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Part B Insider (Multispecialty) Coding Alert

Carpal Tunnel Syndrome: Bust 4 Myths to Safeguard Yourself Against Carpal Tunnel Denials

You won't find specific guidelines for moving to the next treatment level.

When a patient's carpal tunnel syndrome (CTS) treatment stretches into extended care, don't let carriers' strict guidelines stop rightful reimbursement in its tracks. Train your providers to document medical necessity by carefully outlining the condition's progressive nature.

Myth #1: Treatments Are of Only 1 Variety

Reality: Physician use a range of treatments for CTS patients.

Depending on the severity of the condition, initial treatment may be conservative. It can include having the patient change activities, wear a soft splint, undergo physical therapy or take anti-inflammatory medications. If the patient fails to respond to these more conservative treatments, however, your physician might administer injections to relieve the patient's discomfort, such as 20526 (Injection, therapeutic [e.g., local anesthetic, cortico-steroid], carpal tunnel).

Problem: Carriers expect physicians to try nonsurgical, conservative treatments first, but most policies don't outline specific guidelines for when your physician should move to the next treatment level.

Myth #2: Injections? No Need for a Bilateral Modifier

Reality: If your doctor injects both of the patient's wrists during CTS treatment, you'll need to report it as a bilateral procedure. You can do this with either modifier 50 (Bilateral procedure) or modifiers LT (Left side) and RT (Right side).

Myth #3: You Can Always Report Additional Services

Reality: Doctors often perform other services when a patient comes for an injection -- but that doesn't mean you can always code it separately. You may report an E/M code in addition to the CTS injection codes only if the E/M service is significant and separately identifiable from the injection procedure.

Caution: If the injection is the primary reason your physician sees the patient, you should report only the injection service. For instance, if the doctor has already decided to administer a CTS injection and wants to evaluate the patient prior to the procedure, you cannot report the evaluation as a separate, billable service.

Myth #4: Surgeries Don't Require Pre--Authorization

Reality: Because surgery is a last-resort treatment for CTS, many coders recommend that you obtain preauthorization to determine your carrier's coverage limitations. The most common approaches to relieve the pressure are open or endoscopic procedures for carpal tunnel release. Physicians once opted for open procedures as the norm, but the patient had a longer, more painful recovery. Endoscopic release techniques may significantly shorten the patient's recovery period but have had more reported complications. CPT includes two codes related to surgical treatment of CTS:

- 29848 (Endoscopy, wrist, surgical, with release of transverse carpal ligament), for an endoscopic approach
- 64721 (Neuroplasty and/or transposition; median nerve at carpal tunnel), for an open approach.

For more help in coding CTS and other hand procedures, check out our handy chart on page 294.

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