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Training Workshops/Webinars
Frequently Asked Questions Billing ImPACT

<table>
<thead>
<tr>
<th>Questions from Workshop Attendees</th>
<th>Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Billing Questions</strong></td>
<td></td>
</tr>
<tr>
<td>Q: To make sure I am clear, physicians would only use E&amp;M and 96120 and never use the 96116 and 96118?</td>
<td>A physician can use either E&amp;M codes or neuropsych testing codes. You probably cannot use the E&amp;M and 96116 testing codes on the same date. You should be able to use the E&amp;M code with 96120 but you might have to add the 25 modifier to the E&amp;M code.</td>
</tr>
<tr>
<td>Q: 99215 is an E&amp;M Code?</td>
<td>Correct.</td>
</tr>
<tr>
<td>Q: Would it be possible for an ATC to conduct unsupervised ImPACT tests &amp; provide interpretation for physicians or neuropsychologists in an off-site location and then bill by attaching to the physician or neuropsychologists code?</td>
<td>An ATC is not authorized to bill 96118, 96116 or 96120. A neuropsychologist or physician can bill 96119 under his/her doctor code for the time spent by the ATC as well as 96120 for the unsupervised computer administration of ImPACT.</td>
</tr>
<tr>
<td>Q: So no modifier is needed with 96118 &amp; 96116 on the same day?</td>
<td>Correct.</td>
</tr>
<tr>
<td>Q: Do most insurance cover sports injuries in your experience or are they exclusions?</td>
<td>They are generally covered by insurances. Remember, how he/she received the concussion (sports, fall or accident) is not an issue for insurance companies.</td>
</tr>
<tr>
<td>Q: If the physician actually administers and enters data into the computer for the ImPACT tests, and the patient does not use the computer, do you bill code 96118?</td>
<td>Yes.</td>
</tr>
<tr>
<td>Q: Do you recommend us follow the CMS rule on mod 52? If 45 minutes or less, use mod 52 or 45?</td>
<td>It is recommended that you check with the specific carrier/insurance company.</td>
</tr>
<tr>
<td>Q: So a physician CAN bill 96116, 96118 and 96119? We are not using a neuropsych, so we would bill those VS the E&amp;M?</td>
<td>Yes, a physician can bill 96116, 96118 and 96119. However, typically they would bill the appropriate E&amp;M (type and complexity) rather than bill 96XXX codes.</td>
</tr>
<tr>
<td>Q: I am wondering how to bill the 96118: Do we bill per follow-up visit, or do we wait until we have 31 minutes (keep track of time) or</td>
<td>You can bill multiple visits using 96118 on the last date of service by adding them all up. It is recommended that you retain good documentation of DOS and amount of time of each visit in case of an audit.</td>
</tr>
</tbody>
</table>
Q: What if there was no face-to-face contact with the patient on the last date of service when billing 96118? Is it still allowable to use this date of service without patient contact when using the accumulated time?

Yes. This assumes that there was face-to-face contact during the first visit. In fact, this is a common scenario.

Q: I’m not clear on when you use EM code?

Physicians would use an E&M for the initial and follow-up evaluations and assessments of a sports concussion.

Q: You first bill 96116 when a patient follows up, how is that recommended to be coded?

Yes, you would bill 96116 as the initial interview and subsequent time can be billed under 96118.

Q: Can you bill an EM level with ImPACT test on first visit?

Yes, assuming you meet the requirements of the E&M code being billed.

Q: Would billing/coding be different based on testing site -- i.e. PCP office vs. Urgent Care vs. Sports Medicine MD.

In general, no. The only issues would entail with how the offices are designated (outpatient or hospital base). Even then, billing and coding is the same, but reimbursement is different.

Q: We do all of our testing in an office setting. I always bill the 96120 with an office visit code. Is that right?

Unsure what you mean by “office visit code.” If that means an E&M code and 96120, they can bill for that -- and they should consider using modifier 25 (answered above).

Q: Are there any dx codes you recommend using with the 96120 to help insurance companies pay?

Yes for ICD-9 850.x (concussion codes).

Q: I was told at a billing course that ImPACT could be billed by our Occupational Therapist utilizing 96125 Standardized Cognitive Performance Testing. We do a battery of other tests in conjunction with ImPACT. Have you seen any issues with “non-physician” providers such as Occupational Therapists charging for this test? Our physicians are interpreting the reports, but I am not sure how they are billing for that.

Yes, I suspect they can. However, this assumes the OT stays in the room the entire time when the athlete is taking ImPACT. I would recommend billing 96120 instead. The reimbursement rate is higher and after setting up the athlete, the OT can do other work while the athlete is taking the test.

Q: In scenario 1, if a nurse practitioner performed the ImPACT test with the patient, how might the billing change?

A nurse practitioner does not require supervision for billing 96119 and can bill for it independently. Alternatively, they can bill 96120 (if they do not stay in the room with the athlete). Please consider the reimbursement rate before deciding which the best option is.

Q: Could 96120 be used for ImPACT baseline testing? An example could be providing ImPACT baseline testing in preseason for a HS football player or team.

Baseline testing is not billable to one’s health insurance.
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**Q:** If a doctor hasn’t billed a 96120 can they go back and resubmit the bill with the 96120 code?

Yes, if it was actually done.

**Q:** Is there ever a time when a physician will be an E/M + 25-mod, + 96116 + 96118?

That is not a combination we have seen. It is recommended that you bill the appropriate E/M code with the 25 modifier and 96120. The physician would likely reach the higher level of complexity by billing all aspects of the exam (except 96120) under the E/M which would probably yield a higher reimbursement rate than billing the lower E/M complexity with 96118. We do not think one can bill 96116 and the E/M code as there is too much overlap between the two.

**Q:** We are new to this and want to understand the billing; all services are billed with the last date of service, even the initial visit (99215) which may have been held 4 days prior?

Not exactly. Only 96118 is combined and billed on the last date of service. The E/M codes are billed on the date administered.

**Q:** With the ImPACT codes can you also bill a 99215?

You can bill 99215 if you reach the criteria for the code.

**Q:** If a patient has BC/BS and they come back for a 2nd ImPACT, is there any way for it to be covered?

Yes. Bill it the same way you billed the initial evaluation using E/M or neuropsych testing codes, making sure you meet all the criteria for each code.

**Q:** When you say “physician,” can a pediatrician perform the ImPACT and bill these codes?

Yes.

**Q:** What are typical charges for baseline testing?

It varies greatly – anywhere from $5-$75, depending upon your goal. Please consider your costs and expectations for offering baseline testing.

**Q:** On the activity log, what date of service do you use for the combination of your time? The last date of service?

It depends. This pertains only to the neuropsych testing codes; 96118 can be performed over multiple days, combined and all billed on the last date of service.

**Q:** But if there is no Psy can a Physician use the 96116 and 96118 if he does not do a full ROS or Exam to reach a 99204 or 99244?

Yes.

**Q:** What codes (if any) can ATC’s or PT’s direct bill for ImPACT Testing if there is no physician on site?

Difficult to answer. ATCs or PTs can act as technicians and bill 96119 under the doctor code assuming that the definition of “supervision” has been met.

**Q:** In Wisconsin, we are told to bundle the E/M into the 96120. You show billing separately for the E/M and the test. Some carriers inform us to bill the codes separately. Do you have any references to back up the billing of each code separately?

This is a specific regional carrier issue that is likely highly idiosyncratic.
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Q: Can the physician bill for baseline ImPACT testing of large groups?

One cannot bill health insurance for baseline testing. However, the schools or individuals can be billed (similar to a physical).

Q: Can you bill 96119 and 96118 on same date? Our athletic trainer charges 96119 AND physician bills 96118 on same day. We are getting denied stating there is an NCCI edit.

You should be able to bill 96119 and 96118 on the same date of service, per CMs and Medicare. Please refer to my slides. However, some ins co deny it. I would mention the Medicare ruling on that (MM5240). Other options include billing the 96118 on the next day (so if the physician did his report the next day you can bill the 96118 as the day after the 96119 and DOS. Then it should not be denied. I know of no insurance company that pays for baseline testing.

Q: Is it possible, and if so how, can a physician and a neuropsychologist bill for one patient in the same day?

The physician would bill the E/M codes and the neuropsychologist would bill the neuropsych codes.

Q: If using 96120 is an ATC a qualified healthcare professional, as it applies to 96120? Does this code have the "general supervision" rule like the 96119?

No. No need for supervision. 96120 is an unsupervised code billed under Physician or Ph.D.

Q: Would you use code 96116 to bill for graded exercises with an exercise physiologist under a physician?

No.

Q: Can you use this same documentation and billing procedures if we are implementing RTP graded exercise protocol under the supervision of our medical director? I know our competitor is billing this way but would like to confirm.

Yes, but I do not know what billing code you would use – not any of the codes I discussed.

Q: Have you had difficulty getting reimbursed when using multiple ImPACT’s testing dates to track athlete’s recovery and make RTP decision?

Occasionally. However, if you do too many and there is no change in status then I can see why it will be rejected. You are only allowed to assess one time for the same condition. So if there is no change and you have multiple assessments I can see why they are sometimes rejected (assuming different dates of service. If you try to bill multiple 96120 with the same 96118 then all but one 96120 will be rejected as you can only have on 96120 per eval. (Defined by the 98118.

Q: If a patient has mental health benefits do the neuropsych CPT and ICD codes have to go to the mental health carrier as opposed to medical claims.

Depends how NP testing is covered by insurance. If it is covered under the medical benefits then use an 850 code and bill under medical. If it falls under mental health use 310.2 and bill under mental health.
**Q: I’m in a rehab clinic and we have a medical director who interprets the test that I have administered during a full PT evaluation. Can I bill 96119 or is it better to just include my time and cost of test into our evaluation charge?**

You can bill 96119, but in order to bill 96119 it must be done under the physician with 96118, which I doubt he is billing. Also, you must stay in the room while the patient takes ImPACT in order to bill 96119. The physician can bill 96120 if you set up the pt and let them complete ImPACT alone.

**Q: Do you have any information for physical therapy clinics performing the test?**

A physical therapist (PT) can administer ImPACT as a technician under a physician or psychologist only. PTs cannot bill for the administration, reporting, or interpretation directly.

**Q: We are using modifier 25 on our E/M with the 96120 but keep getting denials telling us to reference billing guidelines. Any thoughts?**

The denial is specific to the rules of that insurance carrier. I would check with their written rules for 96120. After reviewing them see what would need to be changed to have 96120 approved. It may be a separate report for ImPACT scores. It is difficult to know how to respond without seeing the insurance carrier’s rules.

**Q: When should I use the 96118 CPT code?**

The CPT code 96118 is the “professional” code and can only be used by a full licensed psychologist or physician. It entails all aspects of your evaluation including preparation time, testing time, scoring time, report writing and any other time directly related to your evaluation (e.g., communicating information to a trainer or parent). There is a separate interview code (96116), however, there is strict time and procedures that must be part of the interview in order to use it (e.g., fully documented mental status examination). Alternatively, if the interview does not reach the 96116 threshold the time can be billed using 96118. Both are time based codes where one unit equals one hour of time spent performing the service and the reimbursement is higher for 96118. The general rule is to round to the nearest hour. If you do 70 minutes of testing you bill for one hour or one unit. If you tested for 91 minutes you bill for two hours or units.

**Q: Does the CPT Code need to match with the diagnosis?**

Yes, the CPT procedure code and the diagnosis codes (ICD-9 and not DSM-IV) do need to “match.” By that I mean whether or not they are either mental health codes or medical codes (terms used by the insurance companies and not meant to be pejorative). Diagnosis codes are easily divided into mental health codes (290.0 – 319) or medical codes (all others with nervous system codes ranging from 320 – 389.9).

**Q: How do I know whether the procedure should be coded as being medical or mental health?**

The designation of the neuropsychological procedure codes as being either medical or mental health based is tricky and often idiosyncratic and dependent upon the individual insurance company. For example, some insurance companies consider neuropsychological testing a mental health service and as such will only allow for a mental diagnosis when billing. Other insurance companies consider it a medical procedure and require a medical diagnosis (non-mental health). Still for some companies it goes either way but the coverage for neuropsychological testing is drastically

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Q: When should I use the 96119 CPT code?
The CPT code 96119 is the “technical” code and is used for face-to-face testing only. This CPT code is for an individual who performs direct administration of neuropsychological tests that is less than fully licensed at the Ph.D. level. There is no minimal educational requirement so it would include post-doctoral fellows, interns, and psychometrists (at either the Master’s level or Bachelor’s degrees). The operative phrase is “face-to-face.” One can only bill for the time the technician actually administers the tests. Scoring time is not billable, unless the scoring is done in the same room when the patient is completing something else (such as a questionnaire or computerized testing). While this may seem counter-intuitive (or even a complete contradiction in terms), the technician is still “face-to-face” and as such could bill for time scoring when the patient is completing a form and being supervised by the technician. Otherwise, non-face-to-face scoring time (for example: when done after the patient has left) is not billable. Also, any preparation time, interviewing or report writing done by the technician (if they were a psychology intern or post-doctoral fellow, for example) is not billable. CPT code 96119 is a time based code identical to 96118.

Q: Do you have any advice on being reimbursed consistently?
Bottom line is that reimbursement is a very fickle thing and often without a consistent pattern. For example, my regional Blue Cross Blue Shield in 2005 always allowed for neuropsychological testing of sports concussion as long as I used a diagnosis of “Concussion” (ICD-9 850.X). However, in 2006 they are reversing this and saying I need to use a mental health diagnosis (ICD-9 310.2 post-concussion syndrome). In my experience, I have found that most carriers will cover neuropsychological testing for sports-concussion as long as you know their rules. This document will help you to learn some of the rules necessary to be reimbursed.

Q: What are some typical reimbursement rates?
One can bill all they want, but the question I am sure everyone has is it profitable? Again that depends on the reimbursement rates of the individual carriers you deal with. However, CMS set the rate for CPT
procedure codes (see the table below) which is used by commercial FFS (fee for service) insurance companies when setting their own rates. Please note that there are different reimbursement rates depending upon if you are a hospital based or out-patient based facility. The distinction may not be that simple. Many out-patient clinics part of a larger health care organization may be designated as a hospital facility even if they are not attached to a hospital. For example, I work within a large non-profit hospital system. My clinic is in a building several blocks from the hospital. There is only one outpatient clinic in our building with the rest being administration. However, all buildings within our system are designated as hospital-based and as such receive the lower reimbursement rate. The reason for the lower reimbursement rates for hospital-based facilities has to do with CMS’s Medicare payments that cover resident training and care of Medicare patients.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Rate for Outpatient</th>
<th>Rate for Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>96116</td>
<td>$96.95/unit</td>
<td>$103.83</td>
</tr>
<tr>
<td>96118</td>
<td>$96.59/unit</td>
<td>$124.09/unit</td>
</tr>
<tr>
<td>96119</td>
<td>$33.28/unit</td>
<td>$63.31/unit</td>
</tr>
<tr>
<td>96120</td>
<td>$25.32 (flat rate)</td>
<td>$45.94 (flat rate)</td>
</tr>
</tbody>
</table>

Some of you may be having trouble with individual carriers telling you that these new codes are not reimbursable. Federal law states that all carriers must acknowledge these codes (i.e. reimbursable). Whether an insurance company includes it in their policy is a different matter. An example of a carrier incorrectly excluding the codes is Wisconsin Medicare, which covers Wisconsin, Illinois, Minnesota and Michigan, whose current policy states that 96119 is not a reimbursable code. This is wrong and there is a lot of political and legislative action to correct this. Michigan Blue Cross and Blue Shield acknowledged the codes as of January 2006, but decided not to reimburse them until starting April 1, 2006 and making it retroactive.

Q: What is the relationship between when services were rendered and the date of service for billing purposes?

The answer to this problem is rather simple. Use the last date of rendered services as the date of service (DOS) for billing. Often times it has been my experience that our professional services rendered for a sports concussion evaluation can extend beyond the evaluation date. There are telephone calls with trainers, referring physicians and parents. Often times I like to follow up with a call to the parents. All of this is billable time, but you can not bill for 10 minutes on one day and 25 minutes on another. However, you can combine them into the testing time with the DOS being the last date of services rendered. You might want to explain this to the parent so they do not think you billed incorrectly.

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Q: When should I use the 96120 CPT code?
There is one other neuropsychological testing code, 96120, that is used for any unsupervised computer-based testing. It is a one-time charge that is not time-based. Please note that if the technician or psychologist is in the room while the athlete is testing you would bill the time it took the athlete to complete ImPACT using either 96119 or 96118 (depending upon who is in the room) rather than the computer code. You cannot bill for both. It is more financially advantageous to be in the room while the athlete completes ImPACT, as the reimbursement rate is higher.

Q: If you are working as an Athletic Trainer in a school, can you bill for administering baseline and retake of ImPACT tests?
The retaking of ImPACT can be billed for as part of a medical service. However, the person administering ImPACT must be working for the physician/psychologist seeing the athlete and you must bill the correct location site.

Q: What are the billing codes that Dr. Podell typically uses and has the most “success” with in terms of reimbursement? Either with cognitive diagnoses or those that are more psychiatric in nature.
As a neuropsychologist, I bill 96116, 96118, 98120 and 96119 (if I use an examiner/technician). Remember, the dx code is based upon the referral question and not your clinical diagnosis. So, I use the 850.x codes. If I must use a psychiatric-based dx as determined by the regional carrier, then I would use 310.2 (post-concussion syndrome).

Q: What are some possible billing scenarios?
The example below is a common scenario encountered in my practice and is for descriptive purposes only. They are not meant to indicate the exact amount of time one needs to spend on a particular case. All cases are different and some can take much longer. Technically I would bill for two (2) units of 96118 (rounding to closet hour) and all billed on the last date of service.

**Scenario 1:**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interview &amp; brief neurological and balance exam with athlete</td>
<td>40 minutes</td>
</tr>
<tr>
<td>2. Brief interview with parent (if a minor)</td>
<td>15 minutes</td>
</tr>
<tr>
<td>3. Brief discussion with trainer</td>
<td>10 minutes</td>
</tr>
<tr>
<td>4. ImPACT testing (in the room)</td>
<td>30 minutes</td>
</tr>
<tr>
<td>5. Review results and discuss concussion and return to play with athlete and parent</td>
<td>20 minutes</td>
</tr>
<tr>
<td>6. Brief report (dictated)</td>
<td>20 minutes</td>
</tr>
<tr>
<td><strong>Total Time =</strong></td>
<td><strong>135 minutes</strong></td>
</tr>
</tbody>
</table>

**Scenario 2.**
Imagine if we take scenario 1 and in this case the post-concussion scores were at baseline but the athlete was still symptomatic. Often times I would continue to work with the trainer and family tracking symptom scores and helping explain symptoms to parents and how to avoid exacerbation of symptoms. Sometimes I need to write a letter to the school excusing the player from school work. If all this took an additional

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30 minutes over several days it would increase my billable time to 165 minutes. I would document my time spent and in this case submit for three (3) hours of 96118 (round to nearest hour) on the last date I did any service on the case (e.g., talking with the trainer about exerting the athlete once his symptoms resolved).

**Scenario 3.**
Let’s take scenario 1 but instead of being in the room while the athlete completed ImPACT, I decided to be in my office doing other work. This would change my billing to the following: two hours or units of 96118 and one unit of 96120. See below for the difference in reimbursement using CMS rates for an outpatient facility.

<table>
<thead>
<tr>
<th>In the room during testing</th>
<th>Not In The Room During Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three units of 96118 = $372.27</td>
<td>Two Units of 96118 = $248.18</td>
</tr>
<tr>
<td>One unit of 96120 $ 45.94</td>
<td>Total = $294.12</td>
</tr>
<tr>
<td>Total = $372.27</td>
<td></td>
</tr>
</tbody>
</table>

One can see that it is financially better to be in the room during the testing. One could be doing work while the athlete takes the test but as long as you are in the room supervising the testing it is billable at the higher 96118 rate.

There are times when additional neuropsychological testing is required. The same scenario holds in that the reimbursement is higher when the fully licensed neuropsychologist or physician performs the testing, plus scoring time is billable. Compared to when a technician tests and the rate is lower (almost half) and scoring time may not be billable if done away from the patient.

Q: My insurance company will not pay for ImPACT because I am not a Psychologist. What can I do?

There are many different ways to bill for ImPACT. I have, with great difficulty, managed to have most of the payers in Connecticut pay for the ImPACT test code 96120, which I charge at each visit. On the initial visit, I bill a 99244 or 99245 for all patients referred to me that are not my patients. I then send those physicians or trainers a cover letter and copies of my note and ImPACT test. Follow-up visits are billed as a 99214. Patients that I have seen before I bill as a 99215 with no cover letter (obviously) and follow-ups as a 99214. Other than one or two MCOs I have been paid reasonably well for these visits.

Q: Do you get paid if you use code 96120? Do you bill the 96120 with a qualifier?

All insurers except for one (ironically, the one that serves the self-insured teachers union of Wisconsin) pay for this code. This includes big hitters like United Healthcare, which is the dominant insurance in our market. 96120 has no time value or parameter. It is merely for the testing
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| Q: What should I do if the insurance company is saying we do not hold the specialty for the 96120 code? | CPT 96120 indicates that one needs to be a "qualified health care professional" to bill for an "interpretation and report". It does NOT indicate that one needs to be a neuropsychologist to use this code. (It also doesn't indicate that it is a onetime use code as many coders will assume.) Successful reimbursement in this case is often a matter of establishing you are "qualified". That would most easily be substantiated by showing them a certificate of completion from an ImPACT training course or achieving CIC status as determined by ImPACT and listed on [www.impacttest.com](http://www.impacttest.com). |
| Q: How can I get proof that ImPACT is actually a neuropsychological test for my insurance company? | ImPACT yields objective, reliable, valid, normed data on verbal and visual memory, processing speed, and reaction time, all of which are parameters of neuropsychological/psychological performance or functioning. [http://www.aetna.com/cpb/medical/data/100_199/0158.html](http://www.aetna.com/cpb/medical/data/100_199/0158.html) "Psychological tests assess a range of mental abilities and attributes, including achievement and ability, personality, and neurological functioning. Psychological testing, including neuropsychological assessment, utilizes a set of standardized tests, whose validity and reliability have been established empirically. They allow for an assessment of a patient's cognitive and behavioral functioning and an analysis of changes related to mental or physical disease, injury, or abnormal development of the brain. Research has shown that the scores from these tests are reproducible and can be compared to those of normal persons of similar age, sex and demographic background to yield valid conclusions." |
| Q: Can a PT/OT bill for their typical evaluation using rehab codes as well as billing for the ImPACT test with 96120 or 96119? Does a neuropsych have to be involved? Often a PT post-concussion patient is sent from the doctor with vestibular/balance/pain issues. If we are providing the ImPACT test along with this evaluation can we charge for both? | A: A PT or OT cannot bill for 96120 (ImPACT administration) independently. it must be billed under a PhD or physician code. ImPACT will not address the issues of vestibular/balance/pain issues. |
| Q: If a patient is referred to Occupational therapy for cognitive rehab s/p concussion, if neuropsych testing has been done, can the OT bill for an ImPACT in addition to their cognitive eval? | A: A PT or OT cannot bill for 96120 (ImPACT administration) independently. it must be billed under a PhD or physician code. ImPACT will not address the issues of vestibular/balance/pain issues. The issue has to do with scope of practice and how the test is categorized. It must be billed as a technical code when given by non physician or non-psychologist, meaning it has to billed under a MD/DO or... |
ImPACT’s products provide information regarding potential cognitive decline and related symptoms that may be experienced after head trauma. ImPACT’s products are not diagnostic, do not determine whether an individual has a particular head or brain injury and should not be used to make a return to play decision without an examination by a qualified and licensed health care professional. Many jurisdictions have rules and regulations governing the process and procedures under which an individual may be returned to play. Please check the rules and regulations in your state, county, organization and/or school district for legal requirements and further guidance.

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| Q: Why is the reimbursement higher for non-supervised computerized testing than it is for supervised? | A: That is the way the RVU came out after they were recently revised. Has to do with cost and type of provided that submitted answered to CMS questionnaire. Turns out that a lot of doctor’s office with high overheads started using it and thus driving up the cost of administering it thus increasing the reimbursement rate. |
| Q: Would a Speech Language Pathologist or an Occupational Therapist be able to use the 96119 code or any other codes other than 96120 or 96119? You had mentioned exception for NP or PAs. | A: The speech therapist or OT can billed 96119 or 96120 under a physician or psychologist’s code, not independently. If done so then that DO/MD or psychologist must issue a report billing 96118. NP and PA do not need supervision and thus can bill those codes. That is how the laws are set up. |