

Coding and Billing Guidelines
Electroconvulsive Therapy (ECT) PSYCH-025

Contractor Name

Wisconsin Physicians Service (WPS)

Contractor Number

00951, 00952, 00953, 00954
05101, 05201, 05301, 05401,
05102, 05202, 05302,
05402, 52280

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Title XVIII of the Social Security Act section 1862 (a) (1) (A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act section 1862 (a) (7). This section excludes routine physical examinations and services

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

42 CFR 410.155 Outpatient mental health treatment limitation.

42 CFR 412.113(c) Anesthesia services furnished by hospital or CAH employed non-physician anesthesiologists or obtained under arrangements

Please refer to CMS Medicare publications, regulations, billing, and/or applicable LCDs for services that apply to CMS Medicare services for Electroconvulsive therapy services not covered in the policy or coding and billing guideline.

Coding Guidelines Part A

1. The outpatient mental health limitation appears in 42 CFR 410.155 and applies to this ECT policy and applies to outpatient treatment services when an individual is not an inpatient of a hospital. It is applied based on both the procedure and the diagnosis code.
2. ICD-9 codes must be reported to the highest level of specificity for the date of service.
3. Screening tests, in the absence of signs and symptoms of illness should be billed with "V" codes for a screening denial.
4. Separate payment is not allowed for the psychiatrist's performance of the anesthesia service associated with the electroconvulsive therapy if the psychiatrist performs the electroconvulsive therapy.
5. Effective for dates of service on or after January 1, 1994 if anesthesia is given by the same physician who is performing the therapy, the anesthesia would be included in the therapy service. Separate payment for anesthesia service to psychiatrists who provide electroconvulsive therapy will no longer be allowed. The RVUs for CPT 90870 have been increased to include payment for anesthesia when performed by the Psychiatrist (Medicare Matters November 2002).
6. Facility billing of 90870 and 00104 on the same date of service is a bundled service in the APC 0320. *Under the OPSS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPSS. No separate payment is made for packaged services, because the cost of these items and services is included in the APC payment for the service of which they are an integral part. It is extremely important that hospitals report all HCPCS codes consistent with their descriptors; CPT and/or CMS instructions and correct coding principles, and all charges for all services they furnish, whether payment for the services is made separately paid or is packaged (CMS Publication, Medicare Claims Processing Manual, 100-04, Chapter 4, Section 10.4).*
7. *IPFs receive an additional payment for each ECT treatment furnished during the IPF stay.....The ECT base rate is adjusted by the wage index and any applicable COLA factor. An IPF must report revenue code 0901 along with the number of units of ECT on the claim. The units should reflect the number of ECT treatments provided to the patient during the IPF stay. In addition, IPFs must include the ICD-9-CM procedure code for ECT (94.27) in the procedure code field and use the date of the last ECT treatment the patient received during their IPF stay. It is important to note that since ECT treatment is a specialized procedure, not all providers are equipped to provide the treatment. Therefore, many patients who need ECT treatment during their IPF stay must be referred to other providers to receive the ECT treatments, and then return to the IPF. In accordance with 42 CFR 412.404(d)(3), in these cases where the IPF is not able to furnish necessary treatment directly, the IPF would furnish ECT under arrangements with another provider. While a patient is an inpatient of the IPF, the IPF is responsible for all services furnished, including those furnished under arrangements by another provider. As a result, the IPF claim for these cases should reflect the services furnished under arrangements by other providers (CMS Publication, 100-04, Medicare Claims Processing Manual, Chapter 3, 190.7.3 and CR 6077).*
8. *When a hospital provides electroconvulsive therapy (ECT) on the same day as partial hospitalization services, both the ECT and partial hospitalization services should be reported on the same hospital claim. In this instance, the claim should contain condition code 41. As noted above, report charges for all services and supplies associated with the ECT service, which were furnished on the same date(s) on the same claim (CMS Publication, Medicare Claims Processing Manual, 100-04, Chapter 4, Section 170).*
9. When billing for services in a non-covered situation (e.g., does not meet indications of the related LCD), use the appropriate modifier. To bill the patient for services that are not covered (investigational/experimental or not reasonable and necessary) will generally require an Advance Beneficiary Notice (ABN) be obtained before the service is rendered.

- a. GA: Waiver of Liability statement on file. Use for patients who do not meet the covered indications and limitations of the LCD and for who an ABN is on file. ABN does not have to be submitted but must be made available upon request.
- b. GZ: Waiver of liability statement on file. Use for patients who do not meet the covered indications and limitations of this LCD and who did **not** sign an ABN.
- c. GY: item or service is statutorily excluded or does not meet the definition of any Medicare benefit.

Coding Guidelines Part B

1. ICD-9 codes must be reported to the highest level of specificity for the date of service.
2. Screening tests, in the absence of signs and symptoms of illness should be billed with "V" codes for a screening denial.
3. **Physician Billing:**
 - a. Code 90870 is limited to use by physicians (MD/DO) only.
 - b. Separate payment is not allowed for the psychiatrist's performance of the anesthesia service associated with the electroconvulsive therapy if the psychiatrist performs the electroconvulsive therapy. The RVUs for CPT 90870 have been increased to include payment for anesthesia when performed by the Psychiatrist.
4. **Anesthesia Billing:** CPT code 00104, Anesthesia for electroconvulsive therapy anesthesia is limited to one time unit (fifteen minutes).
 - a. Claims must be billed with one of the following modifiers for anesthesia services:
 - AA Anesthesia services performed personally by anesthesiologist
 - AD Medical direction by a physician; more than four concurrent procedures
 - QK Medical direction; two, three, or four concurrent anesthesia procedures involving qualified Individuals
 - QS Monitored anesthesia care service
 - QY Medical direction of **one** CRNA by anesthesiologist
 - b. **CRNA and AA**
 - QS Monitored anesthesia care service
 - QX CRNA service – with medical direction by a physician
 - QZ CRNA service – without medical direction by a physician
 - c. The CRNA or AA must accept assignment.
 - d. For complete information for anesthesia service requirements please refer to any LCD on the WPS website and/or regulations in the CMS Publication Manuals.
5. When billing for services in a non-covered situation (e.g., does not meet indications of the related LCD), use the appropriate modifier. To bill the patient for services that are not covered (investigational/experimental or not reasonable and necessary) will generally require an Advance Beneficiary Notice (ABN) be obtained before the service is rendered.
 - a. GA: Waiver of Liability statement on file. Use for patients who do not meet the covered indications and limitations of the LCD and for who an ABN is on file. ABN does not have to be submitted but must be made available upon request.
 - b. GZ: Waiver of liability statement on file. Use for patients who do not meet the covered indications and limitations of this LCD and who did **not** sign an ABN.
6. Type of Bill and Revenue Codes DO NOT apply to Part B.

Diagnoses that Support Medical Necessity Above

Documentation Requirements

The medical record documentation will provide an explanation of why ECT is prescribed and must meet the conditions stated in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD.

Any clinical history supporting the use of ECT needs to clearly document the medical reasonable and necessary conditions as described in the “indications and limitations” section on the policy

Documentation supporting the medical necessity of this procedure must be a part of and kept in the medical record. It must be available upon request. Failure to provide the required documentation will result in a denial of the claim(s).

Documentation should include, but is not limited to, the following:

- History and Physical Examination.
- Medical record containing established psychiatric diagnosis according to the DSM-IV.
- Medical records containing the patient’s evaluation and management findings and treatments with relevant clinical signs, symptoms, and/or abnormal diagnostic/lab tests.
- The clinical record should further indicate changes/alterations and response or non-response to medical management or treatment of the patient’s condition and reflect the continued need and appropriateness of ECT based on psychiatrist’s ongoing assessment and mental status examination of the patient during the course of treatments.
- It is understood that any diagnostic and clinical information submitted and presented in the medical record must substantiate that the components of the procedure performed and billed were actually performed.
- Procedure Record.

Reasons for Denial

Does this LCD contain a "Least Costly Alternative" Provision?

No

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Publication Date

06/01/2010

Notes:

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