Psychiatry Coding & Reimbursement Alert

CPT® Coding: Benefit From 3 Helpful Tips to Stimulate Your TMS Reporting Success

Hint: Don't report multiple units of the code for one calendar date of service.

When your psychiatrist performs transcranial magnetic stimulation (TMS), you need to be aware of what the treatment procedure included to determine the right code you will report for the session. You should also be aware of coverage guidelines for the procedure otherwise, you might risk chances of denials.

Background: Transcranial magnetic stimulation is a non-invasive procedure that your clinician will generally perform without any anesthesia. Your clinician will use an alternating current to perform stimulation of the cortex of the brain to help the release of certain neurotransmitters like dopamine, serotonin, and norepinephrine. The treatment procedure has been considered for use in a host of behavioral and neurological conditions, including depression, Alzheimer's disease, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), schizophrenia, panic disorder, epilepsy, Parkinson's disease, migraine headache, etc.

Use these three tips that will help you know if the TMS procedure that your clinician is planning to perform will receive coverage and the codes that you will report for the procedure during each session.

#1 Know When TMS is a Covered Service

Many payers do not provide coverage for treatment through repetitive transcranial magnetic stimulation. Some payers do provide coverage for the treatment but may provide the coverage only for certain diagnoses while treatment for other diagnoses might be denied.

Even though the use of repetitive TMS has been considered in the treatment of a host of behavioral and non-behavioral conditions, payers still consider the use of this modality of treatment investigational in patients with many of these conditions. If the treatment is considered investigational for a particular condition, you will not receive any coverage if your clinician performs the procedure for a patient with that particular condition. So, if your clinician is planning on performing TMS for a patient, you will need to check if the treatment procedure is covered by the payer and if so, whether that particular condition is covered or not.

Currently, most payers provide coverage for TMS when your clinician performs the procedure on a patient with severe major depressive disorder without psychotic symptoms (F32.2, Major depressive disorder, single episode, severe without psychotic features or F33.2, Major depressive disorder, recurrent severe without psychotic features) that is not responding to medication. However, in order to receive coverage, you should include the details of the medication that was tried out with the patient in the documentation. Most payers require that the medication should have been tried, without much result, over a minimum period of a month.

Reminder: If your clinician is planning to perform TMS for a patient with major depression or for any other behavioral conditions, it is best to check with the payer if they are providing coverage for the treatment. If so, you should check if you need any preauthorization prior to performing the treatment and what documentation they will need for it. This will help you stay clear of denials for the procedure at a later date.

#2 Choose From 3 Codes for Specific Sessions of Treatment

When your psychiatrist performs repetitive transcranial magnetic stimulation, you have to use one of the three CPT® codes that are available for this procedure, depending on what is performed during that session. The three codes that you have for reporting TMS procedures that your clinician performed include:

- 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)

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- 90869 (...subsequent motor threshold re-determination with delivery and management).

You report 90867 for the initial session during which your clinician started performing the TMS for the patient. You should note that 90867 is only reported once for a patient during the initial session and should not be reported again throughout the course of the treatment. During the initial session, your clinician will perform mapping of the cerebral cortex to determine the location where the electric stimulation will be applied. Usually, your clinician will focus this stimulation to the left dorsolateral prefrontal cortex in the treatment of depression.

In the same session, your clinician will also determine the motor threshold or, in other words, the minimum strength of electric current that is need to evoke a motor response and the repeated application of this electric current to bring about the therapeutic effects. Since the descriptor to 90867 includes the terms, "cortical mapping, motor threshold determination, delivery and management," you just report one unit of the code for the entire session and not multiple units of the code for each part of the treatment.

Your clinician will repeat the TMS treatment on a daily basis, usually for a period of about five to six weeks. During succeeding visits, he will use the previously determined motor threshold to repeat the delivery of the electrical stimulation to the same area of the cortex to bring about the desired therapeutic effects. For these subsequent visits, you will have to report 90868. Again, like 90867, you will report only one unit of the code for the entire session.

Sometimes, your clinician might observe that the applied stimulation is not having desired effects and might plan to re-determine the motor threshold. In such a case, this subsequent visit should not be reported with 90868. Instead, you should use 90869 to report this visit. Again, 90869 is also reported only once for the entire session.

#3 Watch Edit Bundles When Reporting With Other Psychiatry Services

All the three CPT® codes that you use when your clinician performs TMS carry edit bundles from Correct Coding Initiative (CCI), if you are trying to report any of these three codes with each other. All the edits carry the modifier indicator '0,' which means you cannot unbundle the codes under any circumstances. For instance, you cannot report 90869 and 90868 for the same patient on the same calendar date of service. If you do this, then your claim for 90868 will be denied as this is the column 2 code in the edit bundle with 90869.

"Each of these CCI edits is consistent with CPT® instructions not to report any of the TMS codes with each other," says **Kent Moore,** senior strategist for physician payment at the American Academy of Family Physicians.

In addition, you will face edits if you try reporting other psychiatry codes with any of the TMS codes. You cannot report TMS codes with psychodiagnostic evaluation codes (90791 or 90792) as these edits also carry the modifier indicator '0' with TMS codes being the column 2 codes.

If you are planning on reporting TMS codes with same day psychotherapy codes, you have to check CCI edits as these sets of codes are again bundled. However, the modifier indicator for these edits is '1,' which means you can undo the code bundling by using a suitable modifier. Since TMS codes are column 2 codes in this bundling, you will use a modifier such as 59 (Distinct procedural service) to overcome the edits.

Apart from these, CCI also lists edits for TMS with other psychiatry related codes which 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 (Narcosynthesisfor psychiatric diagnostic and therapeutic purposes [e.g., sodium amobarbital (Amytal) interview])
- 90870 (Electroconvulsive therapy [includes necessary monitoring])
- 90880 (Hypnotherapy)
- E/M codes.

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However, in these above mentioned edits, TMS codes are column 1 codes and the other codes that are listed are column 2 codes. So, you will have to append the modifier (such as 59) to these psychiatry codes or 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) in case of E/M, while TMS codes will be reported with no modifier.

"Note that, per CPT®, evaluation and management activities directly related to cortical mapping, motor threshold determination, and delivery and management of TMS are not separately reportable. So, if you are going to report an E/M code in addition to a TMS code, the selection of the E/M service should not reflect these elements of the TMS service," Moore says.

"It's also worth noting that for TMS motor function mapping for therapeutic planning other than for repetitive TMS, CMS directs you to use a category III CPT® code, 0310T (Motor function mapping using non-invasive navigated transcranial magnetic stimulation [nTMS] for therapeutic treatment planning, upper and lower extremity)," Moore adds. Category III CPT® codes are temporary codes for emerging technology, services, and procedures.

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