# Part B Insider (Multispecialty) Coding Alert

## Mental Health Coding: Avoid Billing Add-on Codes With Other Add-on Codes

**Mental health services have very precise rules find out what they are with these FAQs.**

Coding for mental health services can create confusion for Part B coders, particularly since many insurers have different rules for psychiatric care than other outpatient services. Find out where your mental health coding skills stand with expert answers to these three frequently-asked questions.

**Can You Use Prolonged Service Codes With Psychotherapy?**

**Question 1:** Recently, I was going through CCI edits and I observed that prolonged services codes are allowed with 90837 but cannot be reported with the add-on code +90838. However, since prolonged services codes can be reported with an E/M code, is it possible to report an extended psychotherapy with E/M session by using a prolonged service code?

**Answer 1:** You are correct in your observation that a prolonged service code such as +99354 (Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour [List separately in addition to code for office or other outpatient Evaluation and Management service]) can be used for extended psychotherapy sessions that are performed beyond the duration of 90 minutes.

You are also correct in noting that a prolonged service code can only be used with 90837 (Psychotherapy, 60 minutes with patient and/or family member) and not with the add-on code, +90838 (...when performed with an evaluation and management service [List separately in addition to the code for primary procedure]). Correct Coding Initiative (CCI) edits are in place with the modifier indicator '0,' which means you cannot use a prolonged service code with +90838. CPT® guidelines preceding the psychotherapy codes are very explicit on this point and state, in part, "Prolonged Services may not be reported when psychotherapy with E/M (90833, 90836, 90838) are reported."

Even though a prolonged service code can be used in conjunction with an E/M code, you cannot typically use it with an E/M code that you are reporting as a primary service along with psychotherapy. Since the session was extended because of a longer than normal psychotherapy session and not because of the evaluation service, you cannot claim for additional compensation by using the add-on code with the E/M code that you are reporting.

**Do Home Health Certs Differ for Mental Health Providers?**

**Question 2:** What is the proper use of G0180? Must our psychiatrists always follow the home-health program, or is planning, certifying and ordering the home-health plan sufficient to bill the code?

**Answer 2:** When billing for G0180 (Physician certification for Medicare-covered home health services under a home health plan of care [patient not present], including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period), your psychiatrist is expected to stay actively involved in the patient's home-health services. As Novitas Solutions, Pennsylvania's Medicare administrative contractor, notes on its web site, "The physician billing for physician certification must be the provider supervising the patient's care."

According to Novitas, a physician's services involved in physician certification (and recertification) of Medicare-covered home health services include creation and review of a plan of care and verification that the home health agency initially complies with the physician's plan of care. The physician's work in reviewing data collected in the home health agency's patient assessment would also be included in these services.

To the extent the psychiatrist is providing ongoing care plan oversight of a Medicare home health patient, he may be able to report those services using code G0181 (Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present)...within a calendar month, 30 minutes or more). As this description implies:

The physician must furnish at least 30 minutes of care plan oversight (CPO) within the calendar month for which payment is claimed, and the physician billing for CPO must document in the patients record which services were furnished and the date and length of time associated with those services.

The following are examples of services that count toward the physician's required minimum 30 minutes of CPO services: development or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan, and/or adjustment of medical therapy. Care plan oversight does not include the routine pre-and post-service work associated with visits and procedures. Also, telephone calls with patients and/or their families are not included.

Only one physician can bill for CPO for each patient per month. Even though the homecare provider is actually filing the home- health claims, if the physician is knowingly certifying patients for homecare who don't meet the criteria, then that physician can be considered to be assisting in the submission of a false claim. Therefore, it is very important always to document and follow up on all patients for whom the physician is certifying Medicare-covered home health.

**Resources:** For more information, visit www.novitas-solutions.com/webcenter/faces/oracle/webcenter/page/scopedMD/sad60252a_5537_4c5d_9350_ca405e36e159/Page133.jspx?contentId=00081587&_adf.ctrl-state=om2qmpugk_96&_afrLoop=174542618189000#.

**Should You Count on EMDR Payment?**

**Question:** One of our psychiatrists plans to start performing EMDR for patients suffering from PTSD, but we are unsure of how to bill it. Can you advise?

**Answer:** EMDR (Eye movement desensitization and reprocessing) is a type of psychotherapy that is based on the thought that a patient suffers from a psychiatric issue due to disturbing memories. When performing EMDR, your clinician will aim at processing these memories, try to reduce their effects, and help the patient try to overcome them by developing mechanisms to cope with the problem.

When performing EMDR, your clinician will integrate cognitive behavioral, psychodynamic, interpersonal, and body-centered therapies in an eight phase treatment approach to help patients overcome their disturbing thoughts. Since disturbing memories are commonly experienced in patients suffering from post-traumatic stress disorder (PTSD), your clinician might often use EMDR in the treatment of patients suffering from this condition.

Coverage for EMDR varies from payer to payer. For example, WellCare covers it for patients meet diagnostic criteria for acute stress disorder (ASD) and PTSD and the doctor is licensed in EMDR. Excellus Blue Cross and Blue Shield, however, consider EMDR investigational and therefore won't cover it.

If your clinician is planning to perform EMDR on patients, it is best to check with the individual payer to know if the service is covered. If the service is covered, it is best to see if the payer requires any additional specialization in performing this particular type of psychotherapy or has other limitations for it to be a covered service. Also, check if the service needs pre-authorization for it to be a covered service.

If the service is covered, you will have to report it using one of the psychotherapy codes in Current Procedural Terminology (CPT®), since there are no other CPT® or Healthcare Common Procedure Coding System codes that specifically describe the service. You will have to report the services of your clinician based on the time that he spends in performing the service, as you would do when reporting any cognitive behavioral psychotherapy session. For example, if he spends 45 minutes on performing the EMDR, you will have to report 90834 (Psychotherapy, 45 minutes with patient and/or family member) to report the service.