures (PNES)
- Chronic pain with associated psychological factors
- Somatic symptom and related disorders
- Adjustment disorders related to medical or neurological conditions
- Anxiety or depression secondary to chronic neurological conditions (e.g., migraines, functional movement disorders)

Neuropsychological Evaluation

- **96132** – Neuropsychological testing evaluation services by provider or QHP, first hour
- **+96133** – Each additional hour

Appropriate for assessing conditions with neurological, cognitive, or developmental complexities, including executive function, language, attention capabilities and memory, visual-spatial, and sensorimotor functioning.

Common examples include:

- Neurodegenerative diseases (e.g., mild cognitive impairment, early Alzheimer's disease, Parkinson's disease with cognitive impairment)
- ADHD with significant executive dysfunction or neurological comorbidities
- Traumatic brain injury (TBI), post-concussion syndrome, stroke, and cerebrovascular disorders affecting cognition
- Neurological psychosis (e.g., psychosis secondary to brain injury or neurodegenerative disease)
- Other neurodevelopmental or neurocognitive disorders requiring detailed functional assessment

Reimbursement Considerations:

- Base codes (96130, 96132) require 31+ minutes of service.
- Add-on codes (+96131, +96133) require 91+ minutes on the same date or 31+ minutes on a separate date (billed with the base code).
- Clear documentation of total evaluation time is critical, face-to-face services in addition to non-face-to-face activities are required to report for this service.
- Typically reimbursed when medical necessity is supported.
- Frequency limits vary by payer, generally 3-4 times per year, as medically necessary.

Test Administration Codes

Test administration codes capture the direct application of psychological and neuropsychological testing, whether by a provider, QHP, or technician. Accurate time documentation is key for proper reimbursement. Below are the relevant codes and reimbursement considerations.

Test Administration by Provider/QHP	Test Administration by Technician
• **96136** – Psychological/neuropsychological test administration via any method, 2+ tasks, first 30 minutes (by a provider or QHP) • **+96137** – Each additional 30 minutes	• **96138** – Psychological/neuropsychological test administration via any method, 2+ tasks, first 30 minutes (by a technician) • **+96139** – Each additional 30 minutes
Test Administration Unsupervised or Single Task	
• **96146 –** Test administration of single task, with automated result (admin unsupervised)	

Reimbursement Considerations:

- Base codes (96136, 96138) require 16+ minutes of service.
- Add-on codes (+96137, +96139) require 46+ minutes (billed with the base code).
- Accurate time documentation is essential for billing additional units.
- Coding should reflect whether a provider or technician supervised the administration of the test.
- Frequency limits vary by payer, typically 3-4 times per year, as medically necessary.

Screening Codes

Screening assessments are essential for evaluating a patient's emotional, behavioral, or developmental health. These codes are used to capture brief assessments, which can guide further evaluation and treatment planning.

Screening for Emotional/Behavioral Assessment	Screening for Developmental Delay Assessment
• **96127** – Brief emotional/behavioral assessment (e.g., depression, anxiety, or ADHD screening) • **G0444** – Annual depression screening, 5 to 15 minutes (Medicare)	• **96110** – Developmental screening (e.g., autism screening)

Commercial Payer - Screening and Intervention for Alcohol and/or Substance Abuse	Medicare Payer - Screening and Intervention for Alcohol and/or Substance Abuse
• **96160** – Administration of patient-focused health risk assessment instrument • **99408** – Alcohol and/or substance abuse structured screening, and brief intervention (SBI) services (eg, AUDIT, DAST); 15-30 minutes • **99409** – Alcohol and/or substance abuse structured screening, and brief intervention (SBI) services (eg, AUDIT, DAST); 30+ minutes	• **G2011** – Alcohol and/or substance abuse structured screening, and brief intervention (SBI) services (eg, AUDIT, DAST); 5-14 minutes • **G0396** – Alcohol and/or substance abuse structured screening, and brief intervention (SBI) services (eg, AUDIT, DAST); 15-30 minutes • **G0397** – Alcohol and/or substance abuse structured screening, and brief intervention (SBI) services (eg, AUDIT, DAST); 30+ minutes

Reimbursement Considerations:

- Can be billed separately from an E/M visit if MDM and time are separate, with appropriate documentation support.
- When billed with an E/M service, must be separately identifiable. Requires modifier 25 appended to the E/M code (e.g., 99202-99215).
- Should not be reported on the same date as testing services codes (e.g., 96130-96146) and/ore care planning service (e.g., 99483).
- Frequency limits vary by payer, typically allowed as medically necessary.

Annual Preventative Visits

Annual wellness and preventive visits play a vital role in assessing a patient's overall health, identifying risk factors, and guiding proactive care. These visits focus on preventive screenings, personalized health planning, and early detection of potential health concerns. By evaluating key health indicators and discussing lifestyle, medical history, and preventive strategies, providers can develop a tailored approach to maintaining and improving patient well-being.

Commercial Payer - Annual Preventative Visit (New Patient)	Commercial Payer - Annual Preventative Visit (Established Patient)
• **99381** – Periodic preventative medicine, new patient age <1 year	• **99391** – Periodic preventative medicine, established patient age <1 years
• **99382** – Periodic preventative medicine, new patient age 1-4 years	• **99392** – Periodic preventative medicine, established patient age 1-4 years
• **99383** – Periodic preventative medicine, new patient age 5-11 years	• **99393** – Periodic preventative medicine, established patient age 5-11 years
• **99384** – Periodic preventative medicine, new patient age 12-17 years	• **99394** – Periodic preventative medicine, established patient age 12-17 years
• **99385** – Periodic preventative medicine, new patient age 18-39 years	• **99395** – Periodic preventative medicine, established patient age 18-39 years
• **99386** – Periodic preventative medicine, new patient age 65+ years	• **99396** – Periodic preventative medicine, established patient age 65+ years

Medicare Payer - Annual Wellness Visit
• **G0438** – Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
• **G0439** – Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit

Reimbursement Considerations:

- Can be billed separately from an E/M visit if MDM and time are separate, with appropriate documentation support.
- When billed with an E/M service, must be separately identifiable. Requires modifier 25 appended to the E/M code (e.g., 99202-99215).
- May be reported on the same date as cognitive assessment and care planning services (e.g., 99483).
- Subject to frequency limitations, typically covered only once per year.

Diagnosis Considerations

In a primary care setting, diagnosing a wide range of conditions is crucial for comprehensive patient management. These diagnoses help guide care plans, identify risk factors, and ensure timely interventions. While the diagnostic categories may overlap with neurological concerns, primary care providers focus on recognizing symptoms and coordinating referrals or treatments based on medical history, functional status, and presenting issues

Cognitive Impairments, Mental, Behavioral, and Neurodevelopmental Disorders

- **F01-F03:** Vascular dementia, dementia in diseases classified elsewhere, unspecified dementia
- **F04-F09:** Amnesia, delirium, and other disorders due to known physiological conditions
- **F30-F39:** Mood [affective] disorders
- **F70-F79:** Intellectual disabilities
- **F80-F89**: Pervasive and specific developmental disorders
- **F90-F98:** Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- **G10-G14:** Systemic atrophies primarily affecting the central nervous system
- **G30-G32:** Other degenerative diseases of the nervous system
- **G35-G37:** Demyelinating diseases of the central nervous system
- **I69:** Sequela of cerebrovascular disease
- **R41:** Other symptoms and signs involving cognitive functions and awareness
- **S00-S09:** Injuries of the head

While additional diagnoses may apply, these represent the most commonly encountered categories in primary care settings.

Key Takeaways for Reimbursement Success

A comprehensive approach that includes accurate coding, strategic scheduling, and thorough documentation is essential to ensure optimal reimbursement outcomes.

Consider the following:

- **Verify payer-specific policies** – Coverage, frequency limits, and medical necessity criteria may differ.
- **Ensure clear documentation** – Differentiate between test administration, evaluation, and screening to support medical necessity.
- **Plan service scheduling strategically** – Separating testing from E/M visits can help prevent denials due to bundled payments.
- **Use modifiers appropriately** – Apply modifier 25 for separately identifiable E/M services and modifier 59 for procedural services when required, but always check NCCI edits for restrictions.
- **Maintain thorough records** – Even with correct coding and modifier use, reimbursement is subject to payer review. Detailed documentation is key.

By adhering to payer-specific guidelines and maintaining clear distinctions between services, providers can help mitigate the risk of denials and maximize reimbursement success.