# Part B Insider (Multispecialty) Coding Alert

## Part B Coding Coach: 64479-+64484: Heed These Warning Signs to Safely Navigate Injection Pitfalls

**Transforaminal epidural injections are a major audit target, so plan ahead for coding success.**

Pick an auditing body  OIG, CMS, RAC  and chances are it's reviewing and finding fault in transforaminal epidural injection claims. Land on the right side of an audit by knowing how to avoid the biggest coding troublemakers. And to take your know-how up another notch, master the related Category III codes, RAC issues, and anatomy graphics featured in this issue.

**Include Proper Add-On Use in Early Training**

The procedure in focus here, transforaminal epidural injection, involves inserting a needle into the foramen (opening) between two vertebrae to perform an injection at the nerve root area. The radiologist injects the medication into the lateral epidural space (space between the vertebral canal walls and the spinal cord dura mater) to target a specific spinal nerve as it exits the spinal cord. The physician may inject an anesthetic agent, steroid, or both in patients with conditions such as disc degeneration or spinal stenosis. If the patient has an epidural steroid injection, you may see the abbreviation ESI used.

The codes for transforaminal epidural injection are designed to offer a "single level" code for the initial spinal level and an add-on code for each additional spinal level:

64479, Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
+64480, ... cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483, Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
+64484, ... lumbar or sacral, each additional level (List separately in addition to code for primary procedure).

**Add-on code essentials:** Don't mix and match the "single level" codes and add-on codes. CPT® specifies that +64480 is for use with 64479 while +64484 is for use with 64483. So if the physician performs a lumbar injection and a thoracic injection, you should report 64479 and 64483 (both "single level" codes) rather than using one "single level" code, such as 64479, and one add-on code, such as +64484.

Also remember that you should report the add-on code once for "each additional level," so you may report the add-on code more than once if documentation supports doing so.

**Heed Code Definition References to 'Level' and 'Imaging Guidance'**

The code definitions reveal a few key points highlighted by **Judi Blaszczyk RN, CPC, ACS-PM,** of Auditing for Compliance and Education, in her 2012 CodingCon pain management presentation (www.codingconferences.com).

**Level:** The first key point is that these codes are billed by level. For these codes, a single level will be referred to by naming two vertebrae because the injection goes into a space between those two vertebrae. For instance, L1-L2 is one

level.

As an example, suppose the physician performs transforaminal injections on the right side of C4-C5 and C5-C6 under fluoro. You should report 64479-RT (Right side) for the first level and +64480-RT for the additional level, Blaszczyk said.

**Imaging:** The second key point is that the procedure must be performed with radiological guidance, and that guidance is included in the injection code, Blaszczyk said.

Imaging guidance is needed to avoid injury during transforaminal injections because of the "close proximity of the nerve root to the vertebral artery and spinal cord," explained **Stephanie Ellis, RN, CPC,** of Ellis Medical Consulting, during her CodingCon presentation, "ASC Frequently Miscoded Procedures."

**Take Advantage of Bilateral Reporting Opportunities**

The injection code definitions may help remind you about spinal levels and imaging, but the definitions don't reveal whether the codes are considered unilateral or bilateral.

**Answer:** These codes are unilateral. CPT® guidelines for this code range offer confirmation: "64479-64484 are unilateral procedures. For bilateral procedures, use modifier 50 [Bilateral procedure]." Additionally, you'll find that Medicare agrees with the unilateral nature of these codes, paying bilateral injections at 150 percent of the unilateral rate.

**Bilateral example:** Suppose the physician performs transforaminal injections bilaterally at L4-L5 under fluoroscopy. You should report 64483-50 to indicate the bilateral lumbar injections, Blaszczyk said.

**Keep in mind:** Generally speaking, the appropriate way to report a bilateral procedure is to report the code on a single line with modifier 50 appended and a single unit of service. But other payers may instruct you to report the codes as separate line items using modifiers RT (Right side) and LT (Left side) and a single unit for each line. In that case, you'll report the same CPT® code on two separate lines, but you won't append modifier 50.

"Your provider's contracts with different insurance companies might have a section on bilateral procedures and how they're to be billed," notes **Dawn Shanahan, CPC,** supervisor of coding for Florida Gulf to Bay Anesthesiology Associates in Tampa. "If so, you need to follow these guidelines or you might not get paid."

**Head Off Denials by Checking Payer Policy**

To add the finishing touch to your injection claim, you'll have to do some homework to fully understand individual payer coverage limitations.

There are three areas in particular that you'll want to check, said Blaszczyk:

Does the payer limit the number of injections per encounter, considering any exceeding that number to not be medically necessary?

Does the payer limit the "number of injections in a certain time period and frequency within that time period"?

Does the payer "require a certain percentage of improvement before the next in a series may be performed"?

You may find crucial documentation requirements outlined in your local coverage determination (LCD). In MLN Matters article SE1102, Medicare underscores the importance of checking local payer policies for these injections. The article highlights LCD requirements such as documentation of the patient's pain history, descriptions of failed conservative measures, and details of the patient's spinal pathology. For more on how to correctly report these services, read MLN Matters article SE1102 at www.cms.gov/MLNMattersArticles/Downloads/SE1102.pdf, and search for your contractor's LCD

at www.cms.gov/medicare-coverage-database/.