Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 4 Common Interventional Pain Management Procedures You Can't Afford To Miss

Get the lowdown on when to code separately for fluoroscopy.

If your physician performs interventional pain management(IPM) services, you'll need to be up to speed on four top IPM procedures to make sure you're earning full deserved reimbursement for your claims.

Difference: Pain management specialists are physicians who study pain and perform less invasive injections (soft tissue, peripheral nerve, and joint injections) and medication management to help relieve patients' pain.

One common pain management procedure is trigger point injection (20552, Injection[s]; single or multiple trigger point[s], 1 or 2 muscle[s]) or 20553, ... single or multiple trigger point[s], 3 or more muscle[s]). An interventional pain management specialist's scope includes spinal diagnostic and therapeutic procedures and other invasive techniques like nerve stimulator or opioid pump insertion, says **Scott Groudine, MD,** an anesthesiologist in Albany, N.Y. When submitting claims, you'll use specialty designation 72 for pain management or 09 for interventional pain management.

Learn the Most Common Injections

All injections are not created equal -- and they're not coded the same. Here's your guide to four types of treatments that commonly fall under the IPM umbrella.

Facet injections: CPT® includes a range of codes describing the various sites and levels associatedwith paravertebral facet joint and facet joint nerve injections. You'll find these in code family 64490- 64495 (Injection(s), diagnostic or therapeutic agent, paravertebral facet [zygapophyseal] joint [or nerves innervating that joint] with image guidance [fluoroscopy or CT] ...). If your physician uses ultrasound guidance during the injection procedure, turn to the Category III code section of CPT® instead. There you'll find codes 0216T-0218T (Injection[s], diagnostic or therapeutic agent, paravertebral facet [zygapophyseal] joint [ornerves innervating that joint] with ultrasound guidance ...). You'll choose the appropriate code based on the anatomic injection site and the number of levels injected.

Epidural injections: You'll report most epidural injections your provider administers with codes distinguishing between single shot or continuous administration, and the injection location:

- 62310 or 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 ...
- 62318 or 62319 -- 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 ...

If your specialist administers a transforaminal epidural instead, submit the correct code from 64479- +64484 (Injection[s], anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance [fluoroscopy or CT] ...). For a transforaminal epidural using ultrasound guidance, choose from 0228T- +0231T (Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance ...).

Sacroiliac (SI) joint injections: The correct code for SI joint injection is 27096 (Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid). Coding notes direct you to only report 27096 if you have documentation of

imaging confirmation of intra-articular needle positioning. In the past, some practitioners would inject the SI joint "blindly" in the office, which might be the reason behind the coding note. Experts say that approach is nearly impossible to complete accurately without image guidance, however, so it shouldn't be an issue with your coding.

Nerve destruction procedures: Your specialist might administer injections to somatic or sympathetic nerves to stop the nerve function and relieve the patient's pain. Codes 64600- 64681 address individual nerves that might be treated. Pay special attention when reporting paravertebral facet joint nerve destruction because of the single and additional-level options.

Code Fluoroscopy Separately -- Sometimes

CPT® lists several fluoroscopic guidance codes, but interventional pain specialists most often focus on 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural, subarachnoid, or sacroiliac joint], including neurolytic agent destruction).

Caution: Just because your provider uses fluoroscopic guidance with injections doesn't mean you always add 77003 or a similar code to your claim. Some procedure codes --" such as those for paravertebral facet joint injections or transforaminal epidurals -- include fluoroscopic or ultrasound guidance in the descriptor. Double check code descriptors before submitting 77003.

Payday: If you can include 77003 on the claim, you could add approximately $62 to your physician's bottom line for facility or non-facility service (based on the 2011 national average Medicare Physician Fee Schedule conversion factor of 33.9764). A physician performing the procedure in a facility place of service won't bill the global 77003, however, reminds **Marvel Hammer, RN, CPC, CCS-P, PCS, ASC-PM, CHCO,** owner of MJH Consulting in Denver, Co. "Rather, the physician would bill the professional component only with modifier 26, which does have a reduced reimbursement compared to the global allowance."