

In the News

Why Proper Coding for IV Ketamine Matters – and What You Should Do

Proper coding for IV ketamine is essential to ensure eligible patients—especially those with treatment-resistant depression (TRD)—can receive coverage for this effective, often lower-cost therapy. While ketamine is FDA-approved as an anesthetic, it is widely used for behavioral health indications such as TRD and acute suicidal ideation. **Most claim denials do not occur because ketamine is “not covered,” but because it is coded incorrectly**, such as being billed as an administrative visit, anesthesia service, or pain infusion rather than a medically necessary psychiatric treatment.

When coding is inaccurate or documentation is missing, payers cannot confirm medical necessity or psychiatric indication—leading to avoidable denials, delays in care, patient financial burden, and reimbursement challenges for providers. Accurate coding supports faster claim processing, reduces patient costs, and improves access to an important and rapid-acting mental health treatment.

Common Mistakes That Lead to Denials

Mistake	Why It Matters
Missing or incorrect diagnosis code	Payers need to see a clear behavioral health indication like TRD (e.g. F33.2 — Major depressive disorder, recurrent, severe).
Billing only under administrative office visit, anesthesia or pain codes	If billed solely as an administrative office visit, a pain infusion or off-label anesthetic, the claim is often denied.
No treatment history or clinical justification	Payers need to see that other treatments have failed and that ketamine is medically necessary.

What to Do Instead

1. Code with behavioral health in mind (when appropriate).

Use appropriate ICD-10, CPT and revenue codes to reflect the patient's diagnosis (e.g., F33.2 for TRD, 96372 for the administration of ketamine) and every treatment administered. Avoid billing as only an administrative office visit or an anesthetic service if the indication is psychiatric.

2. Submit the documentation when required.

Check the patient's plan benefits and submit the necessary forms before initiating treatment. We cover IV ketamine for diagnoses such as TRD when documentation is submitted properly.

3. Document clearly.

Include prior treatment failures, current symptoms and clinical rationale for ketamine in the chart.

Example: Improved Claim Submission

- Diagnosis: F33.2 – Major depressive disorder, recurrent, severe
- Procedure codes: Administration code, IV ketamine HCPCS code (e.g., J3490, etc.) and National Drug Code (NDC) (e.g., 00143950801) (billed using insurer-preferred codes — varies by plan)
- Documentation: Chart notes might include prior failed treatments, PHQ-9 scores, psychiatrist evaluation

4. Ask for help.

If you're unsure about billing, consult your Medical Mutual Provider Contracting Manager or you can reach us at 1(800) 625-2583.

Why This Matters

Correct coding ensures IV ketamine is billed as a behavioral health treatment rather than as an office visit or anesthesia service. This protects patients from unnecessary financial burden, improves access to an evidence-supported therapy and reduces avoidable claim denials stemming from coding errors. Coding accurately can help close the mental-health access gap and support streamlined reimbursement.

Medical Mutual does not advise providers on billing for ketamine or related services. This content is for educational purposes only and does not recommend treatment.