

## **CODING AND BILLING ISSUES WITH PAIN MANAGEMENT PROCEDURES**

It is very important to code Pain Management procedures correctly, to assure you are not leaving any money on the table, while avoiding compliance problems. This seminar will update your coding knowledge and skills and provide you with specific tips you can use for the most common Pain Management procedures performed.

### **Billing Issues with Pain Management**

- Billing for new procedures (which do not have an existing CPT code) with a code for a procedure that does not fit [to be paid]. Carefully check out advice on coding for new technology or equipment you get from salespeople and equipment reps. – if they give you flawed advice and you code incorrectly, YOU are still responsible.
- Upcoding of CPT procedure or diagnosis codes.
- Performing Pain Management procedures too often on the same patient.
- Unbundling of CPT procedure codes.
- Failure to refund Credit Balances in a timely manner.
- Medical Necessity issues.
- Physicians use of “Canned Operative Reports” to document Pain Management procedures.
- Changing the Date of Service on claims to correspond with coverage dates.

### **General Billing Basics and Tips**

- If you review EOBs/RAs for denial reasons, they will provide you with a wealth of information of what is being done incorrectly with the insurance verification processes, as well as with the coding and the billing at your practice or facility. The EOBs tell the story.
- Always check CCI Unbundling material when coding multiple procedures. Keep the CCI material current (usually updated quarterly).
- Sequence CPT codes for billing correctly on claim forms. Never list an “Add-on” (+) Code for a Pain Management procedure performed at a level subsequent to the initial level before the code for the initial level. Do not list an Add-on Code alone on the claim without the code for the initial level.

- For ASC facilities, list CPT codes on claims from Highest to Lowest fee listed on the Medicare ASC List for Medicare patients. Sequence CPT codes on claims from highest to lowest Payment Groupings for those other payors with which the ASC facility is contracted who use Groupers. ASCs should sequence CPT codes on claims from highest to lowest RVUs for those other payors with which the ASC is contracted who do NOT go by Payment Groupers or with whom the facility does not have a contract.
- Be sure OP Reports for Pain Management procedures properly identify the ASC facility, hospital or physician's office as the Place of Service (Use POS 24 on claim forms for ASCs) where the Pain Management procedure was performed. Surgeons should NOT do OP Reports on their own office stationary or at the hospital offsite from where the procedure was performed without properly identifying the location/facility where the Pain Management procedure was actually performed – this can make it unclear where the procedure was performed, which can be a fraud issue with Medicare, BC/BS and other payors.
- Read and carefully check Medicare Bulletins monthly for changes to existing policies/rules and new policies that affect Pain Management coding and billing.
- Be aware of any Medicare Local Medical Review Policies (LMRP) or Local Coverage Determination (LCD) policies that affect Pain Management procedures done, services provided, or implants, supplies/equipment used in your ASC facility or practice. These policies list covered diagnoses for the procedure, which must be followed carefully to assure proper reimbursement for the provider. Remember – any diagnosis not listed in the LCD used on a claim will usually result in a claim denial for “Medical Necessity” reasons. However, you cannot use a diagnosis from the LCD list which does not pertain to the patient. If you cannot find a supporting diagnosis in the OP Report, review the H & P and/or Pathology Report for a symptom or path. result that is covered on the LCD list.

### **Diagnosis Coding in Pain Management/Spine Procedures**

It is very important for Pain Management procedures to code these complicated conditions as specifically as possible and to not use the 724.2 Low Back Pain symptom code (or something as equally as general and non-specific) to code every claim. If you cannot locate the patient's true condition in the Procedure Report, review the H & P for this information.

#### **Spinal Stenosis**

Spinal Stenosis is the narrowing or stricture of the spinal canal. Cervical Spinal Stenosis is code 723.0 and Lumbar Spinal Stenosis is code 724.02.

#### **Radiculitis**

The inflammation of the root of a spinal nerve, particularly that portion of the nerve root lying between the spinal cord and the intervertebral canal. Pain from this disorder is called

Radicular Pain, and it can also be referred to as Radicular Neuritis. Use code 724.4 for Lumbosacral or Thoracic Radiculitis and code 723.4 for Cervical Radiculitis.

### **Spondylosis**

Spondylosis is a degenerative change of a vertebral joint due to osteoarthritis. Coding is based on whether or not Myelopathy (a disease affecting the spinal cord) is involved. Use code 721.90 for Spondylosis (Unspec. site) without Myelopathy and code 721.91 for Spondylosis with Myelopathy. Use code 721.3 for Lumbar Spondylosis without Myelopathy and code 721.0 for Cervical Spondylosis without Myelopathy.

### **Enthesopathies**

Enthesopathies are degenerative disorders of the peripheral ligaments or muscles and tendon attachments to the bones. Common areas of involvement are the shoulder, the elbow, the wrist, the hip, and the knee.

### **Postlaminectomy Syndrome**

Some patients have chronic pain following back surgery, which is also called Postlaminectomy Syndrome or Failed Back Syndrome. This problem may require Pain Management Procedures or further Spine Procedures. Use code 722.81 for the Cervical region, 722.82 for the Thoracic region and code 722.83 for the Lumbar region.

### **Displaced or Herniated Discs**

Use code 722.0 for the Displacement of a Cervical intervertebral disc without myelopathy, code 722.10 for a Displaced Lumbar disc without myelopathy, code 722.11 for a Displaced Thoracic disc without myelopathy and code 722.2 for a Displaced intervertebral disc at an Unspecified site, without myelopathy.

### **Degenerative Disc Disease**

Use code 722.4 for Degeneration (DJD) of a Cervical intervertebral disc, code 722.51 for DJD of a Thoracic or Thoracolumbar disc, code 722.52 for DJD of a Lumbar or Lumbosacral disc and code 722.6 for DJD of an Intervertebral Disc of an Unspecified site.

### **Disorders of the Sacrum**

When Pain Management procedures are performed in the Sacral (SI Joint Injections), they are usually performed for either Sacroiliitis (code 720.2) or other Disorders of the Sacrum (code 724.6).

## Pain Management Procedures

With Pain Management Procedures, it is very important to know the destination of the needle in the Pain Management procedure performed. Knowing the spinal anatomy for Pain Management Procedures will enable you to understand which procedure the physician is performing – even if it is difficult to tell from the documentation.

### Needle Destinations:

- Epidural Space/Extradural Space – This area is located inside the spinal canal and is separated from the spinal cord and the surrounding CSF (Cerebrospinal Fluid).
- “Epidural” – Which is short for “Epidural Anesthesia” and is a form of regional anesthesia involving drugs administered through a catheter placed in the epidural space.
- Dura Mater (Dura) – Separates the epidural space and the arachnoid membrane.
- Arachnoid Mater – This area is adherent to the inside of the dura and is more fragile.
- Subarachnoid Space – This area is inside the arachnoid space and contains CSF and the spinal cord.
- Vertebral Column – Also referred to as “the Spine” is composed of 33 bones, which are divided into 5 regions:
  - Cervical – 7 vertebral segments
  - Thoracic – 12 vertebral segments
  - Lumbar – 5 vertebral segments
  - Sacral – 5 vertebral segments
  - Coccyx – 4 vertebral segments

A vertebrae is a cylindrically-shaped body anteriorly and a neural arch posteriorly (composed primarily of the laminae and pedicles, as well as the other structures in the posterior aspect of the vertebrae), which protect the spinal cord.

An Intervertebral Disk is the tough elastic structure that lies between the bodies of spinal vertebrae. The disk consists of an outer annulus fibrosis enclosing an inner nucleus pulposus.

Pain Management procedures are done for patients having pain requiring treatment.

- Acute Pain is the pain associated with the treatment of post-operative procedural pain. This type of pain management is usually provided on an inpatient basis and is short-term.
- Chronic Pain is associated with the treatment of ongoing pain (usually lasting for 6 months or more), and is not always related to surgery. Pain Management procedures for chronic pain are typically done on an outpatient basis.
- The decision to perform pain management procedures involves the severity of the patient’s pain and the *lack of other treatment* options.

## **Epidural/Subarachnoid Steroid Injections CPT Codes 62310-62319**

Epidural Steroid Injections are also called ESIs. CPT code 62310 is for an ESI Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid of the Cervical or Thoracic areas.

Use code 62311 for ESI Injections of the Lumbar or Sacral (caudal) areas.

- The 62310 Cervical or Thoracic Epidural injections are done for patients with pain in the arms, neck, chest or high back area.
- The 62311 Lumbar or Caudal Epidural injections are done for patients with pain in the legs and/or lower back/buttock(s) area.

Procedure: The patient is placed in a prone or decubitus position, using fluoroscopy to guide the placement of the needle and confirm the tip of the needle is in the epidural/subarachnoid space. The injection of substance is performed. The subarachnoid route is performed when more specific effects on a nerve root are desired. These codes include the contrast material. Report the Fluoroscopy code 77003-TC/-26 or Global with no modifier, when documented and billable to the payor.

62318 – ESI Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; Cervical or Thoracic

62319 – ESI Injection - Lumbar or Sacral (caudal)

Procedure: A catheter is threaded through the needle and placed in the space. A continuous infusion is started for several hours/days. Occasionally, three or more injections might be given over a period of hours/days and may involve different substances.

*These codes include the injection contrast material. If Fluoroscopic Guidance was used, the Fluoroscopy would be separately-billable with CPT code 77003-TC/-26 or Global with no modifier.*

## **Transforaminal Epidural Injections CPT Codes 64479-64484**

64479 - Injection, anesthetic agent and/or steroid, Transforaminal epidural; Cervical or Thoracic, single level

+64480 - Cervical or Thoracic, each additional level

64483 - Injection, anesthetic agent and/or steroid, Transforaminal epidural; Lumbar or Sacral, single level

+64484 – Lumbar or Sacral, each additional level

- A Transforaminal ESI is more difficult to perform, due to the close proximity of the nerve root to the vertebral artery and spinal cord. Transforaminal ESI Injections are performed under fluoroscopy for precise anatomic localization, to avoid injury to the vertebral artery. The contrast will be in either the foramen into the epidural space or it will be in a fascial plane or epidural vein. These codes are unilateral procedure codes; if the procedure is performed bilaterally, you need to bill in a Bilateral manner, by appending either the -RT/-LT or the -50 Modifier.

*The injection of contrast material is inclusive. Report the 77003-TC/-26 or no modifier for Global Fluoro. code separately for use of the fluoroscopic guidance, if billable to the payor.*

### **Bundling Issues with ESI Procedures**

The 64479 code is Unbundled from code 62310 (Regular ESI procedure) in the Mutually Exclusive Table of the CCI Unbundling Material. Code 64483 is Unbundled from code 62311 (Regular ESI procedure) in the Mutually Exclusive Table of the CCI Unbundling Material. Therefore, for Medicare and other payors who observe the CCI edits, these codes are not billable together when they are performed at the SAME spinal area. If the physician does an ESI (62311) at level L5 and a Transforaminal ESI (64483) at area L4-5, the procedures are Unbundled and not both billable – only code 62311 would be billable in that case.

However, if the physician does an ESI (62311) at level L5 and a Transforaminal ESI (64483) at area L3-4, then it is allowable to put a -59 Modifier on the 64483 code and bill it as the 2<sup>nd</sup> code following the 62311 ESI code on the claim form.

## **Paravertebral Facet Joint or Facet Joint Nerve Injections**

Facet Injections involve the physician placing the spinal needle at the medial branch nerve of the facet joint (the Cervical or Thoracic areas), which is smaller than the Lumbar area, which makes the Cervical and Thoracic procedure a higher risk than those performed in the Lumbar area. These codes are unilateral procedure codes; if the procedure is performed bilaterally, you need to bill in a Bilateral manner, by appending either the -RT/-LT or the -50 Modifier.

New Codes for 2010 - For 2010, there are major changes to the Facet Injection codes, and the new 2010 Medicare ASC List fee schedule is reimbursing significantly less for these procedures. The new codes include the use of imaging, so the 77003 Fluoroscopy or other imaging technique codes are not billed separately with the new codes. The new codes have a different code for each level billed. The last code allowable for each spinal area (i.e., Cervical, Lumbar, etc.) is for the 3<sup>rd</sup> level and the code states that it “cannot be billed more than once per day,” which in CPT rules means that only a maximum of 3 levels are allowed to be billed - so if the physician performs Facet Injections at a 4<sup>th</sup> level or beyond, there is no code for those levels and they are not billable. While the direction in the CPT book is to use the -50 Modifier if these procedures are performed Bilaterally, if the payor prefers the use of the RT/LT Modifiers for Bilateral procedures, their requirements should be observed when billing these codes.

The new codes for 2010 for Facet Joint Injections are as follows:

Code 64490 — Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level.

Code 64491 —...second level Injection, cervical or thoracic; single level.

Code 64492 —...third and any additional level(s) – This code would only be used once per day and once on a claim, which means if there are injections at 4 or 5 levels, they are not separately coded – you can only code and bill for injections at 3 levels.

64493 — Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level.

64494 —... second level Injection, lumbar or sacral; single level.

64495 —... third and any additional level(s) – This code would only be used once per claim, which means if there are injections at 4 or 5 levels, they are not separately coded – you can only code and bill for injections at 3 levels.

## **Sacroiliac Joint Injections** **CPT Codes 27096/G0260**

27096 - Injection procedure for Sacroiliac Joint, Arthrography and/or Anesthetic/Steroid

G0260 - Injection procedure for Sacroiliac Joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without Arthrography

- The professional side (Physician claim) for SI Joint Injections should be billed to Medicare with the 27096 code.
- ASC facilities should use code G0260 to bill SI Joint Injections to Medicare.
- The G0260 code is on the Medicare ASC List of covered procedures. The 27096 is NOT on the Medicare List. The physician and facility claim coding will not match in this instance, but this coding is the correct way to code the procedure.
- The 27096 code is for use when the ASC facility is billing SI Joint Injections to payors other than Medicare, unless that payor requires use of the G-code instead. The facility would NOT bill the 27096 code to Medicare.
- Radiology codes – for SI Joint Injections performed with Arthrography, the 73542 code should be billed. The Fluoroscopy code to use with SI Joint Injections when Arthrography is not performed is code 77003. These codes are billable provided the payor allows the billing of radiology services.
- The G-code and 27096 codes are for use billing SI Joint Injections performed with Fluoroscopic Guidance. If the SI Joint Injection is performed *without* the use of Fluoroscopic Guidance, neither the G-code nor code 27096 should be billed. SI Joint Injections performed *without* the use of Fluoroscopic Guidance should be billed using code 20610 for an Injection into a Major Joint. The 20610 code would be used by both the physician and the ASC facility in this situation.

The most common diagnosis codes for SI Joint Injection procedures are 724.6 for Disorders of the Sacrum and 720.2 for Sacroiliitis.

Procedure: The needle tip is placed in the caudal aspect of the joint and contrast material is injected, the contrast delineates the articular cartilage,

If an injection is administered in the Sacroiliac Joint without the use of Fluoroscopic guidance, report only the procedure code for the SI Joint Injection. A formal radiologic report must be dictated when using the 73542 code for the Arthrography. Do not report code 77003 with code 73542.

*The injection of contrast material is inclusive. This is a unilateral procedure; when a bilateral procedure is performed, bill it in a Bilateral manner by appending the -RT/-LT or -50 Bilateral Modifiers. Report CPT code 73542 for the Arthrography.*

## **Lysis of Adhesions CPT Codes 62263 and 62264**

62263 - Percutaneous Lysis of Epidural Adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), Multiple Adhesiolysis sessions; 2 or more days

62264 - Percutaneous Lysis of Epidural Adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), Multiple Adhesiolysis sessions; 1 day.

This procedure is used for patients with chronic pain - namely low back pain with radiculopathy. It is a Percutaneous Epidural treatment involving targeted injection of various substances via an epidural catheter. The catheter remains in place until the treatment is completed. Adhesions or scarring may also be lysed by mechanical means, including maneuvering of the catheter or by use of an epiduroscope.

The appropriate Lysis of Adhesions code is sometimes used for Racz Catheter procedures. This Lysis of Adhesions procedure includes the contrast material for epidurography. For the placement of an epidural catheter inserted and removed at the same session, use code 72275. There must be a formal Interpretation documented. The Fluoroscopic guidance used in the procedure (code 77003) is not separately-billable, as it is bundled into the 72275 code.

## **Radiofrequency or Pulsed Radiofrequency Neurotomy (PRFN) CPT Codes 64622-64627 for Destruction or 64999 for Pulsed Radiofrequency**

64622 - Destruction by Neurolytic agent, Paravertebral Facet Joint Nerve; Lumbar or Sacral, single level  
+64623 – Lumbar or Sacral, each additional level

64626 - Destruction by Neurolytic agent, Paravertebral Facet Joint Nerve; Cervical or Thoracic, single level  
+64627 – Cervical or Thoracic, each additional level

The difference between the two Radiofrequency codes is that in the Pulsed Radiofrequency procedure they apply an electrical field to the target nerve for short intervals at a lower temperature, which does not destroy nerve tissue, but “stuns” the nerve. The Radiofrequency procedure “destroys” the nerve. Use codes 64622-64627 for the spinal Radiofrequency procedures. The Pulsed Radiofrequency procedure must be coded using the 64999 Unlisted code, since there is not a specific CPT code which accurately describes the procedure. Submit supporting documentation with the claim which describes the nature, extent, need, time and effort of the procedure. The Destruction by Neurolytic Agent codes 64600-64681 would not be appropriate for the Pulsed Radiofrequency procedure.

Code Rhizotomy procedures from the Destruction by Neurolytic Agent codes.

Procedure: The patient is placed in a prone position; an electrode is then placed at the border of the vertebrae where the medial branch nerve crosses the vertebrae. Chemical destruction involves injection of a neurolytic substance (e.g., alcohol, phenol, glycerol) into the affected nerve root. Thermal techniques utilize heat. Electrical techniques utilize an electrical current. Radiofrequency, also referred to as Radiofrequency Rhizotomy, utilizes a solar or microwave current.

*The Destruction of a Paravertebral Facet Joint Nerve with a neurolytic agent codes are unilateral procedures; when a Bilateral procedure is performed, bill it in a Bilateral manner by appending the -RT/-LT or -50 Bilateral Modifiers.*

## **Injections for Post-Operative Pain Control**

When a patient is to receive an Injection or has a Catheter placed for post-operative pain control following an Arthroscopic Knee, Shoulder or other surgical procedure, there are certain requirements which must be met in order to bill the Injection/Catheterization procedure separately to payors. We strongly recommend that you do NOT bill these injections to Medicare.

- The Injection/Catheterization procedure must be performed by a ***different physician*** from the surgeon who performs the Shoulder, Knee or other surgical procedure. The Post-Op pain block must not be the only anesthesia for the ortho. case.
- There must be a separate Procedure Report for the Injection/Catheterization procedure – not a part of the anesthesiologist’s Anesthesia Record or the ortho. surgeon’s OP Report.
- If there is a separate OP Report for the Injection/Catheterization procedure and the Injection/Catheterization procedure was performed by a different physician, you may bill for the Injection/Catheterization procedure to payors other than Medicare. Use a different claim form from the ortho. surgery procedure and bill the Injection/Catheterization procedure claim in the name of the anesthesiologist (or other physician) who performed the Injection/Catheterization procedure (as the performing physician) done for post-op pain control. You do not need to use a -59 Modifier on the Injection/Catheterization code, however, if you receive a denial for bundling reasons, it might need to be used.
- Codes for billing the Injection/Catheterization post-operative pain control procedure for ortho. cases are as follows:
  1. 64415 – Brachial Plexus Block (also use this code for an Interscalene Block) for a Single Injection  
OR
  2. 64416 – Brachial Plexus Infusion by Catheter

If Injections are given for Post-Op Pain Control after Knee Surgery, the 64447 code for a Femoral Nerve Block Injection or code 64448 for a Femoral Block with a Catheter would usually be used.

Medicare has recently issued specific guidance that in most cases they consider Injections performed routinely for Post-Operative Pain Control to be bundled into the orthopedic surgeon's global services (even when the Injection is performed by a different physician, such as the anesthesiologist), so we would recommend not billing them to Medicare.

### **Trigger Point Injections**

Use code 20552 for Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s).

Use code 20553 for Injection(s); single or multiple trigger point(s), 3 or more muscle(s).

Use caution when coding Trigger Point Injection procedures. Detailed documentation is very important in the coding of Trigger Point Injection (TPI) procedures. The OP Report must indicate how many different muscles were injected – not just the number of injections performed. If the physician performs 6 TPI injections, but the injections are only performed along 1 or 2 different muscles, the 20552 code is billable. Only bill one or the other TPI CPT code – not both. Medical Necessity must be supported for these procedures and it is a “red flag” to Medicare and other payors (where they might audit you) when these procedures are performed too often, (such as every 2 weeks), or too many procedures are performed at one time (10-14 at a time).

### **Fluoroscopy**

Fluoroscopic Guidance – when Epidural, Subarachnoid, Facet, or Transforaminal Epidural Injection procedures are performed under fluoroscopic guidance, you may report the fluoroscopic guidance in addition to the injection (unless it is not covered by the payor, such as Medicare). Report code 77003 when fluoroscopic guidance is required during spinal injection procedures, unless it is Unbundled from the injection code, per the CCI material. Many payors do not cover the fluoroscopic guidance charges in an ASC setting, however, do not make the decision not to bill Fluoro. to any payors – you may be losing reimbursement. ASC facilities should use the –TC Modifier on this code, physician practices should use the -26 Modifier when they do not own the C-arm, and if the Pain Management procedure is performed at the physician's office and they own the C-arm, no modifier is used, as you are billing Globally for the Fluoro. procedure.

Do not report Fluoroscopy codes separately with Arthrograms or Epidurograms. Fluoroscopy may be coded in addition to injection codes for procedures (if they are not Unbundled in the CCI material).

## **Discograms**

### **Injection Procedure for Discography CPT Codes 62290-62291**

62290 - Injection procedure for Discography, each level; Lumbar

62291 - Injection procedure for Discography, each level; Cervical or Thoracic

72285 - Discography, Cervical or Thoracic, radiological supervision and interpretation

72295 - Discography, Lumbar, radiological supervision and interpretation

Procedure: A Discogram is an enhanced X-ray examination of the pads of cartilage (intervertebral disks) that separate the vertebral segments (vertebrae). Dye is injected into the center of the disk for more visibility on the X-ray films to detect structural damage in a disk and to determine if the disk is causing the patient's pain. In the test, the physician is trying to mimic the patient's pain. A CT scan is also performed following the Discogram to assess physical changes in the disk.

The Discogram tests are coded per level, if the procedure is performed at four levels (L2-S1), bill the 62290 code for the Discography Injection procedure four (4) times - the 72295 Radiological supervision and interpretation will also be billed four times. It is advisable to append the Modifier -59 to the second, third, and fourth procedure codes (depending on the requirements), to help avoid a payor denial.

While the Radiologic Supervision & Interpretation (S&I) is billable, the 77003 Fluoroscopy code is not separately billable, as it is included in the S & I code billed.

Stephanie Ellis, R.N., CPC  
Ellis Medical Consulting, Inc.  
One Maryland Farms, Ste. 102  
Brentwood, TN 37027  
(615) 371-1506  
(615) 371-5302  
[www.ellismedical.com](http://www.ellismedical.com)