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Psychiatry Coding & Reimbursement Alert

CPT® Coding Strategies: Get Proficient With TMS Reporting Using This Expert Advice

Check CCI when planning on reporting with E/M or other psychiatry related codes.

When your clinician performs therapeutic repetitive transcranial magnetic stimulation (TMS), you'll need to be aware of coverage guidelines and the list of diagnoses for which the procedure is covered. You will also need to be aware of what other codes you can or cannot report with the CPT® codes you will report for the TMS procedure.

Report From These Codes For TMS Sessions

When your psychiatrist performs therapeutic repetitive transcranial magnetic stimulation, you'll have to report from one of the following CPT® codes:

- 90867 (Therapeutic repetitive transcranial magnetic stimulation [TMS] treatment; initial, including cortical mapping, motor threshold determination, delivery and management)
- 90868 (...subsequent delivery and management, per session)
- 90869 (...subsequent motor threshold re-determination with delivery and management)

Note That TMS Codes are not Time Based

As the code descriptor says, you'll have to report the CPT® code 90867 for the initial session in which your clinician plans the treatment that includes:

Cortical mapping to determine where the magnetic field has to be applied;

Determination of stimulus intensity required to produce a minimal motor evoked response (motor threshold);

The delivery of the magnetic fields to stimulate the neurons.

You'll report this code only for the first session of treatment and further sessions of delivery and management only are reported using 90868.

Further, during course of treatment, if your clinician decides to reassess the patient to check if an alteration to the motor threshold has to be done to evoke the minimum required response, then you should report that session with 90869 instead of 90868. You should not report 90869 and 90868 for the same session as these codes are bundled with the modifier indicator '0' according to Correct Coding Initiative (CCI) edits. This modifier indicator denotes you cannot report these two codes together under any circumstances. "If you report 90869 and 90868 together, only 90869 will be allowed, per CCI," notes **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians. "Likewise, CCI bundles 90868 and 90869 into 90867 with a modifier indicator of '0.' These edits are consistent with parenthetical instructions in CPT® that advice not reporting 90867 in conjunction with 90868 or 90869 and also not reporting 90869 in conjunction with 90868," Moore adds.

If you look at the descriptors of the CPT® codes 90867-90869, you'll notice that there is no time description provided to these codes. You'll have to only report one unit of any one of the appropriate TMS codes for a session as these codes are not time based codes. "In fact, the descriptor for 90868 explicitly says, 'per session'," Moore points out.

Understand Indications for Coverage of TMS

You will find that TMS is considered investigational for a host of conditions, and not all payers provide coverage for it.

Most payers who do provide coverage for TMS will only do so only for a diagnosis of major depressive disorder (single or recurrent episode) wherein the patient has not responded to at least one antidepressant medication. This medication should have been taken at the prescribed dose for a minimum of four weeks.

The patient should show good response to TMS treatment schedules, and this is assessed by the use of rating scales such as, PHQ-9 (Patient Healthcare Questionnaire), HAM-D (The Hamilton Rating Scale For Depression) or BDI (Beck Depression Inventory).

When your clinician performs TMS for a patient, you should link it with a suitable ICD-9 code to inform the payer that the treatment is for a covered diagnosis and is medically necessary. Depending on the condition for which your clinician performs TMS, you may report one of the following ICD-9 codes, for example:

- 296.23 (Major depressive affective disorder, single episode, severe degree, without mention of psychotic behavior)
- 296.33 (Major depressive affective disorder, recurrent episode, severe degree, without mention of psychotic behavior)

ICD-10 change: When you begin using ICD-10 codes, 296.23 crosswalks to F32.2 (Major depressive disorder, single episode, severe, without psychotic features) while 296.33 maps to F33.2 (Major depressive disorder, recurrent, severe, without psychotic features).

Caveat: As noted, not all payers provide coverage for TMS. So, if your clinician is deciding to perform TMS for a patient, check with the payer to see if they do cover the procedure, and if so, ask for the list of diagnoses for which coverage is provided.

Observe Caution When Reporting Same Session E/M Codes

When your clinician provides a TMS treatment session to a patient, you do not face any bundling from Correct Coding Initiative (CCI) edits if your clinician also performs a psychodiagnostic evaluation (90791 or 90792). However, you will run into edits if you are planning on reporting TMS codes with same session psychotherapy (90832-90838). Since the modifier indicator for these edits is '1,' you can separately report the codes by using a modifier with the TMS codes as these form the column 2 codes in the edits.

You'll also run into edits if you are planning on reporting an E/M code with a code from 90867-90869. So, if your clinician performs any E/M service or pharmacological management in addition to TMS, then you'll face bundling when trying to report both the codes. But the modifier indicator for this code bundling is '1,' which means you can unbundle the codes by using a suitable modifier. Any time you use a modifier, make sure your physician has supporting documentation.

Since the E/M code forms the column 2 code in the CCI edits with TMS codes (90867-90869), you'll have to append the modifier to the E/M code. The modifier that you will have to use with the E/M code is 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). "Note that, per CPT®, E/M activities directly related to cortical mapping, motor threshold determination, delivery and management of TMS are notseparately reported," Moore observes.

You'll also run into edits if you are planning to report same session psychotherapy (90832-90838) with TMS. In these edits, the psychotherapy codes are the column 1 code, and the TMS codes are the column 2 code. The modifier indicator is "1" in each case, so an appropriate modifier can override the edit so long as you have supporting documentation. "These edits and the ones with the E/M codes are consistent with CPT® instructions that state,'If a significant, separately identifiable evaluation and management, medication management, or psychotherapy service is performed, the appropriate E/M or psychotherapy code may be reported in addition to 90867-90869'," Moore adds.

Other edits: In addition to E/M codes, you'll also face bundling when trying to report TMS codes with other psychiatry related codes. Some of the other CPT® codes with which you will face edits with TMS codes include:

- 90845 (Psychoanalysis)
- 90846 (Family psychotherapy [without the patient present])

- 90847 (Family psychotherapy [conjoint psychotherapy] [with patient present])
- 90849 (Multiple-family group psychotherapy)
- 90853 (Group psychotherapy [other than of a multiple-family group])
- 90865 (Narcosynthesis for psychiatric, diagnostic, and therapeutic purposes [e.g., sodium amobarbital [Amytal] interview])
- 90870 (Electroconvulsive therapy [includes necessary monitoring])
- 90880 (Hypnotherapy)

These above mentioned edits also carry the modifier indicator '1.' You can unbundle the code edits by using a suitable modifier. Since TMS codes are column 1 codes for the above mentioned code bundles, you will have to use a suitable modifier with the other psychiatry codes mentioned above.