Part B Insider (Multispecialty) Coding Alert

Coding Quiz: Can You Code These Pain Management Scenarios?

Hint: Equate Marcaine with lidocaine rules when it comes to injections.

Coding for pain management procedures has never been more complex. With various specialties providing pain care, dozens of OIG directives on how to bill the services properly and injection codes changing every year, your mind could be swirling with the coding possibilities. If you'd like to get a handle on how to tackle common pain coding scenarios, test yourself by reading these three commonly-asked questions and then figuring out what you'd do before you read the answers.

Trigeminal Nerve Branches Can Be Confusing

Question 1: Our pain management specialist documented "0.5 ML across the right and 0.5 ML across the left supra orbital and supratrochlear and infraorbital nerves. All are part of ophthalmic division." Coding for trigeminal nerve blocks confuses me because the trigeminal nerve is also the fifth cranial nerve. How should I code this?

Answer 1: First, know that part of the information documented is not correct. Not all three of the branches mentioned are from the V1 ophthalmic nerve. The infraorbital nerve is a branch of the V2 maxillary nerve.

The correct code for injections of the divisions and/or branches of the trigeminal nerve (Cranial nerve V) is 64400 (Injection, anesthetic agent; trigeminal nerve, any division or branch). This particular cranial nerve has three divisions referred to as V1 (ophthalmic nerve), V2 (maxillary nerve), and V3 (mandibular nerve). Each of the divisions has multiple nerve branches (such as V1 includes the supratrochlear and supraorbital nerves).

According to CPT® Assistant in December 2008, "The descriptor of code 64400 represents a single injection into a single nerve in the anatomy and sensory distribution of the peripheral trigeminal nerve. Injection of each specific nerve has effects on different anatomy sensation in different areas. The code 64400 is considered to be unilateral and when performed bilaterally can be reported as such."

Modifier note: Many Medicare contractors require providers to use an alternate modifier to indicate a repeat procedure and only use modifier 59 (Distinct procedural service) when appropriate.

If your physician performed a total of six separate injections (the right and left supratrochlear nerves, right and left supraorbital nerves, and right and left infraorbital nerves), you have two coding options:

- 64400-50 (Bilateral procedure) x 3 OR
- 64400-50 x 1 and 64400-50-76 (Repeat procedure or service by same physician or other qualified health care professional) x 2.

If the forehead area was only injected twice once for right side and once for the left blocking both the supratrochlear and supraorbital branches with a single injection, the coding would be:

- 64400-50 x 2 OR
- 64400-50 x1
- 64450-50 76 x 1.

Verify the number of injections to each nerve before submitting the claim.

Use Unlisted Code Sparingly

Question 2: How would you code a left L5-S1 zygapophyseal (facet) joint aspiration for a facet cyst? Is there a better code than 64999?

Answer 2: CPT® does not include a code for aspiration only of a synovial cyst at a facet joint. Therefore, you should report 64999 (Unlisted procedure, nervous system). If your provider uses fluoroscopic guidance during the procedure, report it with 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural or subarachnoid]).

Another possibility: Physicians sometimes also inject a local anesthetic or corticosteroid into the facet joint before aspirating the cyst. If so, you would choose the appropriate injection code from 64490-64495 (Injection[s], diagnostic or therapeutic agent, paravertebral facet [zygapophyseal] joint [or nerves innervating that joint] with image guidance [fluoroscopy or CT ...]). You would not report additional codes for the aspiration or fluoroscopy because they will be considered part of the injection procedure.

Filing tip: Be sure to clearly indicate in Box 19 of the 1500 form (or electronic equivalent) what specific service or procedure your provider completed. Your documentation should include any specific information about the procedure, such as an adequate definition or description of the nature, extent, and need for the procedure or service. Notes regarding the time, effort, and equipment necessary to provide the service should also be included.

Marcaine Coding Mirrors Lidocaine

Question 3: Dictation from an encounter states that the physician used 2 ml of 0.75% Marcaine and 0.25ml of Kenalog for a trigger point injection. I know I shouldn't code the Marcaine, but would J3301 be billed at 1 unit?

Answer 3: Yes, you should report one unit for this situation. Code J3301 (Injection, triamcinolone acetonide, not otherwise specified, 10 mg) for triamcinolone (Kenalog) is reported per 10 mg. Kenalog comes in two strengths Kenalog 10 is 10 mg per 1 ml and Kenalog 40 is 40 mg per 1 ml

An injection of 0.25 ml of Kenalog-10 would be 2.5 mg, whereas 0.25 ml of Kenalog-40 would be 10 mg.

Best practice: You don't specify which strength Kenalog your physician injected, but we're assuming it was Kenalog-10 since you refer to J3301. Work with your providers to ensure that their documentation includes the specific drug that is administered as well as the total amount injected (mg, mcg, or Gm, not the volume).

You are also correct in not billing separately for the Marcaine administration. Similar to Lidocaine, Marcaine is a local anesthetic that is used in part to numb an area as part of a diagnostic/therapeutic injection. The local anesthetic is bundled by most payers into the code for the injection and as such is not separately payable.