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Psychiatry Coding & Reimbursement Alert

Reader Question: Reporting Same Session 99407 and E/M? Can This be Done?

Question: I am billing 99407 with 99213 and getting denials. I have used the modifier 25 with 99213, but it seems to be asking for a modifier for the 99407. Can anyone help me with this modifier? Also I am using TOS 9 for consultation, would this be correct or should I be using TOS of 1?

New Jersey Subscriber

Answer: The code 99407 describes "Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes." This code may be reported in addition to other E/M services provided on the same day, but it does require face-to-face counseling by the physician personally to do so. That is, in order for your physician to personally report these codes, he or she must be the one providing the direct counseling rather than having it done by another provider, such as a nurse or social worker. The two services should be distinct, but can be related to the same presenting problem.

There are no CCI edits between 99407 and E/M codes, so there is no need to use a modifier when reporting both these codes together. As such, your denial should not be related to billing both services on the same date of service, with or without a modifier, unless the payer in question is using a claims edit that is not part of CCI.

Your type of service (TOS) should be 1 (Medical care) and not 9 (Other medical items or services). This may be the cause for denial if you do not identify any other issues with this claim.

Another possibility is that the service does not meet the payer's coverage criteria. For instance, CMS provides coverage for smoking and any other tobacco-use cessation counseling. The coverage for counseling includes two attempts at cessation. In each attempt, only four counseling sessions will be covered. So, in one year, a total of eight sessions will be covered. Once a person receives a total of eight sessions in the period of one year (365 days), another round of counseling can be taken up only after 11 months have passed since the first Medicare-covered cessation counseling session was performed.

For example, a beneficiary received the first of eight covered sessions in January 2011. The count starts beginning February 2011. The beneficiary is eligible to receive a second series of eight sessions in January 2012. Other payers may follow their own coverage guidelines. If your patient does not meet his payer's coverage guidelines, that could explain the denial.

Finally, claims for smoking and tobacco use cessation counseling services require an appropriate diagnosis code. According to CMS, diagnosis codes should reflect: the condition the patient has that is adversely affected by tobacco use or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use. As with coverage requirements, other payers may have different diagnosis requirements. Check to ensure that the diagnosis(es) you used on the claim are correct.

In the end, if your claim passes all of the criteria suggested above and is still not accepted and paid by the payer then you need to call the payer for further explanation or otherwise accept the payer's decision on the claim.

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