Part B Insider (Multispecialty) Coding Alert

Pain Management: Avoid These Top Interlaminar Injection Pitfalls

Distinguish region from level to prevent denials.

The next time you're faced with an interlaminar epidural injections claim, be sure to mark the differences between interlaminar epidurals and other common spinal injections.

Skip the Bilateral Modifier

If your physician performs more than one interlaminar epidural injection in the same spinal region, you should not append modifier 50 (Bilateral procedure) or append modifiers RT (Right side) and LT (Left side) to 62310-62311 (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 ...).

Here's why: When your provider injects a substance into the epidural space via an interlaminar approach, the drug diffuses into the entire area, explains CPT Assistant (November 2008). The spreading eliminates the need to inject medication into both sides of the space to achieve the desired results. Therefore, you won't need to include modifier 50 (Bilateral procedure) on your claim or in any way report 62310-62311 more than once to document that the provider treated the complete space. The Medicare physician fee schedule backs up this interpretation of the code and service by indicating that the 150 percent fee adjustment for bilateral procedures does not applyfor these codes. Instead, if you append 50 or RT/LT, you will receive the lower of:

- the total actual charge for each side
- the fee schedule amount for one unit of the reported code.

Watch Levels, Not Injections

By the same token, multiple attempts to reach the same epidural space don't equal multiple procedures, CPT Assistant states. This is because the codes are defined by region, not by vertebral segment or interspace:

- 62310 -- ... cervical or thoracic
- 62311 -- ... lumbar, sacral (caudal).

In other words: Code descriptions for interlaminar epidural injections do not include the term "level." In contrast, transforaminal epidural injection code descriptions refer to "single level" or "each additional level," and "level" refers to an individual vertebral segment.

Codes 62310 and 62311 (as well as related procedures 62318- 62319, Injection, including cathter placement, continuous infusion or intermittent bolus ...) describe injections to ananatomic region (cervical, thoracic, lumbar, or sacral) rather than levels, or individual segments. Therefore, you only report 62310 and 62311 once per date of service.

Caution: Verify that you and your payer speak the same language when discussing spinal anatomy. One problem coders encounter when dealing with worker's compensation was the "point of entry." For example, the physician might note that he injected the needle at L4 when the payer had preapproved the claim for an injection to L3. If the MAC denies the claim saying it wasn't the approved level, you'll have to clearly explain that the injection wasn't to treat that exact level, but was treating the whole region.

Remember Separate Fluoro Is OK

Most physicians use fluoroscopic guidance to pinpoint the injection site and ensure they inject medication into the correct location. If your physician uses fluoroscopy, add 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural, transforaminal epidural, subarachnoid, or sacroiliac joint], including neurolytic agent destruction) to your claim.

Confusion: Some insurance companies deny 77003 with 62310 and 62311, stating the procedure includes fluoroscopic guidance. The description clearly does not include "fluoroscopic guidance," but does include the physician work of the actual injection of contrast during fluoroscopic guidance and localization.

So, it's the actual physician injection of contrast that you cannot separately report, not the radiologic service of using fluoroscopic guidance for needle placement.

Interesting note: Correct Coding Initiative (CCI) edits do not bundle 77003 with the 6231x injection codes, giving you clearance to report the codes together.

Assign the Correct Diagnosis

Many conditions can lead to a patient having interlaminar epidural injections, so be sure to choose the most accurate diagnosis. Common options include:

- Reflex sympathetic dystrophy/CRPS Type I (337.2x)
- Spondylosis without myelopathy (721.0, 721.2, 721.3)
- Disc displacement without myelopathy (722.0-722.11)
- Disc degeneration (722.4-722.5x)
- Postlaminectomy syndrome (722.8x)
- Sciatica (724.3)
- Radiculitis (724.4)
- Spinal stenosis (723.0, 724.01-724.02).

Check the individual payer's coverage policy for ICD-9 codes that meet their medical necessity requirements. For example, many payers don't cover interlaminar epidural injections for spondylosis with myelopathy (such as 721.4x, Thoracic or lumbar spondylosis with myelopathy). Remember, however, to always report the patient's condition as documented by the physician, regardless of your expectations of coverage.