

LCD for Electroconvulsive Therapy (ECT)

Contractor Name

Wisconsin Physicians Service

Contractor Number

00951, 00952, 00953, 00954
5101, 5201, 5301, 5401
05102, 05202, 05302, 05402,
52280

Contractor Type

Carrier
Fiscal Intermediary (FI)
MAC A
MAC B

LCD ID Number

LCD Title

Electroconvulsive Therapy (ECT)

Contractor's Determination Number

PSYCH-025

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CMS National Coverage Policy

Social Security Act

- Title XVIII of Social Security Act, § 1862 (a) (1) (A) this section allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.
- Title XVIII of the Social Security Act, 1862 (a) (7) excludes routine physical examination and screening tests performed in the absence of signs and symptoms from coverage.
- Title XVIII of Social Security Act, § 1833 (e) prohibits Medicare Payment for any claim which lacks the necessary information to process the claim.

CMS Publications

- CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1, Section 160.25.
- CMS Publication, 100-04, *Medicare Claims Processing Manual*, Chapter 3, 190.7.3
- CMS Publication 100-04, *Medicare Benefit*, Chapter 12, Section 50.

Code of Federal Regulations

- 42 CFR 410.155 Outpatient mental health treatment limitation.
- 42 CFR 412.113(c) Anesthesia services furnished by hospital or CAH employed non-physician anesthetists or obtained under arrangements.
- 42 CFR 412.50 Furnishing of inpatient hospital services directly or under arrangements.
- 42 CFR 482.13(b)(2) in the Patients' Rights CoP discusses the patient's or patient's representative's right to make informed decisions regarding the patient's care.
- 42 CFR 482.24(c)(2)(v) in the Medical Records CoP discusses the requirement that the hospital must ensure that patient medical records contain properly executed informed consent forms for procedures or treatments specified by the hospital Medical Staff, or by Federal or State law if applicable, to require written patient consent.

CMS Medicare Carriers Manual, Transmittal 1816, Change Request 2682 dated August 22, 2003.

Program Memorandum AB-03-003, January 10, 2003. Non-coverage of Multiple Electrocardiograms. (MECT)

Primary Geographic Jurisdiction

Carrier: Wisconsin, Illinois, Michigan, Minnesota

MAC A/B: Iowa, Missouri, Nebraska, Kansas

Fiscal Intermediary A: Alaska, Alabama, Arizona, Arkansas, California - Entire State, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Iowa, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Michigan, Minnesota, Missouri - Entire State, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia, Wyoming, American Samoa, Guam, Northern Mariana Islands, U.S. Virgin Islands

Secondary Geographic Jurisdiction

Oversight Region

Original Determination Effective Date

Original Determination Ending Date

Revision Effective Date

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

Abstract:

Electroconvulsive therapy (ECT) is a procedure where electrodes are positioned on the patient's scalp, and measured-electrical current is passed through to the brain. ECT is effective for a narrow range of psychiatric disorders. It is effective for mood disorders both bipolar and unipolar. It can also be used to augment the treatment of schizoaffective disorder and schizophrenia. Most ECT is performed to treat depression and is not typically the first-line of treatment. However, ECT works more quickly than medications and should be used as a first line treatment in life threatening catatonia or someone who is extremely suicidal. Research shows that ECT may be appropriate for patients with recurrences who were prior ECT responders and for refractory depression in patients with contraindications to medications or who are unwilling to take medications. When ECT is prescribed it should be part of a treatment plan overseen by a board certified psychiatrist in conjunction with other therapies when indicated.

Indications of Coverage:

ECT is a highly structured treatment involving a complex and repeatedly administered procedure. ECT should be used to achieve rapid resolution of severe symptoms. ECT may be most helpful when other treatments have failed, although there are situations when ECT can be used as a first line treatment. The decision to use ECT should be made jointly by the beneficiary and/or their legal representative and the clinicians responsible for treatment. Consent should be obtained where the patient and/or their legal representative is able to give such permission.

Pre-ECT Evaluation:

In accordance with the Task Force Report of the American Psychiatric Association, each facility administering ECT treatment will determine the requirements of a pre-ECT evaluation. Patient medical evaluation is an essential component of the pre-treatment process and may include but is not limited to:

1. Psychiatric history and examination, including past response to ECT treatments and a baseline neuropsychiatric evaluation.
2. Medical evaluation that includes history and examination (i.e. neurological, cardiovascular, pulmonary systems, and previous response to anesthesia).
3. Review of dental problems including examining loose or missing teeth, presence of dentures or other appliances.
4. Appropriate laboratory and diagnostic tests: common tests include but are not limited to complete blood count, serum electrolytes, electrocardiogram, chest x-ray, and pregnancy test on child-bearing age patients (determined on a case-by-case basis).

Treatment:

Prescribed therapy usually consists of six to 12 ECT treatments administered over a period of two to six weeks, after which a re-evaluation is recommended.

Primary indication:

According to the APA Task Force, ECT treatment could be prescribed as a first-line or primary treatment when a rapid or higher probability of response is needed and the patient symptomatology is severe.

Situations would include, but are not limited to:

- Primary or secondary severe major depression with/without psychotic features
- Manic delirium
- Acute mania
- Catatonia
- At risk for self harm or others
- Medication-resistance or intolerance (i.e. anti-depressants and/or neuroleptic medications that pose a particular medical risk)

- When ECT is safer than alternative treatments in conditions such as with the infirm elderly and during pregnancy

Secondary indication:

ECT treatment could be prescribed as a second-line or secondary treatment for patients that have the following, but are not limited to:

- Poor or little response to other modalities of treatment
- Deterioration in psychiatric condition
- Onset of suicidal ideations or intent to harm self or others
- Lack of or decrease in the will to live (i.e. exhaustion, dehydration, lack of vigor)

ECT Continuation or Maintenance:

Continuation or maintenance ECT may be used to reduce the risk for relapse and recurrence of illness. Treatments may be started on a weekly basis with the interval treatments gradually extended to a month, depending on patient response. Patient referral for maintenance ECT should meet one or more of the following indications:

- History of illness that is responsive to ECT
- History of medication-resistant depression
- Medication intolerance or patient unwillingness to take medication.
- Comorbid conditions that complicate management of the psychiatric disorder
- Either non-compliance or intolerance to pharmacotherapy
- Patient preference for continuation ECT therapy; and
- Ability and willingness of the patient to comply with overall treatment plan to prevent relapse

ECT, including maintenance ECT, has been helpful for patients with Parkinsonism where pharmacotherapy with dopamine agonists or precursors is either of limited efficacies and/or precipitates psychosis or other severe behavioral or mental health changes and can be considered for medical necessity (Office of mental health).

For narcoleptic malignant syndrome (NMS) supportive care combined with immediate discontinuation of the causative agent is the primary treatment. NMS research shows ECT as an effective treatment and can be considered for coverage with supporting medical documentation.

ECT is generally initiated in an inpatient setting, but can be administered on an outpatient basis in a facility with treatment and recovery rooms where appropriate healthcare professionals are available and should include equipment and medications that could be used in the event of cardiopulmonary or other complications. Treatments are typically administered by a psychiatrist and an anesthesiologist, with a specially trained nurse in attendance.

Wisconsin Physicians Service considers ECT reasonable and necessary when one or more of the following indications of coverage is met:

- Major depressive episode and/or major depressive disorder that meet the criteria according to the DSM-IV.
- Depression with acute suicide risk, extreme agitation, or unresponsive to pharmacological therapy.
- Bipolar illness with either mania or depression where medications are ineffective or not tolerated, or severe mania presenting a safety risk to the patient or to others.
- Intolerance to the side effects of antidepressant medication or to antidepressant or psychotropic medications that pose a particular medical risk.

- When rapid resolution of depression is necessary, e.g., the patient is acutely suicidal or physically compromised, and the time factor to achieve maximal effectiveness of antidepressants or mood stabilizers places the patient at immediate risk to health or safety.
- Inability to medically tolerate maintenance medication.
- Catatonia
- Acute schizophrenia, or severe, life-threatening psychoses, which have not responded to, or cannot be treated with short term, high dose tranquilization.
- When continuation of ECT treatments is necessary to sustain remission or to sustain significant improvement.

Limitations of Coverage

Multiple-Seizure Electroconvulsive Therapy:

Clinical Effectiveness of the multiple-seizure electroconvulsive therapy has not been verified by scientifically controlled studies. In addition, studies have demonstrated an increased risk of adverse effects with multiple seizures. Accordingly, MECT cannot be considered reasonable and necessary and is not covered by the Medicare Program. Effectiveness for services provided on or after April 1, 2003 (CMS Publication 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Section 160.25). Effective for dates of service on or after April 1, 2003, CMS Medicare will not pay for this therapy in any setting or under any code.

Although there are no “absolute” contraindications for ECT treatment, it is pertinent to weigh the relative risk to the potential benefits of treatment. There are medical conditions that substantially increase the risk of treatment and should be evaluated on a case-by-case basis by the attending physician and treating psychiatrist. Relative contraindications in ECT treatment include space-occupying lesions of the brain, high intracranial pressure, recent cerebral infarct (hemorrhagic or ischemic within past 90 days), recent myocardial infarction (six weeks for mild MI and up to six months for severe MI), retinal detachment, pheochromocytoma, high anesthesia risk, adolescents and children, or significant medical illness in which risk outweighs potential benefit. Careful evaluation is an essential component of the treatment process and may include consultations with internists, cardiologists, neurologists, and other specialties.

ECT is not considered reasonable and necessary for the following conditions/situations:

- Alcoholism as the primary diagnosis
- To aid in developing conditioned aversions to the taste, smell and sight of alcoholic beverages
- Ability to tolerate effective antidepressant or psychotropic medications, and rapid resolution of depression is unnecessary because the patient is not a immediate risk of suicide
- No evidence of ECT effectiveness in patients who have been treated previously (e.g. use of bilateral electrode placement for a series of 12 treatments)
- Major depression and bipolar disorder when the patient tolerates and is responding to antidepressant medications

Bill Type Codes

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type and the policy should be assumed to apply equally to all claims.

XXX000 TBD

Revenue Codes

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary or MAC Part A. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or MAC Part B.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

0901	Psychiatric/psychological treatments-electroshock treatment
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CPT/HCPCS Codes

Listing of HCPCS codes contained in this instruction does not assure coverage of the specific service. Current coverage criteria still apply.

90870	Electroconvulsive Therapy (includes necessary monitoring)
00104	Anesthesia for electroconvulsive therapy

ICD-9 Codes that Support Medical Necessity

It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

Non-covered diagnosis codes may be covered upon appeal on an individual consideration basis with supporting evidence of medical necessity. (Title XVIII of the Social Security Act, Section 1862(a) (1)(A). The codes selected are those codes which appear in the ICD-9-CM and that are defined in *The Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV-TR™).

Note: Every effort has been made to attempt to reflect the psychiatric diagnostic coding conventions of DSM-IV-TR™ in the psychiatric diagnoses section. Cases that fall outside DSM-IV-TR™ coding may be considered for coverage on a case-by-case basis.

Diagnoses that Support Medical Necessity

Not applicable.

ICD-9 Codes that DO NOT Support Medical Necessity

The ICD-9 codes not meeting the requirements for medical necessity in the narrative section titled “Indications and Limitations” of this LCD.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Not applicable

Diagnoses that DO NOT Support Medical Necessity

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.

Utilization Guidelines

Tests for screening purposes that are performed in the absence of signs, symptoms, complaints, or personal history of disease or injury will be considered non-covered.

Exams required by insurance companies, business establishments, government agencies, or other third parties, without rationale for necessity will be denied.

Tests that are not reasonable and necessary for the diagnosis or treatment of an illness or injury are not covered according to the statute.

Failure to provide documentation of the medical necessity of tests will result in denial of claims.

Beneficiary Liability

The beneficiary is not financially liable if services are denied as not medically reasonable and necessary unless an Advance Beneficiary Notice (ABN) is obtained.

The outpatient mental health limitation appears in 42 CFR 410.155 and applies to this policy.

This policy does not reflect the sole opinion of the contractor or medical director (CMD). Although the final decision rests with the contractor, this policy was developed in consideration of input from relevant interested parties and specialists.

Sources of Information and Basis for Decision

WPS does not guarantee the continued availability of websites below.

American Psychiatric Association, Public Information, ECT. Available at: www.psych.org/public_info.

American Psychiatric Association. (1994). Practice guideline for the treatment of patients with bipolar disorder. *AM J Psychiatry*. 151 (12 Suppl): 1-36.

American Psychiatric Association (2000). Practice guideline for the treatment of patients with major depressive disorder. *Psychiatry Online*. 1-49. Available at: http://www.psychiatryonline.com/popup.aspx?aID=49371&print=yes_chapter. Accessed on April 23, 2009.

American Psychiatric Association (2006). American Psychiatric Association, Task Force on Electroconvulsive Therapy: recommendations for treatment, training, and privileging (2nd ed). A Task Force Report of the American Psychiatric Association. Available at: <http://www.ect.org/apa-task-force-report-on-electroconvulsive-therapy>. Accessed on 05/11/2009.

Andrade, C. and Kurinji, S. (2002). Continuation and maintenance ECT: A review of recent research. *Journal of ECT*, September 18(3): 149-58.

Electroconvulsive Therapy. (1985) NIH Consensus Statement Online, Jun 10-12; 5(11): 1-23. Available at: <http://consensus.nih.gov/1985/1985electroconvulsivetherapy051html.htm>. Accessed on April 28, 2009.

Ellis, P. (2004). Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression. Australian and New Zealand clinical practice guidelines for the treatment of depression. *Aust NZ J Psychiatry*, 38(6): 389-407.

Frederikse, M, Petrides, G, and Kellner, C. (2006). Continuation and maintenance therapy for the treatment of depressive illness: a response to the National Institute for Excellence report. *Journal of ECT*, March; 22(1): 13-17.

Geddes J, Carney S, Cowen P, et al. (2003). Efficacy and safety of electroconvulsive therapy in depressive disorders: A systematic review and meta-analysis. *Lancet*, 361 (9360): 799-808.

Greenberg, R., et al. (2005). Electroconvulsive Therapy: A Selected Review, *American Journal of Geriatric Psychiatry*, April 13(4).

Kahn, D; Carpenter, D; Docherty, J; Frances, A. Treatment of Bipolar Disorder (no date).

Lisanby, S. (2007). Electroconvulsive Therapy for Depression. *New England Journal of Medicine*, 357: 19: 1939-1945. Available at <http://www.nejm.org>. Accessed on April 28, 2009.

National Institute for Clinical Excellence (NICE) (2003, April). Guidance on the use of electroconvulsive therapy. Technical Appraisal 59. London, UK: NICE. Available at <http://www.nice.org.uk/Docref.asp?d=68306>. Accessed on April 28, 2009.

Onofrj, M, Thomas, A. (2005). Acute akinesia in Parkinson’s disease. Neurology 2005; 64: 1162.

Sackeim, H, Haskett, R, Mulsant, B, et al. (2001). Continuation pharmacotherapy in the Prevention of Relapse following electroconvulsive therapy. The Journal of the American Medical Association, 285: 1299-1307. Available at: <http://jama.ama-assn.org/cgi/content/full/285/10/1299>. Accessed on May, 11, 2009.

Smith, D. (1995). Neuroleptic Malignant Syndrome. P&T News April, 1995, Volume 15, No. 10. Available at: <http://www.healthcare.uiowa.edu/pharmacy/PTNews/1995/04.95.html>. Accessed on June 1, 2009.

U.S. Department of Health and Human Services (2001, December), Office of the Inspector General. Medicare Reimbursement for electroconvulsive therapy. OEI-12-01-00450. Washington, DC; U.S. Department of health and Human Services. Available at <http://oig.hhs.gov/oei/reports/oei-12-01-00450.pdf>. Accessed on April 29, 2009.

US Department of Health and Human Services, “Clinical Practice Guidelines”, pp. 41, 95-96.

Advisory Committee Meeting Notes

Illinois	09/16/2009
Michigan	09/09/2009
Minnesota	09/24/2009
Wisconsin	09/25/2009
J5 MAC	10/08/2009
Jurisdictional Open Meeting	08/19/2009

Start Date of Comment Period

10/08/2009

End Date of Comment Period

11/23/2009

Start Date of Notice Period

Revision History Number

Revision History Explanation

Reason for Change

Last Reviewed On Date

07/28/2009

Related Documents

[See Billing and Coding Guidelines for Electroconvulsive Therapy \(ECT\)](#)

LCD Attachments

There are no attachments for this LCD

Other Versions

Coding and Billing Guidelines

Article Title

Billing and Coding Guidelines for Electroconvulsive Therapy (ECT)

Effective Date:

Revision Effective Date

NA

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Article Text

This article contains the coding guidelines and reasons for denial for Electroconvulsive Therapy (ECT). This article should be used in combination with LCD Electroconvulsive Therapy (ECT).

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 OPFS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPFS. 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 or NCP 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.

CMS National Coverage Policy:

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

Notes:

Italicized font - represents CMS national policy language/wording copied directly from CMS Manuals or CMS Transmittals. Carriers are prohibited from changing national policy language/wording. Providers, through their associations/societies, should contact CMS to request changes to national policy through the Medicare Coverage Policy Process at <http://www.cms/hhs.gov/coverage>

Revision History Number/Explanation