Psychiatry Coding & Reimbursement Alert

Mythbuster: Don't Allow These 4 ECT Myths to Falter Your Claims

Know when you can report an E/M code in addition to ECT.

When reporting electroconvulsive therapy (ECT), you should be aware of payer guidelines for coverage and who can perform this treatment so that you don't run the risk of denials to your claim. You should also be aware of which other codes you can or cannot report with the code for ECT.

Bust these four common myths that will help you overcome coding hurdles and help you better understand the rules for reporting ECT code, 90870 (Electroconvulsive therapy [includes necessary monitoring]) when your clinician performs this procedure.

Myth 1: All Payers Provide Coverage for ECT

Reality: Not all payers will provide coverage for ECT. Even if they provide coverage, they may not cover the treatment for every diagnosis that your clinician is planning to use this treatment for.

ECT is considered to be a first line of treatment in certain conditions, especially when the patient needs a rapid alleviation of symptoms as he/she is suicidal or homicidal. It is also considered as a medically necessary service when other modalities of treatment such as psychotherapy and medications have not produced the desired results.

Most payers won't provide coverage for multiple monitored ECT as they consider this procedure to be experimental and investigational and claim that its effectiveness has not been established. "For instance, section 160.25 of chapter 1 of the Medicare National Coverage Determinations Manual states that the clinical effectiveness of the multiple-seizure electroconvulsive therapy has not been verified by scientifically controlled studies and that studies have demonstrated an increased risk of adverse effects with multiple seizures. Thus, Medicare does not consider multiple ECT to be reasonable and necessary, so Medicare does not cover it," says **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians.

Some diagnoses where payers will consider ECT as medically necessary include major depression, mania, catatonia, and some types of acute schizophrenia. Some of the other diagnoses that payers will provide you coverage for ECT include post traumatic stress disorder, dementia, obsessive compulsive disorder, body dysmorphic disorder, and complex regional pain syndrome.

So, it is best for you to check with the individual payers whether or not they provide coverage for ECT prior to your clinician performing the treatment. Also, it is necessary for you to check if the particular diagnosis for which your clinician has planned ECT will receive coverage or not.

Note: Payers who provide coverage for the treatment have guidelines for the provider who performs the ECT. Most payers specify that only a psychiatrist who has specialized in this treatment modality can perform ECT. Check payer guidelines well prior to your clinician performing the treatment to ensure that they are being met, or you might risk the chances of denial to your claim.

Myth 2: 90870 is a Time Based Code

Reality: Even though many codes in psychiatry practice are time based codes, the CPT® code for electroconvulsive therapy, 90870, is not a time based code. So, irrespective of the amount of time that your clinician spends in performing this therapy, you will have to report only one unit of the code.

When your clinician performs ECT for a patient, he will monitor the patient in course of the treatment and also during the recovery phase. "Code 90870 includes this monitoring time," Moore says. Therefore, you should not separate out the components of the service and report additional units of 90870. You will only report one unit of the code for one calendar date of service for a given patient.

However, you clinician will not typically perform the ECT on only one session for a patient. He will usually repeat the treatment with a planned set of sessions on different dates. You may claim for additional units of the code only when your clinician repeats the session on other calendar dates of service.

Myth 3: Report E/M Codes For Evaluation Prior to ECT

Reality: When your clinician performs ECT, he will perform an evaluation of the patient to see if the patient can receive the treatment. Any pre-evaluation and post evaluation of the patient when your clinician performs the ECT is included in the work described by 90870. So, you should not report this evaluation using a separate E/M code.

However, there are some circumstances where you can report a separate E/M code for an evaluation performed by your clinician. If the patient is evaluated for a significant and separately identifiable evaluation and management service that is not related directly to the ECT procedure that your clinician performed, you can report it with an appropriate E/M code.

But, if you look at Correct Coding Initiative (CCI) edits, you will see that E/M codes are bundled into 90870 with the modifier indicator '1.' In order to report both these codes on the same calendar date of service, you will have to append a suitable modifier to the column 2 code. Since E/M codes are column 2 codes in the edit bundle with 90870, you will have to append the modifier to the E/M code that you are reporting. The modifier that you will 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).

Don't make the mistake of trying to report a psychodiagnostic evaluation code with 90870. According to CCI edits, 90870 is bundled into psychodiagnostic evaluation codes, 90791 (Psychiatric diagnostic evaluation) and 90792 (Psychiatric diagnostic evaluation with medical services). These edits carry the modifier indicator '0,' which means you cannot overcome the edit bundle under any circumstances. If you try reporting 90870 with either of the psychodiagnostic evaluation codes, your claim for 90870 will be denied, and you will only receive reimbursement for 90791 (or 90792).

Myth 4: 90870 Can be Reported With Same Day Psychotherapy Codes

Reality: Similar to the edits you face with psychodiagnostic evaluation codes, you are not allowed to report psychotherapy codes (90832-90838) for the same calendar date of service as 90870. As with psychodiagnostic evaluation codes, this bundling between psychotherapy codes and the ECT code also carries the modifier indicator '0,' which means you cannot undo the edit bundling using any modifiers.

Since psychotherapy codes are the column 2 codes in the edit bundle, you cannot report same day psychotherapy codes along with 90870. If you do so, your claim for only the ECT code will be paid out, and your claim for the psychotherapy service will be denied.

Reminder: However, if you are trying to report family psychotherapy codes, 90846 (Family psychotherapy [without the patient present]) or 90847 (Family psychotherapy [conjoint psychotherapy] [with patient present]) with ECT, you will be able to report both the codes when appropriate, as the modifier indicator to these edits is '1.' Since the ECT code is the column 2 code in these edits, you will have to append a modifier to 90870. The modifier that you will use with the ECT

code is 59 (Distinct procedural service). Similarly, 90870 is a column 2 code for group psychotherapy codes, 90849 (Multiple-family group psychotherapy) and 90853 (Group psychotherapy [other than of a multiple-family group]).

But, if you check CCI for edit bundling with narcosynthesis code, 90865 (Narcosynthesis for psychiatric diagnostic and therapeutic purposes [e.g., sodium amobarbital [Amytal] interview]) and hypnotherapy code, 90880 (Hypnotherapy), you will find ECT as a column 1 code. So, you will have to append the modifier to 90865 or to 90880 if a case scenario arises wherein you are trying to report these procedures with ECT.

"The bottom line is that, if you plan to report 90870 in addition to another psychotherapy code, you should check the CCI edits relative to the 90870 and the code in question. If the edits permit you to report both codes under appropriate circumstances, then you will also need to pay attention to which code is the column 2 code and append the correct modifier to that code," Moore says.

Resource: For more information, check this link at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part2.pdf.