Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Put Your ECT Reporting on Track With This Guidance

Hint: Don't report the pre-treatment evaluation with an E/M code as a norm.

When your psychiatrist performs electroconvulsive therapy (ECT) on a patient, knowing the other codes you can and cannot report along with the CPT® code for this therapy will help improve your claims success.

Select a Single Code for Therapy and Monitoring

You report 90870 (Electroconvulsive therapy [includes necessary monitoring]) when your clinician performs electroconvulsive therapy in order to induce a seizure or series of seizures that is intended to reduce or alleviate mental health symptoms. Your clinician will also monitor the patient during the convulsive phase, as well as during the recovery phase. You do not report any additional code to cover the monitoring, as this is included in the work described by 90870.

FYI: 90870 is not a time-based code. So, you will report one unit of the code only once per session. Only a physician (typically a psychiatrist) who is qualified in the administration of the treatment is allowed to report the code.

Understand The Scope of Electroconvulsive Therapy

ECT is considered to be a medically necessary service in certain psychiatric conditions, especially when other means of treatment, such as medications and psychotherapy, have failed to have the desired effect. It is also considered as a first line of treatment in certain conditions, especially when the patient needs a rapid alleviation of symptoms because he/she is suicidal or homicidal.

ECT is used primarily for the treatment of major depression (unipolar, bipolar or mixed types) that does not respond to medication. Some of the other conditions in which the therapy is considered medically necessary include:

- Mania
- Catatonia
- Certain types of acute schizophrenia and other psychotic conditions

Reminder: Some payers also consider the use of ECT to be appropriate in conditions like post-traumatic stress disorder, dementia, obsessive compulsive disorder, body dysmorphic disorder, and complex regional pain syndrome. So, it is best to check with the payer if coverage is provided for a particular diagnosis prior to the procedure. Also, most payers don't provide coverage for multiple monitored ECT, as this procedure is considered experimental and investigational and its effectiveness has not been established.

Example: Your psychiatrist reviews a 40-year-old male patient who is under his care for major depression for the past eight months. The patient had been diagnosed with moderate major depression that had an onset after the patient's wife died in a car accident, an incident where he had been driving the car but had escaped with very minor injuries. Your clinician had previously prescribed selective serotonin reuptake inhibitors (SSRIs) and also tried a combination of SSRIs with atypical antidepressants when the patient developed suicidal tendencies. He was also undergoing cognitive behavioral therapy with your clinician.

The patient was reviewed by your clinician when he was brought in by his brother, who stated that the patient was behaving strangely lately and seemed to be having suicidal thoughts that were constantly on his mind. His brother also suspected that he had not been taking his medications as prescribed.

Since the combination medication and the psychotherapy were not having the desired effect and the patient had suicidal thoughts, your clinician decided to evaluate the patient to receive ECT. As the patient's medical evaluation did not contraindicate ECT, your clinician performs the ECT. You report the session with 90870. You clinician plans thrice weekly sessions of the therapy on non-consecutive days, and he recalls the patient for the next session after two days.

Know When to Report Same Session E/M Codes

Prior to performing an ECT procedure, your psychiatrist will evaluate the patient. This evaluation will include but is not limited to the following components as indicated by the American Psychiatric Association:

- Psychiatric history and examination, including past response to ECT treatments and a baseline neuropsychiatric evaluation.
- Medical evaluation that includes history and examination (i.e. neurological, cardiovascular, pulmonary systems, and previous response to anesthesia).
- Review of dental problems including examining loose or missing teeth, presence of dentures or other appliances.
- Appropriate laboratory and diagnostic tests: common tests include but are not limited to complete blood count, serum electrolytes, electrocardiogram, chest x-ray, and pregnancy test on child-bearing age patients (determined on a case-by-case basis).

This evaluation of the patient prior to receiving the ECT is included in the work described by 90870. So, you should not report a separate E/M code or a psychodiagnostic evaluation code (90792, Psychiatric diagnostic evaluation with medical services) to report the evaluation of the patient.

However, if the patient is evaluated for a significant and separately identifiable evaluation and management service, you can report it with the appropriate established patient E/M code. However, as Correct Coding Initiative (CCI) edits bundle 90870 with E/M codes, you will have to override the edit in such a scenario by appending a modifier such as 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) to the E/M code that you are reporting for the service.

Caveat: The psychodiagnostic evaluation code 90792 is also bundled with 90870 with the modifier indicator '0,' which means that you cannot report these two codes under any circumstances and you cannot unbundle the codes with the use of any modifiers. "Only 90870 is payable if both services are provided to the same patient on the same date," notes Kent Moore, senior strategist for physician payment at the American Academy of Family Physicians.

Don't Report Anesthesia Service Separately

When your clinician performs electroconvulsive therapy, the procedure is performed under general anesthesia. There is a separate CPT® code to cover the anesthesia for the ECT procedure, namely, 00104 (Anesthesia for electroconvulsive therapy). "Although there is a separate code to describe the anesthesia, reporting the anesthesia component separately will not yield additional payment if the payer is following CCI edits," observes Moore.

According to CCI edits, code 00104 is bundled into the code for ECT with the modifier indicator '0' that does not allow you to report these two procedures together under any circumstances. The reason for the edit is stated as "Anesthesia service included in the surgical procedure."

Red flag: "Interestingly, this is contrary to CPT® guidance," adds Moore. "The March 2010 edition of CPT® Assistant advises, 'When the psychiatrist also administers the anesthesia for ECT, the anesthesia service should be separately reported using anesthesia code 00104, Anesthesia for electroconvulsive therapy.' So you may want to check with the payer in question regarding whether they adhere to CPT® or CCI," advises Moore.