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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Watch These 4 Group Psychotherapy Myths That Could Prove Costly

Hint: Use HCPCS codes for group psychotherapy in a partial hospitalization setting.

When reporting a psychotherapy session that your clinician conducts for a group of patients, you will need to focus on how many units of the code you can report on one calendar date of service. You should also be aware of what other services you can or cannot report for the same patient on the same calendar date of service.

Bust these four common myths that will help you achieve reporting success and help you better understand the rules for reporting the group psychotherapy code, 90853 (Group psychotherapy [other than of a multiple-family group]).

Myth 1: Units of Service for 90853 Depend on the Length of the Session

Reality: Unlike many of the time based psychotherapy codes, group psychotherapy code (90853) does not contain a time component to it. So irrespective of the time taken by your clinician in performing the group psychotherapy for a patient, you will not have to worry much about the duration of the session. Instead, you will have to remember that you should report only one unit of 90853 regardless of the length of the session on one calendar date of service.

However, you should not confine to reporting just one unit of 90853 for the entire group that is taking up the session. Instead, you will have to report one unit of the code for each and every member in the group who is participating in the session. Although it is typical for a group therapy session to have about eight to ten patients, the maximum number of patients that is permissible to participate in a group therapy session is 12. "In other words, the number of units of 90853 that you report depends on the number of patients in the group, not the length of time spent with the group," observes **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians.

As with any psychotherapy service, the documentation should include details about why and how this group psychotherapy is beneficial and medically necessary for the patient's treatment. To establish the medical necessity of the session, the documentation should include the diagnosis for which the patient is being treated. The documentation should also include how much time was spent on the session (even though that does not impact coding of the service) and the number of sessions your clinician intends to perform for the patients.

Myth 2: +90785 Can be Reported Only Once for Group With Communication Issues

Reality: When your clinician is conducting a group psychotherapy session, it is likely that he may face difficulties in communicating with some patients in the group. In such a scenario, you can get deserved reimbursement to compensate for the additional time and effort your clinician had to spend in performing the group psychotherapy with these patients. For this, you will have to report the add-on code +90785 (Interactive complexity [List separately in addition to the code for primary procedure]) along with the group psychotherapy code.

Again, as with the group psychotherapy code, you will have to report the add-on code +90785 for each patient in the group for which communication difficulties complicated the clinician's provision of the service. Do not report it once for the entire group. "Also, do not report it for every patient in the group unless it applies to every patient in the group," Moore adds. So, for instance, if your clinician encountered communication issues with five of the ten patients in the

group, you will report +90785 for each of these five patients as an add-on code to 90853.

Reimbursement: According to the Medicare Physician Fee Schedule, the add-on code +90785 carries a total of 0.39 non-facility relative value units [RVUs]. When you multiply the RVUs by the 2016 Medicare conversion factor of 35.8279, you'll get a national average payout of almost $14. So, watch out for in the documentation to spot instances where your clinician had to spend extra time and effort with the patient in overcoming communication issues, or else you will be foregoing much deserved reimbursement. You can also suggest to your clinician that he/she document in the patient's chart notes about communication difficulties he/she encountered, so you will not lose out on the additional pay.

Myth 3: 90853 Cannot be Reported With Another Individual Psychotherapy Code

Reality: It may not be uncommon for you to encounter situations where your clinician would have scheduled individual psychotherapy and group psychotherapy on the same calendar date of service for the same patient. So, can both the services be reported on one calendar date of service for the same patient?

You will face Correct Coding Initiative (CCI) edits if you try reporting 90853 with an individual psychotherapy code from the range 90832-90838. However, the modifier indicator to the above mentioned edit is '1,' which means you can overcome the edits with a modifier.

As the individual psychotherapy codes are column 2 codes in the bundling edits with 90853, you will have to append a suitable modifier to the individual psychotherapy codes. The modifier that you will have to use with these individual psychotherapy codes to overcome the bundling is 59 (Distinct procedural service) or modifier XE (Separate encounter), if the payer, like Medicare, recognizes modifier XE.

If your clinician performs an E/M service such as medication management on the same day on which he also performed a group psychotherapy session, you will again look at CCI edits, as you face bundling edits if you're reporting an E/M code with 90853. Again, as the modifier indicator is '1,' you are allowed to overcome the edit by using a suitable modifier. Here you will have to append the modifier 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 you are reporting along with the group psychotherapy code.

Myth 4: 90853 Can Also be Reported for Patients in Partial Hospitalization Programs

Reality: "This depends on the payer," Moore says. When your clinician performs a group psychotherapy session to a group of Medicare patients in a partial hospitalization program, you cannot report 90853 for these patients. For Medicare patients in partial hospitalization program settings, you will have to use G0410 (Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minutes).

Again, you cannot use +90785 if your clinician encountered difficulties in communicating with these Medicare patients in the partial hospitalization program. For patients in the group psychotherapy session with whom your clinician encountered problems with interaction, you will have to report G0411 (Interactive group psychotherapy, in a partial hospitalization setting, approximately 45 to 50 minutes) instead of G0410. For instance, if your clinician encountered communication issues with four of the twelve patients in the group psychotherapy session, you will have to report G0411 for these four patients and report G0410 for the other eight patients.

For payers other than Medicare, check with the payer to see how it wants you to report group psychotherapy in the partial hospitalization setting. Ask if they prefer you to use the CPT® codes or the "G" codes favored by Medicare.

Don't forget: When reporting a group psychotherapy session for patients in a partial hospitalization program, you will have to use 52 (Psychiatric facility-partial hospitalization) as the place of service code. This should be true regardless of the payer.

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