

Follow Up-Questions/Answers – 12/06/06 Mental Health Teleconference

1. **QUESTION:** At the initial visit, patients at our clinic see the Clinical Psychologist for a Psychiatric Evaluation (90801) and then see the Psychiatrist on the same day. Many times the Psychiatrist will also use a 90801, which is rejected as a duplicate. How can we bill this so it is compliant with Wisconsin Physicians Service (WPS) Medicare Policy? We are an Outpatient Community Mental Health Clinic and this workflow (seeing both the Psychologist and Psychiatrist same day) works the best for our clients. Many of them have transportation issues.

Could you please address using 90801 and an Evaluation and Management (E/M) code or consultation code the same day, for the same patient, but for two different providers?

ANSWER: According to WPS Medicare Policy PSYCH-014, 90801 is covered once per provider/per discipline at the onset of an illness or suspected illness. Procedure 90801 may be covered again for the same patient if a new episode of illness occurs after a “hiatus” or on admission or readmission to inpatient status due to complications of the underlying condition. A second diagnostic interview is not covered more than once or after a “hiatus” if the patient simply quit coming to therapy.

If 90801 is billed and another provider with a different specialty performs an E/M service or consultation, both services may be considered for reimbursement.

2. **QUESTION:** During the teleconference, I asked about two different Group Therapy Sessions on the same day, for the same patient. I was informed it would be acceptable, but I would need to append the modifier 59. If two different providers did the Group Therapy Sessions, would the modifier 77 be more appropriate in this situation?

ANSWER: During the teleconference, we stated that if the group therapy codes appear on the National Correct Coding Initiative (NCCI) edit lists with an appropriate indicator, the 59 may be used. Upon checking the NCCI edit lists after the teleconference concluded, we found these codes do not appear on the NCCI edit lists, therefore, the 59 modifier may not be used.

It would be unusual that more than one psychotherapy encounter would be medically necessary. Documentation in the medical record must identify the medical necessity of an additional psychotherapy session in the same day. A 77 modifier is not appropriate. If the second psychotherapy encounter is denied, the provider may request an appeal and submit supporting documentation to justify the medical necessity for the second encounter on the same day for the same patient.

3. **QUESTION:** I would like to confirm that when providing a Med Management, 90862 and an injection (90772) is provided at the visit, both can be billed as separate billable procedures.

Would this also be true if an E/M (i.e., 99211 or 99212) and an Injection (90772) is provided? Can both be billed?

ANSWER: Upon checking the NCCI edit tables after the teleconference, we confirmed 90862 and 90772 cannot be billed on the same occasion. Code 90772 bundles into 90862 and cannot be billed with a 59 modifier.

According to WPS Medicare Policy HONC-002, CPT 99211 is not to be billed on the same day as a drug administration code that has a work relative value unit. If a significant separately identifiable E/M service is performed (other than 99211), the appropriate E/M service code should be reported utilizing modifier 25 in addition to the drug administration code.

4. **QUESTION:** It is appropriate to use an E/M code, providing all required elements are present, in place of a 90801 for psychiatry. Can an appropriate E/M service be billed in place of a 90862, providing all required elements are present (documenting history, exam and medical decision making)?

ANSWER: Providers need to bill the code that accurately describes the service he/she performs. If a psychiatrist provides an E/M service, he/she should bill an E/M service. If he/she performs a 90801, he/she should bill the 90801. The same would apply for an E/M versus 90862.

5. **QUESTION:** Is it appropriate to bill Assessment/Testing codes with an E/M code for psychiatry? How do you appropriately capture time spent scoring and interpreting outside of the face-to-face time? Should time spent giving feedback to patient be billed using an E/M or in the testing codes? What if medication management is also done at the time of service?

ANSWER: A Clinical Psychologist may not bill an E/M service. A Psychiatrist may bill an E/M service along with Assessment/Testing codes if documentation in the medical records supports that the E/M service is a separately identifiable medically necessary service.

Psychological assessment/testing codes include the Clinical Psychologist's or Psychiatrist's time both face-face time with the patient and time interpreting test results and preparing the report.

Time spent giving feedback to the patient should not be billed with an additional E/M service, since it is included in the testing code(s).

Medication management is bundled into E/M and Psychotherapy services on the same day. It is not bundled into an assessment/testing service.