American Psychological Association Services, Inc.

For additional information, contact:

APA Office of Health Care Finance
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2019 Psychological and Neuropsychological Testing Billing and Coding Guide

ADDENDUM

Provided below are three (3) examples of entire episodes of care for Psychological or Neuropsychological Assessment. These examples are meant to be a guide for how to code, document, and bill for testing services using the new revised CPT® code set implemented on January 1, 2019. Each example takes into consideration the most significant issues/problems reported by APA members since the new codes went into effect.

For purposes of clarity, we have divided each episode of care into five (5) stages. We understand that individual practice patterns differ and that not all practicing psychologists or neuropsychologists provide testing services in the exact order presented in this five-stage model. We do hope, however, that this approach, along with the content our three (3) examples, helps to clarify how the new code set is meant to be applied, documented and billed. The five (5) stages are as follows:

STAGE 1

- Record review and clarification of referral question
- Initial Test Selection

STAGE 2

- Psychiatric Diagnostic Evaluation/Neurobehavioral Status Examination
- Modification of initial test selection based on clinical interview findings

STAGE 3

- Test Administration and Scoring
  - 3A: By Professional
  - 3B: By Technician

STAGE 4

- Integration/Report Generation

STAGE 5

- Feedback session with patient (and family/caregiver)
- Feedback to the referring physician

EXECUTIVE SUMMARY

TYPICAL NEUROPSYCHOLOGICAL ASSESSMENT

Each neuropsychological and psychological testing episode of care will vary depending on the intensity and complexity of the individual patient's condition. The case example below is intended to assist in understanding proper selection and application of the CPT® codes involved in a neuropsychological assessment episode of care.

Note: *For Psychological Assessment, Neurobehavioral Status Exam (96116/96112)^ would be replaced with 90791, Psychiatric diagnostic evaluation and Neuropsychological Evaluation Service (96132/96133)★ would be replaced with 96130/96131 Psychological Evaluation Services*

<table>
<tr><th>Service(s) Provided</th><th colspan="2">Description of Service(s) Provided</th><th>CPT® code(s)</th></tr>
<tr><td colspan="4">STAGE 1</td></tr>
<tr><td>Testing Evaluation Services</td><td colspan="2">Preliminary selection of tests. Record review. Collaboration with referring physician.</td><td>96132/96133★</td></tr>
<tr><td colspan="4">STAGE 2</td></tr>
<tr><td rowspan="2">Neurobehavioral Status Examination</td><td colspan="2">Clinical interview/assessment for impairments in acquired knowledge, attention, language, learning, memory, planning and problem solving, and visual-spatial abilities. Observe behavior and record responses. Develop clinical impression.
Typical domains assessed: Orientation, motor behavior, speech, thought processes, mood and affect, cooperation, performance and symptom validity, additional test observations.</td><td rowspan="2">96116/96121^</td></tr>
<tr><td colspan="2">Background Information: Presenting problems and symptoms, Relevant medical and/or psychiatric history of symptoms/treatment, Past medical history, Past psychiatric history, Substance use, Developmental/psychosocial history</td></tr>
<tr><td>Testing Evaluation Services</td><td colspan="2">Intra-Session Clinical Decision Making: Modification of test battery based on Neurobehavioral Status Examination/Behavioral Observations</td><td>96132/96133★</td></tr>
<tr><td colspan="4">STAGE 3</td></tr>
<tr><td colspan="2">STAGE 3A: By Professional</td><td colspan="2">STAGE 3B: By Technician</td></tr>
<tr><td>Test Administration and Scoring</td><td>96136/96137</td><td>Test Administration and Scoring</td><td>96138/96139</td></tr>
<tr><td colspan="2" rowspan="6">Administer a series of tests (standardized, rating scales, and/or projective). Record behavioral observations made during the testing. Score test protocol(s) according to the latest method-s for each test. Transcribe all test scores onto data summary sheet.</td><td colspan="2">Under general supervision of the professional, administer a series of tests (standardized, rating scales, and/or projective). Record behavioral observations ma-de during the testing.</td></tr>
<tr><td>Testing Evaluation Services</td><td>96132/96133★</td></tr>
<tr><td colspan="2">Intra-Session Clinical Decision Making by Professional:
Further modification of test battery based on preliminary administration and scoring of tests.</td></tr>
<tr><td>Test Administration and Scoring</td><td>96138/96139</td></tr>
<tr><td colspan="2">Continue administration of tests and recording behavioral observations. Score test protocol(s) according to the latest methods for each test. Transcribe all test scores onto data summary sheet.</td></tr>
<tr><td colspan="4">STAGE 4</td></tr>
<tr><td>Testing Evaluation Services</td><td colspan="2">Integration, Interpretation and Report Generation: Typical domains assessed can include intellectuality (premorbid, current), attention and processing speed, learning and memory, language function, visual-spatial abilities, motor abilities, executive function, symptom validity, and emotional/behavioral status.
Summary and Recommendations: Summary of test findings and diagnostic conclusions (if appropriate), treatment recommendation and plan.</td><td>96132/96133★</td></tr>
<tr><td colspan="4">STAGE 5</td></tr>
<tr><td>Testing Evaluation Services</td><td colspan="2">Interactive Feedback with patient (and family/caregiver). Report distribution and feedback to the referral doctor. Input report into electronic medical record.</td><td>96132/96133★</td></tr>
</table>

DETAILED CASE EXAMPLE 1

Each neuropsychological and psychological testing episode of care will vary depending on the intensity and complexity of the individual patient's condition. The case example below is intended to assist in understanding proper selection and application of the CPT® codes involved in a neuropsychological assessment episode of care.

Neuropsychological Assessment with Test Administration and Scoring Services Performed by the Professional Only

Case Example: A 58-year-old male with a history of diabetes and hypertension presents with a 6 month change in behavior, personality, and cognition and a positive family history of Alzheimer's disease. His physician refers him for neuropsychological testing to establish whether the patient has any suspected mental illness or neuropsychological abnormality or central nervous system dysfunction.

DAY 1: Appointment scheduled for 9:00 a.m.

9:00 a.m.-9:05 a.m.
Pre-service work by the professional (96132):
Record review and clarify the reason for referral
Initial test selection

9:05 a.m.-10:15 a.m.
Conduct Neurobehavioral Status Examination (96116/96121)
Face-to-Face Clinical Interview
Reporting Time

10:15 a.m.-10:20 a.m.
A Neurobehavioral Status Examination section is prepared **on the same day or a different day** as in the sample below:

Neurobehavioral Status Examination/Behavioral Observations

Mr. XXX arrived on time to his appointment and was accompanied by his wife. The patient was appropriately groomed and casually dressed. The patient's gait was slow. No other gross motor abnormalities were observed, and tremors noted by his wife were not apparent during the evaluation. Hearing and vision appeared adequate for testing purposes. He was generally alert and expressed vague understanding of the reason for the evaluation. **Attention was adequate but the patient required prompting and re-direction at times in order to maintain task engagement.** The need for re-direction became more frequent in the afternoon, as Mr. XXX began to appear notably fatigued, occasionally losing focus and appearing to daydream. On some tasks he required frequent reiteration of directions, as he did not always correct his mistakes after receiving feedback. Similarly, on two separate problem-solving measures Mr. XXX demonstrated **very high perseverative responding,** such that he continually responded in the same way despite corrective feedback. However, perseveration was largely absent on another task involving motor behavior. He demonstrated an **occasional instance of utilization behavior.** For example, when the examiner used their pencil to point aspects of tasks, the patient would try to grab the pencil to use for himself. His behavior generally lacked spontaneity. Conversational speech was normal in rate, but low in volume and lacked prosody. Thought processes were logical and goal directed. Notably, the **patient exhibited markedly poor insight regarding changes in his cognition and behavior** based on relative degree of concern expressed by his wife, despite demonstrating understanding that she is concerned. **The patient's affect was flat throughout the evaluation;** he **exhibited no emotional expression (facial or vocal).** Notably, the patient **never lost composure or appeared upset or irritable when faced with feedback that he had provided several incorrect responses in a row.** The patient was cooperative with the testing process and appeared to put forth adequate effort, however, his **lack of insight may have undermined his ability to accurately report his symptoms on self-report measures of psychological functioning.**

10:20 a.m.-10:45 a.m.
Intra-Session Clinical Decision Making (96132/96133)
Patient Symptom Management (96132/96133)

From the interview-based neurobehavioral status examination, the QHP learns that the patient has had behavior changes affecting social comportment for the past 5 years, including loss of social tact and restraint, problems with judgment and memory, and disorganization, all of which are interfering with the patient's ability to effectively manage his diabetes and hypertension. His wife can no longer manage him and is crying in the office looking for direction. This initial evaluation indicates neuropsychological testing is required to determine specific diagnosis or prognosis to aid in treatment planning.

10:45 a.m.-11:00 a.m.
Intra-Session Clinical Decision Making (96132/96133)
Test Review/Modification (96132/96133)

QHP now makes clinical decisions on additional test selection based on the interview and background information, to include tests of attention, executive function, and memory. Heavy emphasis now placed on practical judgment and problem-solving.

The choice of the test(s) administered and scored, and who performs these services, is based on patient indications and circumstances and/or clinical training, familiarity and comfort-level of the provider with the specific test. Examples of the types of tests that might be administered and scored are listed below:

- *Measuring Premorbid and Current Intellectual Function*

- *Wechsler Test of Premorbid Function*
- *Wechsler Abbreviated Scale of Intelligence*

- *Executive Function Measures*
  - *Wisconsin Card Sorting Test*
  - *Test of Practical Judgment*
- *Memory Measures*
  - *Brief Visuospatial Memory Test*
  - *California Verbal Learning Test*
- *Attention/Processing Speed Measures*
  - *Trail Making Test (A and B)*
  - *Stroop Color and Word Test*
  - *Measuring Visual-Spatial Abilities*
  - *Rey Complex Figure*
- *Language Measures*
  - *Boston Naming Test – 2nd Edition*
  - *Verbal Fluency (FAS/Animals)*
- *Neurobehavioral Measures*
  - *Behavior Rating Inventory of Executive Function*
  - *Epworth Sleepiness Scale*
- *Psychosocial Function Measures*
  - *Geriatric Depression Scale*
  - *Independent Living Scale (Health and Safety subtest)*
- *Performance Validity Testing*
  - *Test of Memory Malingering*

11:00 a.m.-11:30 a.m.

Face-to-Face Test administration of standardized tests of cognitive and emotional functioning by QHP (96136-96137)

Note: Code selection for test administration and scoring is determined by who performs the service.

When performed by the Professional/QHP, select 96136 (first 30 mins) / 96137 (each additional 30 min increment)

When performed by Technician, select 96138 (first 30 mins) / 96139 (each additional 30 min increment)

11:30 a.m.-1:00 p.m.

Patient given break for lunch

1:00 p.m.-2:15 p.m.

Continued face-to-face test administration of standardized tests of cognitive and emotional functioning by QHP (96136-96137)

On the same day or a different day, the QHP lists the tests administered in a separate section of the report.

2:15 p.m.

The patient complains of fatigue, becomes more agitated and less attentive. With much cognitive effort by the QHP to ensure participation and test completion, the evaluation is completed.

DAY 2: Non-Face-to-Face Services

9:00 a.m.-10:00 a.m.

Scoring of Test Battery from Day 1 by Professional (96137)and transfer scores to Data Summary Sheet

(Sample detailed data summary sheet below)

	Above Average	Average	Low Average	Borderline Impaired	Impaired
Global Cognitive/Intellectual Skills					
Full-Scale IQ			X		
Verbal Comprehension Index		X			
Perceptual Reasoning Index				X	
Premorbid IQ Estimation		X			
Attention/Working Memory/Processing Speed					
Simple Auditory Attention		X			
Speeded Word Reading					X
Speeded Color Naming				X	
Visuomotor Sequencing		X			
Executive Functioning					
Deductive Reasoning and Sorting					X
Problem Solving					X
Motoric/Behavioral Control		X			
Response Inhibition			X		
Visuomotor Set-Shifting		X			
Language					
Verbal Reasoning		X			
Vocabulary		X			
Naming		X			
Letter Fluency		X			
Category Fluency		X			
Learning / Memory					
Verbal Immediate Recall				X	
Verbal Delayed Recall			X		
Verbal List Discriminability				X	
Visuospatial Figures Immediate Recall					X
Visuospatial Figures Delayed Recall				X	
Visuospatial Figures Discriminability			X		
Sensory Perceptual and Motor					
Motor Dexterity			DH	NDH	
Visuospatial Skills					
Block Construction				X	
Visuospatial Reasoning			X		
Complex Figure Copy					X
Visuospatial Figures Copy			X		
Decision Making and Judgement					
Health and Safety Knowledge		X			
Practical Judgement					X
Mood		**WNL**	**Mild**	**Moderate**	**Severe**
Depression		X			
Anxiety		X			
Daytime Sleepiness		X			

DH = Dominant Hand
NDH = Non-dominant Hand

10:00 a.m.-12:00 p.m.

Integration/Report Generation (96132/96133)

Review of records, behavioral observations, information contained in the clinical history and psychometric test results suggest a possible diagnosis of Frontotemporal Dementia, Behavioral Variant.

Integrated reports will consider and document background information as relevant:

> **Background Information**
> *Information in this section was obtained through clinical interview with Mr. XXX and his wife (Mrs. YYY), a review of available medical records and a history questionnaire that Mr. XXX's wife completed.*
>
> Mr. XXX reported his primary concern as being physically "out of shape." Regarding cognitive functioning, Mr. XXX noted no noticeable issues, but identified that his wife is concerned. He **reported his memory as being "good enough," but worse than it used to be**. He **identified greater ease in recalling remote information than more recent information**. Mr. XXX did not report any additional concerns with daily functioning and noted that he has not worked in 5 years. He is still driving. He noted no major changes in his personality but stated that he sometimes is hard on his daughter as he expects things to be "done right."
>
> In a separate interview, Mr. XXX's **wife reported ongoing concerns regarding her husband's memory and executive functioning, which have become worse over the last two years**. She reported that **he has difficulty remembering conversations and people's names**. She also reported **difficulties with executive functioning, involving difficulty with initiation, planning, judgment, and insight. He reportedly benefits from structure and "constant reminders." Changes in his personality were also noted. Mr. XXX's friends have reportedly "pulled away" and he has demonstrated reduced empathy and kindness, especially towards their daughter**. Ms. YYY noted **increased social inappropriateness and decreased attention to personal hygiene**. She reported that he has been **very resistant to medical follow up**. For example, he does not "acknowledge" having hearing difficulties. She reported that **he is able to independently manage his activities of daily living**.
>
> Mr. XXX's **wife started noticing changes in her husband approximately eight years ago, when he demonstrated paranoid ideation and increased suspiciousness of others**, such that he believed others were breaking in and taking things. Mr. XXX reportedly **received a diagnosis of depression with psychosis in 2008, which was treated successfully with medication (Abilify and Effexor). He had no history of psychological/psychiatric disturbance or treatment prior to 2008. Substance use/abuse was denied**. Around this period, Mr. XXX also began having **difficulties with sleep, which have been continually treated with Ambien**. His wife reported that Mr. XXX has **gained weight and is eating more frequently as he "forgets" that he eats**. She reported that **approximately 5 years ago, Mr. XXX was put on medical leave from work to undergo an evaluation. However, he did not disclose this to his wife, who only became aware after she found him still at home during work hours**. Ultimately, the school "didn't want him back" and he was let go. He did not seek out work at a different school and is now retired.
>
> Mr. XXX's **medical history is significant for high blood pressure and diabetes**, which are treated with losartan and metformin. Mr. XXX's wife also reported that he has "shaky" hands. He underwent **prostate surgery in 2019** and has difficulties with urinary retention. Mr. XXX reported **no history of significant head injury, however he played football in high school and college**. Mr. XXX's wife reported that he **received an MRI of the brain approximately eight years ago, which concluded there was "mass decrease."**

And typically provide an integrated summary of test results and recommendations:

> **Summary and Conclusions**
> Current test results indicate that Mr. XXX is a man **of at least average premorbid intellectual capabilities based on a combination of factors including his word knowledge, educational and occupational attainments (estimated FSIQ=106)**. Current **intellectual evaluation reflects capabilities that are lower (FSIQ = 85), accounted for primarily by increased difficulty performing perceptual–motor problem-solving tasks**. Mr. XXX **displayed significant neuropsychological dysfunction on this evaluation, reflected by impaired performances on measures of executive functioning, memory, and visual spatial abilities**. He evidenced **reduced problem-solving strategies** and had **particular difficulty on tasks that required higher level spatial reasoning**. He was highly perseverative in his responding on certain problem-solving tasks, but when provided with external structure and direction his performance improved substantially. **In contrast to these deficits, Mr. XXX displays intact basic attention, language abilities and retentive memory on two of three measures**. **When presented with more demanding and detailed information to learn**, however, Mr. XXX's **memory capacity declined and retentive memory difficulties were present**. In contrast to these impaired performances, Mr. XXX's **responses to psychological and behavioral questionnaires indicate no complaints of depression, anxiety, or sleep difficulties**. Further, Mr. XXX reports no change in personality, judgment, or executive abilities, while his wife reports dramatic changes in all of these areas.
>
> By history, Mr. XXX has experienced a **change in his behavior and personality dating back to 2008, when he developed neuropsychiatric symptoms for the first time**. **Since then**, Mr. XXX has **undergone gradual and significant deterioration in social functioning, including decreased attention to personal hygiene, loss of social tact and restraint, change in eating predilections, decreased empathy, and loss of drive and initiative that has dramatically affected Mr. XXX's family and placed great tension in his relationships with others**. At this stage, Mr. XXX **appears largely apathetic and disengaged when confronted with descriptions of his behavior**. Likewise, **while he did not perform well, on specific measures of executive function he showed little distress or interest in the integrity of his performance during**

testing. Considering Mr. XXX's history of educational and occupational success, and the lack any prior psychiatric history, it is apparent that **his current neurobehavioral condition reflects a marked departure from his premorbid status**. He reported no current symptoms of depression or anxiety. Taken together, **the insidious onset of above described behavior changes in conjunction with gradually increasing cognitive impairments in executive functions and memory (although not retentive in nature), are strongly suggestive of frontotemporal dementia, behavioral variant**.

Additional neurological workup is strongly indicated for diagnosis. Functional imaging and/or nuclear imaging could be informative in further clarifying his current condition which appears to involve frontal systems dysfunction. At this point, I **recommend that Mr. XXX be referred to the specialists at the ZZZ Hospital, who could provide further diagnostic workup for frontotemporal dementia with access to treatment options and an educational/support network**.

DAY 3: Interactive Feedback and Post-Service Activities

(Both Face-to-Face and Non-Face-to-Face Services)

9:00 a.m.-10:00 a.m.

Interactive Feedback with the patient and family (96133)

Explain diagnosis, provide education to the family, help address the emotional responses to very bad news, help explain the next steps in the treatment plan.

10:00 a.m.-10:05 a.m.

Post-service work by the professional (96133)

Feedback to the referral doctor

Input report in the electronic medical record

DETAILED CASE EXAMPLE 1

Billing/Services Summary

Neurobehavioral Status Exam^	**Base: 96116 (1st 60 mins)**	**Add-on: 96121 (each addtl 60 mins)**
Face-to-Face: 9:05 a.m.-10:15 a.m. (DATE DAY 1)	70 minutes	
Documentation 10:15 a.m.-10:20 a.m. (DATE DAY 1)	5 minutes	
Total Time:	**75 minutes (1 hour 15 minutes)**	
Total Units:	**1**	**0**
Neuropsychological Testing Evaluation Services*	**Base: 96132 (1st 60 mins)**	**Add-on: 96133 (each addtl 60 mins)**
Record Review and Clarify Referral Question 9-9:05 a.m. (DATE DAY 1)	5 minutes	
Intra-Session Clinical Decision Making 10:20-10:30 a.m. (DATE DAY 1)	10 minutes	
Patient Symptom Management 10:30-10:45 a.m. (DATE DAY 1)	15 minutes	
Clinical Decision Making/Battery Modification 10:45 a.m.-11:00 a.m. (DATE DAY 1)	15 minutes	
Integration/Report Generation 10 a.m.-12 p.m. (DATE DAY 2)	120 minutes	
Interactive Feedback Session 9 a.m.-10 a.m. (DATE DAY 3)	60 minutes	
Post-Service Work 10 a.m.-10:05 a.m. (DATE DAY 3)	5 minutes	
Total Time:	**230 minutes (3 hours 50 minutes)**	
Total Units:	**1**	**3**
Test Administration and Scoring by Neuropsychologist	**Base: 96136 (1st 30 mins)**	**Add-on: 96137 (each addtl 30 mins)**
Test Administration *(Face-to-Face)* 11 a.m.-11:30 p.m., 1-2:15 p.m. (DATE DAY 1)	135 minutes	
Scoring *(Non-Face-to-Face)* 9 a.m.-10 a.m. (DATE DAY 2)*	60 minutes	
Total Time:	**195 minutes (3 hours, 15 minutes)**	
Total Units:	**1**	**5**
Diagnosis(es): G31.09 Frontotemporal Dementia		

Note: *For Psychological Assessment, Neurobehavioral Status Exam (CPT® codes 96116/96112)^ would be replaced with 90791, Psychiatric diagnostic evaluation and Neuropsychological Evaluation Service (codes 96132/96133)* would be replaced with 96130/96131 Psychological Evaluation Services*

DETAILED CASE EXAMPLE 2

Each neuropsychological and psychological testing episode of care will vary depending on the intensity and complexity of the individual patient's condition. The case example below is intended to assist in understanding proper selection and application of the CPT® codes involved in a neuropsychological assessment episode of care.

Neuropsychological Assessment with Professional and Technician Performing Test Administration and Scoring Services

Case Example: A 58-year-old male with a history of diabetes and hypertension presents with a 6 month change in behavior, personality, and cognition and a positive family history of Alzheimer's disease. His physician refers him for neuropsychological testing to establish whether the patient has any suspected mental illness or neuropsychological abnormality or central nervous system dysfunction.

DAY 1: Appointment scheduled for 9:00a.m.

9:00 a.m.-9:05 a.m.

Preservice work by the professional (96132):

Record review and clarify the reason for referral

Initial test selection

9:05 a.m.-10:15 a.m.

Conduct Neurobehavioral Status Examination (96116/96121)

Face-to-Face Clinical Interview

Reporting Time

10:15 a.m.-10:20 a.m.

A Neurobehavioral Status Examination section is prepared **on the same day or a different day** as in the sample below:

Neurobehavioral Status Examination/Behavioral Observations

Mr. XXX arrived on time to his appointment and was accompanied by his wife. The patient was appropriately groomed and casually dressed. The patient's gait was slow. No other gross motor abnormalities were observed, and tremors noted by his wife were not apparent during the evaluation. Hearing and vision appeared adequate for testing purposes. He was generally alert and expressed vague understanding of the reason for the evaluation. **Attention was adequate but the patient required prompting and re-direction at times in order to maintain task engagement. The need for re-direction became more frequent in the afternoon**, as Mr. XXX began to appear notably fatigued, occasionally losing focus and appearing to daydream. On some tasks he required frequent reiteration of directions, as he did not always correct his mistakes after receiving feedback. Similarly, on two separate problem-solving measures Mr. XXX demonstrated **very high perseverative responding**, such that he continually responded in the same way despite corrective feedback. However, perseveration was largely absent on another task involving motor behavior. He demonstrated an **occasional instance of utilization behavior**. For example, when the examiner used their pencil to point aspects of tasks, the patient would try to grab the pencil to use for himself. His behavior generally lacked spontaneity. Conversational speech was normal in rate, but low in volume and lacked prosody. Thought processes were logical and goal directed. Notably, the **patient exhibited markedly poor insight regarding changes in his cognition and behavior** based on relative degree of concern expressed by his wife, despite demonstrating understanding that she is concerned. **The patient's affect was flat throughout the evaluation**; he **exhibited no emotional expression (facial or vocal)**. Notably, the patient **never lost composure or appeared upset or irritable when faced with feedback that he had provided several incorrect responses in a row**. The patient was cooperative with the testing process and appeared to put forth adequate effort, however, his **lack of insight may have undermined his ability to accurately report his symptoms on self-report measures of psychological functioning**.

10:20 a.m.-10:45 a.m.

Intra-Session Clinical Decision Making (96132/96133)

Patient Symptom Management (96132/96133)

From the interview-based neurobehavioral status examination, the QHP learns that the patient has had behavior changes affecting social comportment for the past 5 years, including loss of social tact and restraint, problems with judgment and memory, and disorganization, all of which are interfering with the patient's ability to effectively manage his diabetes and hypertension. His wife can no longer manage him and is crying in the office looking for direction. This initial evaluation indicates neuropsychological testing is required to determine specific diagnosis or prognosis to aid in treatment planning.

10:45 a.m.-10:55 a.m.

Intra Session Clinical Decision Making (96132/96133)

Test Review/Modification (96132/96133)

QHP now makes clinical decisions on additional test selection based on the interview and background information, to include tests of attention, executive function, and memory. Heavy emphasis now placed on practical judgment and problem-solving.

The choice of the test(s) administered and scored, and who performs these services, is based on patient indications and circumstances and/or clinical training, familiarity and comfort-level of the provider with the specific test. Examples of the types of tests that might be administered and scored are listed below:

- *Measuring Premorbid and Current Intellectual Function*
  - › *Wechsler Test of Premorbid Function*
  - › *Wechsler Abbreviated Scale of Intelligence*
- *Executive Function Measures*
  - › *Wisconsin Card Sorting Test*
  - › *Test of Practical Judgment*
- *Memory Measures*
  - › *Brief Visuospatial Memory Test*
  - › *California Verbal Learning Test*
- *Attention/Processing Speed Measures*
  - › *Trail Making Test (A and B)*
  - › *Stroop Color and Word Test*
- *Measuring Visual-Spatial Abilities*
  - › *Rey Complex Figure*
- *Language Measures*
  - › *Boston Naming Test – 2nd Edition*
  - › *Verbal Fluency (FAS/Animals)*
- *Neurobehavioral Measures*
  - › *Behavior Rating Inventory of Executive Function*
  - › *Epworth Sleepiness Scale*
- *Psychosocial Function Measures*
  - › *Geriatric Depression Scale*
  - › *Independent Living Scale (Health and Safety subtest)*
- *Performance Validity Testing*
  - › *Test of Memory Malingering*

10:55 a.m.-11:25 a.m.
QHP administers a series of standardized tests of cognitive and emotional function

Test Administration by QHP (96136-96137)

Note: Code selection for test administration and scoring is determined by who performs the service.

When performed by the Professional, select 96136 (first 30 mins) / 96137 (each additional 30 min increment)

When performed by Technician, select 96138 (first 30 mins) / 96139 (each additional 30 min increment)

11:25 a.m.-1:00 p.m.
Patient given break for lunch

1:00 p.m.-1:10 p.m.
Intra-Session Clinical Decision Making (96132/96133)
Test Review/Modification (96132/96133)

QHP meets with the technician to review morning tests and behavioral observations. In this case, the QHP then communicates new clinical decisions on additional test selection based on how the patient is performing on tests of memory and problem-solving.

1:10 p.m.-2:10 p.m.
Test Administration and Scoring by Technician (96138-96139)

QHP directs and supervises the continued administration and scoring of a battery of standardized tests by the test technician.

2:10-2:20 p.m.
Intra Session Clinical decision making (96132/96133)
Test Review/Modification (96132/96133)

QHP again meets with the technician to review progress and test performance, behavioral observations and make final test choice modifications. In this case, the QHP decides that additional tests evaluating practical judgment and knowledge of correct health and safety practices would be required based on poor performance on executive function measures and the fact that the patient is home alone much of the day.

2:20-3:20 p.m.
Test Administration and Scoring by Technician (96138-96139)

QHP directs and supervises the continued administration and scoring of a battery of standardized tests by the test technician.

On the same day or a different day, the QHP lists the tests administered by technician and QHP **in separate sections** of the report, and time is reported separately in the scoring grid at the end of the report.

3:20 p.m.
The patient complains of fatigue, becomes more agitated and less attentive. With much cognitive effort by the QHP to ensure participation and test completion, the evaluation is completed.

DAY 2: Non-Face-to-Face Services

9:00 a.m.-10:00 a.m.

Scoring of Entire Test Battery from Day 1 by Technician (96139)

Transfer scores to Data Summary Sheet

(Sample detailed data summary sheet below)

	Above Average	Average	Low Average	Borderline Impaired		Impaired
Global Cognitive/Intellectual Skills						
Full-Scale IQ			X			
Verbal Comprehension Index		X				
Perceptual Reasoning Index				X		
Premorbid IQ Estimation		X				
Attention/Working Memory/Processing Speed						
Simple Auditory Attention		X				
Speeded Word Reading						X
Speeded Color Naming				X		
Visuomotor Sequencing		X				
Executive Functioning						
Deductive Reasoning and Sorting						X
Problem Solving						X
Motoric/Behavioral Control		X				
Response Inhibition			X			
Visuomotor Set-Shifting		X				
Language						
Verbal Reasoning		X				
Vocabulary		X				
Naming		X				
Letter Fluency		X				
Category Fluency		X				
Learning / Memory						
Verbal Immediate Recall				X		
Verbal Delayed Recall			X			
Verbal List Discriminability				X		
Visuospatial Figures Immediate Recall						X
Visuospatial Figures Delayed Recall				X		
Visuospatial Figures Discriminability			X			
Sensory Perceptual and Motor						
Motor Dexterity			DH	NDH		
Visuospatial Skills						
Block Construction				X		
Visuospatial Reasoning			X			
Complex Figure Copy						X
Visuospatial Figures Copy			X			
Decision Making and Judgement						
Health and Safety Knowledge		X				
Practical Judgement						X
Mood		WNL	Mild	Moderate		Severe
Depression		X				
Anxiety		X				
Daytime Sleepiness		X				

DH = Dominant Hand
NDH = Non-dominant Hand

10:00 a.m.-12:00 p.m.

Integration/Report Generation (96132/96133)

Review of records, behavioral observations, information contained in the clinical history and psychometric test results suggest a possible diagnosis of Frontotemporal Dementia, Behavioral Variant.

Integrated reports will consider and document background information as relevant:

> **Background Information**
> *Information in this section was obtained through clinical interview with Mr. XXX and his wife (Mrs. YYY), a review of available medical records and a history questionnaire that Mr. XXX's wife completed.*
>
> Mr. XXX reported his primary concern as being physically "out of shape." Regarding cognitive functioning, Mr. XXX noted no noticeable issues, but identified that his wife is concerned. He **reported his memory as being "good enough," but worse than it used to be**. He **identified greater ease in recalling remote information than more recent information**. Mr. XXX did not report any additional concerns with daily functioning and noted that he has not worked in 5 years. He is still driving. He not-ed no major changes in his personality but stated that he sometimes is hard on his daughter as he expects things to be "done right."
>
> In a separate interview, Mr. XXX's **wife reported ongoing concerns regarding her husband's memory and executive functioning, which have become worse over the last two years**. She reported that **he has difficulty remembering conversations and people's names**. She also reported **difficulties with executive functioning, involving difficulty with initiation, planning, judgment, and insight. He reportedly benefits from structure and "constant reminders." Changes in his personality were also noted. Mr. XXX's friends have reportedly "pulled away" and he has demonstrated reduced empathy and kindness, especially towards their daughter**. Ms. YYY noted **increased social inappropriateness and decreased attention to personal hygiene**. She reported that he has been **very resistant to medical follow up**. For example, he does not "acknowledge" having hearing difficulties. She reported that **he is able to independently manage his activities of daily living**.
>
> Mr. XXX's **wife started noticing changes in her husband approximately eight years ago, when he demonstrated paranoid ideation and increased suspiciousness of others**, such that he believed others were breaking in and taking things. Mr. XXX reportedly **received a diagnosis of depression with psychosis in 2008, which was treated successfully with medication (Abilify and Effexor). He had no history of psychological/psychiatric disturbance or treatment prior to 2008. Substance use/abuse was denied**. Around this period, Mr. XXX also began having **difficulties with sleep, which have been continually treated with Ambien**. His wife reported that Mr. XXX has **gained weight and is eating more frequently as he "forgets" that he eats**. She reported that **approximately 5 years ago, Mr. XXX was put on medical leave from work to undergo an evaluation. However, he did not disclose this to his wife, who only became aware after she found him still at home during work hours**. Ultimately, the school "didn't want him back" and he was let go. He did not seek out work at a different school and is now retired.
>
> Mr. XXX's **medical history is significant for high blood pressure and diabetes**, which are treated with losartan and metformin. Mr. XXX's wife also reported that he has "shaky" hands. He underwent **prostate surgery in 2019** and has difficulties with urinary retention. Mr. XXX reported **no history of significant head injury, however he played football in high school and college**. Mr. XXX's wife reported that he **received an MRI of the brain approximately eight years ago, which concluded there was "mass decrease."**

And typically provide an integrated summary of test results and recommendations:

> **Summary and Conclusions**
> Current test results indicate that Mr. XXX is a man **of at least average premorbid intellectual capabilities based on a combination of factors including his word knowledge, educational and occupational attainments (estimated FSIQ=106)**. Current **intellectual evaluation reflects capabilities that are lower (FSIQ = 85), accounted for primarily by increased difficulty performing perceptual–motor problem-solving tasks**. Mr. XXX **displayed significant neuropsychological dysfunction on this evaluation, reflected by impaired performances on measures of executive functioning, memory, and visual spatial abilities**. He evidenced **reduced problem-solving strategies** and had **particular difficulty on tasks that required higher level spatial reasoning**. He was highly perseverative in his responding on certain problem-solving tasks, but when provided with external structure and direction his performance improved substantially. **In contrast to these deficits, Mr. XXX displays intact basic attention, language abilities and retentive memory on two of three measures**. **When presented with more demanding and detailed information to learn**, however, Mr. XXX's **memory capacity declined and retentive memory difficulties were present**. In contrast to these impaired performances, Mr. XXX's **responses to psychological and behavioral questionnaires indicate no complaints of depression, anxiety, or sleep difficulties**. Further, Mr. XXX reports no change in personality, judgment, or executive abilities, while his wife reports dramatic changes in all of these areas.
>
> By history, Mr. XXX has experienced a **change in his behavior and personality dating back to 2008, when he developed neuropsychiatric symptoms for the first time. Since then**, Mr. XXX has **undergone gradual and significant deterioration in social functioning, including decreased attention to personal hygiene, loss of social tact and restraint, change in eating predilections, decreased empathy, and loss of drive and initiative that has dramatically affected Mr. XXX's family and placed great tension in his relationships with others**. At this stage, Mr. XXX **appears largely apathetic and disengaged when confronted with descriptions of his behavior**. Likewise, **while he did not perform well, on specific measures of executive function he showed little distress or interest in the integrity of his performance during testing**. Considering Mr. XXX's history

of educational and occupational success, and the lack any prior psychiatric history, it is apparent that **his current neurobehavioral condition reflects a marked departure from his premorbid status**. He reported no current symptoms of depression or anxiety. Taken together, **the insidious onset of above described behavior changes in conjunction with gradually increasing cognitive impairments in executive functions and memory (although not retentive in nature), are strongly suggestive of frontotemporal dementia, behavioral variant**.

Additional neurological workup is strongly indicated for diagnosis. Functional imaging and/or nuclear imaging could be informative in further clarifying his current condition which appears to involve frontal systems dysfunction. At this point, I **recommend that Mr. XXX be referred to the specialists at the ZZZ Hospital, who could provide further diagnostic workup for frontotemporal dementia with access to treatment options and an educational/support network**.

DAY 3: Interactive Feedback and Post-Service Activities

(Both Face-to-Face and Non-Face-to-Face Services)

9:00 a.m.-10:00 a.m.

Interactive Feedback with the patient and family (96133)

Explain diagnosis, provide education to the family, help address the emotional responses to very bad news, help explain the next steps in the treatment plan.

10:00 a.m.-10:05 a.m.

Post-service work by the professional (96133)

Feedback to the referral doctor

Input report in the electronic medical record

DETAILED CASE EXAMPLE 2

Billing/Services Summary

Neurobehavioral Status Exam^	**Base: 96116 (1st 60 mins)**	**Add-on: 96121 (each addtl 60 mins)**
Face-to-Face: 9:05 a.m.-10:15 a.m. (DATE DAY 1)	70 minutes	
Documentation 10:15 a.m.-10:20 a.m. (DATE DAY 1)	5 minutes	
Total Time:	**75 minutes (1 hour 15 minutes)**	
Total Units:	**1**	**0**
Neuropsychological Testing Evaluation Services*	**Base: 96132 (1st 60 mins)**	**Add-on: 96133 (each addtl 60 mins)**
Record Review and Clarify Referral Question 9-9:05 a.m. (DATE DAY 1)	5 minutes	
Intra-Session Clinical Decision Making 10:20-10:30 a.m., (DATE DAY 1)	10 minutes	
Patient Symptom Management 10:30-10:45 a.m. (DATE DAY1)	15 minutes	
Clinical Decision Making/Battery Modification 10:45-10:55 a.m., 1-1:10 p.m., 2:10-2:20 p.m. (DATE DAY 1)	30 minutes	
Integration/Report Generation 10 a.m.-12 p.m. (DATE DAY 2)	120 minutes	
Interactive Feedback Session 10 a.m.-11 a.m. (DATE DAY 3)	60 minutes	
Post-Service Work 10:35 a.m.-10:40 a.m. (DATE DAY 3)	5 minutes	
Total Time:	**245 minutes (4 hours 5 minutes)**	
Total Units:	**1**	**3**
Test Administration and Scoring by Neuropsychologist	**Base: 96136 (1st 30 mins)**	**Add-on: 96137 (each addtl 30 mins)**
Test Administration (*Face-to-Face*) 10:55 a.m.-11:25 a.m. (DATE DAY 1)	30 minutes	
Scoring (*Non-Face-to-Face*)	0 minutes – *All scoring by Technician*	
Total Time:	**30 minutes**	
Total Units:	**1**	**0**
Test Administration and Scoring by Technician	**Base: 96138$ (1st 30 mins)**	**Add-on: 96139 (each addtl 30 mins)**
Test Administration (Face-to-Face) 1:10-2:10 p.m., 2:20-3:20 p.m. (DATE DAY 1)	120 minutes	
Scoring (Non-Face-to-Face) 9-10 a.m. (DATE DAY 2)	60 minutes	
Total Time:	**180 minutes (3 hours)**	
Total Units:	**1**	**5**
Diagnosis(es): G31.09 Frontotemporal Dementia		

Note: *For Psychological Assessment, Neurobehavioral Status Exam (CPT® codes 96116/96112)^ would be replaced with 90791, Psychiatric diagnostic evaluation and Neuropsychological Evaluation Service (codes 96132/96133)* would be replaced with 96130/96131 Psychological Evaluation Services*

$Modifier required when QHP and Technician perform test administration and scoring for same patient, on same date of service. Append Modifier -XE when testing takes place at separate encounters. Append Modifier -59 when occurs during the same encounter.

DETAILED CASE EXAMPLE 3

Each neuropsychological and psychological testing episode of care will vary depending on the intensity and complexity of the individual patient's condition. The case example below is intended to assist in understanding proper selection and application of the CPT® codes involved in a neuropsychological assessment episode of care.

Neuropsychological Assessment with Test Administration and Scoring Services by Technician Only

Case Example: A 58-year-old male with a history of diabetes and hypertension presents with a 6 month change in behavior, personality, and cognition and a positive family history of Alzheimer's disease. His physician refers him for neuropsychological testing to establish whether the patient has any suspected mental illness or neuropsychological abnormality or central nervous system dysfunction.

DAY 1: Appointment scheduled for 9:00a.m.

9:00 a.m.-9:05 a.m.
Preservice work by the professional (96132):
Record review and clarify the reason for referral
Initial test selection

9:05 a.m.-10:15 a.m.
Conduct Neurobehavioral Status Examination (96116/96121)
Face-to-Face Clinical Interview
Reporting Time

10:15 a.m.-10:20 a.m.
A Neurobehavioral Status Examination section is prepared **on the same day or a different day** as in the sample below:

Neurobehavioral Status Examination/Behavioral Observations

Mr. XXX arrived on time to his appointment and was accompanied by his wife. The patient was appropriately groomed and casually dressed. The patient's gait was slow. No other gross motor abnormalities were observed, and tremors noted by his wife were not apparent during the evaluation. Hearing and vision appeared adequate for testing purposes. He was generally alert and expressed vague understanding of the reason for the evaluation. **Attention was adequate but the patient required prompting and re-direction at times in order to maintain task engagement. The need for re-direction became more frequent in the afternoon**, as Mr. XXX began to appear notably fatigued, occasionally losing focus and appearing to daydream. On some tasks he required frequent reiteration of directions, as he did not always correct his mistakes after receiving feedback. Similarly, on two separate problem-solving measures Mr. XXX demonstrated **very high perseverative responding**, such that he continually responded in the same way despite corrective feedback. However, perseveration was largely absent on another task involving motor behavior. He demonstrated an **occasional instance of utilization behavior**. For example, when the examiner used their pencil to point aspects of tasks, the patient would try to grab the pencil to use for himself. His behavior generally lacked spontaneity. Conversational speech was normal in rate, but low in volume and lacked prosody. Thought processes were logical and goal directed. Notably, the **patient exhibited markedly poor insight regarding changes in his cognition and behavior** based on relative degree of concern expressed by his wife, despite demonstrating understanding that she is concerned. **The patient's affect was flat throughout the evaluation**; he **exhibited no emotional expression (facial or vocal)**. Notably, the patient **never lost composure or appeared upset or irritable when faced with feedback that he had provided several incorrect responses in a row**. The patient was cooperative with the testing process and appeared to put forth adequate effort, however, his **lack of insight may have undermined his ability to accurately report his symptoms on self-report measures of psychological functioning**.

10:20 a.m.-10:30 a.m.
Patient Symptom Management (96132/96133)

From the interview-based neurobehavioral status examination, the QHP learns that the patient has had behavior changes affecting social comportment for the past 5 years, including loss of social tact and restraint, problems with judgment and memory, and disorganization, all of which are interfering with the patient's ability to effectively manage his diabetes and hypertension. His wife can no longer manage him and is crying in the office looking for direction. This initial evaluation indicates neuropsychological testing is required to determine specific diagnosis or prognosis to aid in treatment planning.

10:30 a.m.-10:45 a.m.
Intra-Session Clinical Decision Making (96132/96133)
Test Review/Modification (96132/96133)

QHP meets with the technician. Communicates new clinical decisions on additional test selection based on the interview and background information, to include tests of attention, executive function, and memory. Heavy emphasis now placed on practical judgment and problem-solving.

The choice of the test(s) administered and scored, and who performs these services, is based on patient indications and circumstances and/or clinical training, familiarity and comfort-level of the provider with the specific test. Examples of the types of tests that might be administered and scored are listed below:

- *Measuring Premorbid and Current Intellectual Function*
  - › *Wechsler Test of Premorbid Function*
  - › *Wechsler Abbreviated Scale of Intelligence*
- *Executive Function Measures*
  - › *Wisconsin Card Sorting Test*
  - › *Test of Practical Judgment*
- *Memory Measures*
  - › *Brief Visuospatial Memory Test*
  - › *California Verbal Learning Test*
- *Attention/Processing Speed Measures*
  - › *Trail Making Test (A and B)*
  - › *Stroop Color and Word Test*
- *Measuring Visual-Spatial Abilities*
  - › *Rey Complex Figure*
- *Language Measures*
  - › *Boston Naming Test – 2nd Edition*
  - › *Verbal Fluency (FAS/Animals)*
- *Neurobehavioral Measures*
  - › *Behavior Rating Inventory of Executive Function*
  - › *Epworth Sleepiness Scale*
- *Psychosocial Function Measures*
  - › *Geriatric Depression Scale*
  - › *Independent Living Scale (Health and Safety subtest)*
- *Performance Validity Testing*
  - › *Test of Memory Malingering*

10:45 a.m.-12:00 p.m.

Test Administration and Scoring by Technician (96138-96139)

Administration of standardized tests of cognitive and emotional functioning by **technician** under the supervision of the QHP.

Note: Code selection for test administration and scoring is determined by who performs the service.

When performed by the Professional, select 96136 (first 30 mins) / 96137 (each additional 30 min increment)

When performed by Technician, select 96138 (first 30 mins) / 96139 (each additional 30 min increment)

12:00 p.m.-1:00 p.m.

Patient given break for lunch

1:00 p.m.-1:10 p.m.

Intra-Session Clinical Decision Making (96132/96133)
Test Review/Modification (96132/96133)

QHP meets with the technician to review morning tests and behavioral observations. In this case, the QHP then communicates new clinical decisions on additional test selection based on how the patient is performing on tests of memory and problem-solving.

1:10 p.m.-2:10 p.m.

Test Administration by Technician (96138-96139)

Administration of standardized tests of cognitive and emotional functioning by technician under the supervision of the QHP.

2:10 p.m.

The patient complains of fatigue, becomes more agitated and less attentive. With much cognitive effort by the QHP to ensure participation and test completion, the evaluation is completed.

On the same day or a different day, the QHP lists the tests administered by technician and QHPs **in separate sections** of the report, and time is reported separately in the scoring grid at the end of the report

DAY 2: Non-Face-to-Face Services

9:00 a.m.-10:00 a.m.

Scoring of Test Battery from Day 1 (96138-96139) and transfer scores to Data Summary Sheet

Technician scores battery which the QHP then checks to ensure scoring accuracy and transfers scores to data summary sheet. *Sample detailed data summary sheet below.*

	Above Average	Average	Low Average	Borderline Impaired	Impaired
Global Cognitive/Intellectual Skills					
Full-Scale IQ			X		
Verbal Comprehension Index		X			
Perceptual Reasoning Index				X	
Premorbid IQ Estimation		X			
Attention/Working Memory/Processing Speed					
Simple Auditory Attention		X			
Speeded Word Reading					X
Speeded Color Naming				X	
Visuomotor Sequencing		X			
Executive Functioning					
Deductive Reasoning and Sorting					X
Problem Solving					X
Motoric/Behavioral Control		X			
Response Inhibition			X		
Visuomotor Set-Shifting		X			
Language					
Verbal Reasoning		X			
Vocabulary		X			
Naming		X			
Letter Fluency		X			
Category Fluency		X			
Learning / Memory					
Verbal Immediate Recall				X	
Verbal Delayed Recall			X		
Verbal List Discriminability				X	
Visuospatial Figures Immediate Recall					X
Visuospatial Figures Delayed Recall				X	
Visuospatial Figures Discriminability			X		
Sensory Perceptual and Motor					
Motor Dexterity			DH	NDH	
Visuospatial Skills					
Block Construction				X	
Visuospatial Reasoning			X		
Complex Figure Copy					X
Visuospatial Figures Copy			X		
Decision Making and Judgement					
Health and Safety Knowledge		X			
Practical Judgement					X
Mood		WNL	Mild	Moderate	Severe
Depression		X			
Anxiety		X			
Daytime Sleepiness		X			

DH = Dominant Hand
NDH = Non-dominant Hand

10:00 a.m.-12:00 p.m.

Integration/Report Generation (96132/96133)

QHP integrates clinical history from the medical record, neurobehavioral status examination, behavioral observations, and psychometric test results to reach conclusions, make recommendations during report generation. In this case, clinical decision making suggests a possible diagnosis of Frontotemporal Dementia, Behavioral Variant with recommendations for medical workup and family intervention.

Integrated reports will consider and document background information as relevant:

> **Background Information**
> *Information in this section was obtained through clinical interview with Mr. XXX and his wife (Mrs. YYY), a review of available medical records and a history questionnaire that Mr. XXX's wife completed.*
>
> Mr. XXX reported his primary concern as being physically "out of shape." Regarding cognitive functioning, Mr. XXX noted no noticeable issues, but identified that his wife is concerned. He **reported his memory as being "good enough," but worse than it used to be. He identified greater ease in recalling remote information than more recent information**. Mr. XXX did not report any additional concerns with daily functioning and noted that he has not worked in 5 years. He is still driving. He noted no major changes in his personality but stated that he sometimes is hard on his daughter as he expects things to be "done right."
>
> In a separate interview, Mr. XXX's **wife reported ongoing concerns regarding her husband's memory and executive functioning, which have become worse over the last two years. She reported that he has difficulty remembering conversations and people's names**. She also reported **difficulties with executive functioning, involving difficulty with initiation, planning, judgment, and insight. He reportedly benefits from structure and "constant reminders." Changes in his personality were also noted. Mr. XXX's friends have reportedly "pulled away" and he has demonstrated reduced empathy and kindness, especially towards their daughter**. Ms. YYY noted **increased social inappropriateness and decreased attention to personal hygiene**. She reported that he has been **very resistant to medical follow up**. For example, he does not "acknowledge" having hearing difficulties. She reported that **he is able to independently manage his activities of daily living**.
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> Mr. XXX's **wife started noticing changes in her husband approximately eight years ago, when he demonstrated paranoid ideation and increased suspiciousness of others**, such that he believed others were breaking in and taking things. Mr. XXX reportedly **received a diagnosis of depression with psychosis in 2008, which was treated successfully with medication (Abilify and Effexor). He had no history of psychological/psychiatric disturbance or treatment prior to 2008. Substance use/abuse was denied**. Around this period, Mr. XXX also began having **difficulties with sleep, which have been continually treated with Ambien**. His wife reported that Mr. XXX has **gained weight and is eating more frequently as he "forgets" that he eats**. She reported that **approximately 5 years ago, Mr. XXX was put on medical leave from work to undergo an evaluation. However, he did not disclose this to his wife, who only became aware after she found him still at home during work hours**. Ultimately, the school "didn't want him back" and he was let go. He did not seek out work at a different school and is now retired.
>
> Mr. XXX's **medical history is significant for high blood pressure and diabetes**, which are treated with losartan and metformin. Mr. XXX's wife also reported that he has "shaky" hands. He underwent **prostate surgery in 2019** and has difficulties with urinary retention. Mr. XXX reported **no history of significant head injury, however he played football in high school and college**. Mr. XXX's wife reported that he **received an MRI of the brain approximately eight years ago, which concluded there was "mass decrease."**

And typically provide an integrated summary of test results and recommendations:

> **Summary and Conclusions**
> Current test results indicate that Mr. XXX is a man **of at least average premorbid intellectual capabilities based on a combination of factors including his word knowledge, educational and occupational attainments (estimated FSIQ=106)**. Current **intellectual evaluation reflects capabilities that are lower (FSIQ = 85), accounted for primarily by increased difficulty performing perceptual–motor problem-solving tasks**. Mr. XXX **displayed significant neuropsychological dysfunction on this evaluation, reflected by impaired performances on measures of executive functioning, memory, and visual spatial abilities**. He evidenced **reduced problem-solving strategies** and had **particular difficulty on tasks that required higher level spatial reasoning**. He was highly perseverative in his responding on certain problem-solving tasks, but when provided with external structure and direction his performance improved substantially. **In contrast to these deficits, Mr. XXX displays intact basic attention, language abilities and retentive memory on two of three measures**. **When presented with more demanding and detailed information to learn, however, Mr. XXX's memory capacity declined and retentive memory difficulties were present**. In contrast to these impaired performances, Mr. XXX's **responses to psychological and behavioral questionnaires indicate no complaints of depression, anxiety, or sleep difficulties**. Further, Mr. XXX reports no change in personality, judgment, or executive abilities, while his wife reports dramatic changes in all of these areas.
>
> By history, Mr. XXX has experienced a **change in his behavior and personality dating back to 2008, when he developed neuropsychiatric symptoms for the first time**. **Since then**, Mr. XXX has **undergone gradual and significant deterioration in social functioning, including decreased attention to personal hygiene, loss of social tact and restraint, change in eating predilections, decreased empathy, and loss of drive and initiative that has dramatically affected Mr. XXX's family and placed great tension in his relationships with others**. At this stage, Mr. XXX **appears largely apathetic and disengaged when confronted with descriptions of his behavior**. Likewise, **while he did not perform**

well, on specific measures of executive function he showed little distress or interest in the integrity of his performance during testing. Considering Mr. XXX's history of educational and occupational success, and the lack any prior psychiatric history, it is apparent that **his current neurobehavioral condition reflects a marked departure from his premorbid status**. He reported no current symptoms of depression or anxiety. Taken together, **the insidious onset of above described behavior changes in conjunction with gradually increasing cognitive impairments in executive functions and memory (although not retentive in nature), are strongly suggestive of frontotemporal dementia, behavioral variant**.

Additional neurological workup is strongly indicated for diagnosis. Functional imaging and/or nuclear imaging could be informative in further clarifying his current condition which appears to involve frontal systems dysfunction. At this point, I **recommend that Mr. XXX be referred to the specialists at the ZZZ Hospital, who could provide further diagnostic workup for frontotemporal dementia with access to treatment options and an educational/support network**.

DAY 3: Interactive Feedback and Post-Service Activities

(Both Face-to-Face and Non-Face-to-Face Services)

9:00 a.m.-10:00 a.m.

Interactive Feedback with the patient and family (96133)

QHP explains diagnosis, provides education to the family, helps address the emotional responses to very bad news, and helps explain the next steps in the treatment plan.

10:00 a.m.-10:05 a.m.

Post-service work by the professional (96133)

Feedback to the referral doctor

Input report in the electronic medical record

DETAILED CASE EXAMPLE 3

Billing/Services Summary

Neurobehavioral Status Exam^	**Base: 96116 (1st 60 mins)**	**Add-on: 96121 (each addtl 60 mins)**
Face-to-Face: 9:05 a.m.-10:15 a.m. (DATE DAY 1)	70 minutes	
Documentation 10:15 a.m.-10:20 a.m. (DATE DAY 1)	5 minutes	
Total Time:	**75 minutes (1 hour 15 minutes)**	
Total Units:	**1**	**0**
Neuropsychological Testing Evaluation Services*	**Base: 96132 (1st 60 mins)**	**Add-on: 96133 (each addtl 60 mins)**
Record Review and Clarify Referral Question 9-9:05 a.m. (DATE DAY 1)	5 minutes	
Patient Symptom Management 10:20-10:30 a.m. (DATE DAY1)	10 minutes	
Clinical Decision Making/Battery Modification 10:30-10:45; 1:00-1:10; (DATE DAY 1)	25 minutes	
Integration/Report Generation 10 a.m.-12 p.m. (DATE DAY 2)	120 minutes	
Interactive Feedback Session 9 a.m.-10 a.m. (DATE DAY 3)	60 minutes	
Post-Service Work 10 a.m.-10:05 a.m. (DATE DAY 3)	5 minutes	
Total Time:	**225 minutes (3 hours, 45 minutes)**	
Total Units:	**1**	**3**
Test Administration and Scoring by Technician	**Base: 96138 (1st 30 mins)**	**Add-on: 96139 (each addtl 30 mins)**
Test Administration (Face-to-Face): 10:45 a.m.-12 p.m.; 1:10-2:10 p.m. (DATE DAY 1)	135 minutes	
Scoring (Non-Face-to-Face) 9 a.m.-10 a.m. (DATE DAY 2)	60 minutes	
Total Time:	**195 minutes (3 hours 15 minutes)**	
Total Units:	**1**	**5**
Diagnosis(es): G31.09 Frontotemporal Dementia		

Note: *For Psychological Assessment, Neurobehavioral Status Exam (CPT® codes 96116/96112)^ would be replaced with 90791, Psychiatric diagnostic evaluation and Neuropsychological Evaluation Service (codes 96132/96133)* would be replaced with 96130/96131 Psychological Evaluation Services*