Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 847.0 for Whiplash: Persistent Symptoms May Warrant Billing Diagnostic Tests

Watch for scans, TPIs, and more as treatment options intensify.

Coding for whiplash diagnosis and treatment is usually pretty straightforward, but don't be too complacent. Be on the lookout for situations when the patient's symptoms persist despite conservative therapy and warrant more extensive treatment. Missing these diagnoses can mean missed pay.

Watch for Move From Therapy to Scans

When a patient presents with whiplash symptoms, your practitioner will conduct a thorough exam and will often order neck x-rays to rule out fractures.

First steps: Once the physician diagnoses whiplash (847.0, Sprains and strains of other and unspecifiedparts of back; neck sprain), he typically will prescribe conservative treatment. Common options include physical therapy, nonsteroidal anti-inflammatory drugs (NSAIDs), and muscle relaxants. Some patients may also benefit from wearing a soft cervical collar or by using a portable traction device.

If conservative treatment fails, the physician might order additional diagnostic imaging tests. These could include:

- CT scans -- 70490 (Computed tomography, soft tissue neck; without contrast material), 70491 (... with contrast material[s]) and 70492 (... without contrast material followed by contrast material[s] and further sections)
- MRIs -- 70540 (Magnetic resonance [e.g., proton] imaging, orbit, face and/or neck; without contrast material[s]), 70542 (... with contrast material[s]) and 70543 (... without contrast material[s], followed by contrast material[s] and further sequences)
- Bone scans -- CT, MRI, and x-ray tests include basic bone scans. If your physician orders more extensive bone scans for the patient, you might to get authorization for 78300 (Bone and/or joint imaging; limited area) or 78305 (... multiple areas) instead.

Count Trigger Point Injections Correctly

Your physician might also administer trigger point injections to relieve the patient's pain and muscle tenderness. Code these procedures with 20552 (Injection[s]; single or multiple trigger point[s], one or two muscle[s]) or 20553 (...three or more muscles).

Caution: The difference between the two codes is the number of muscles the physician injects, not the number of trigger points or the number of injections he administers, says **Marvel J. Hammer, RN, CPC, CHCO,** president of MJH Consulting in Denver.

The descriptors clarify that if your provider documents a different muscle, you can count the number of muscles to determine the difference between 20552 and 20553. If, however, the provider injects multiple trigger points within the same muscle, you only count one muscle, regardless of the amount of injections.

Watch point: Because of the "one or two muscles" and "three or more muscles" distinction between codes, you'll report a maximum of one unit for either 20552 or 20553 for an encounter -- not both codes. For example, if your physician injects trigger points in a total of four separate muscles, compliant coding would be one unit of 20553.

Move to Nerve Blocks for More Pain Relief

When more conservative treatments for whiplash don't help the patient enough, your physician might administernerve blocks to help diagnose a patient's condition and/or provide therapeutic pain relief. Common options include lidocaine and/or steroids such as methylprednisolone acetate (J1020) into cervical facet joints (such as C3-4 and C4-5).

Code it: Report the block at the first facet joint level with 64490 (Injection[s], diagnostic or therapeutic agent, paravertebral facet [zygapophyseal] joint [or nerves innervating that joint] with image guidance [fluoroscopy or CT], cervical or thoracic; single level). Submit blocks at additional facet joint levels on the following lines of your claim with +64491 (... second level [List separately in addition to code for primary procedure]) and +64492 (... third and any additional level[s] [List separately in addition to code for primary procedure]) as appropriate.

Guidance: Physicians use fluoroscopic guidance to help ensure they inject the correct site. In previous years, you reported fluoroscopic guidance in addition to the injection procedure code. CPT 2010 introduced codes 64490-+64492, which include fluoroscopic or CT guidance. Now you simply report the injection.

Bilateral question: Providers often administer facet joint injections unilaterally. If your physician administers bilateral injections, remember to append modifier 50 (Bilateral procedure) to the injection code(s).

Watch for Add-On Diagnoses

Certain factors (age, gender, and pre-existing conditions like arthritis) can influence the severity and prognosis of whiplash injuries. When the patient does not respond to more conservative treatments or if her symptoms worsen, your physician may re-evaluate her for other disorders.

In these instances, code the additional diagnoses along with whiplash.

Example: Your practitioner might determine that the patient's presenting symptoms and/or test results indicate occipital neuralgia (723.8, Other syndromes affecting cervical region), spondylosis (721.0, Cervical spondylosis without myelopathy) or herniated disc (722.0, Displacement of cervical intervertebral disc without myelopathy). These diagnoses can help justify greater pain management intervention (such as cervical epidurals, facet blocks, or even referral to surgery).

Rely on Nerve Destruction as Last Recourse

If nerve blocks do not bring the patient long-lasting relief, your pain specialist may consider paravertebral facet joint denervation.

Document it: Before taking the patient's treatment to this level, your physician should have thorough documentation of other treatments. The patient's chart should include two important details:

- The appropriate diagnostic paravertebral facet joint block or medial branch nerve block studies that identify the specific joint level
- Documentation that the patient had significant -- but not long-lasting -- pain relief from the facet joint blocks. Some payers are beginning to require actual documentation and quantification of the patient's status, Hammer says. For example, the payer might want details regarding the percentage of change in pain, duration of pain relief, and changes in the patient's functional status during relief from the diagnostic blocks.

If the patient meets these criteria, your physician mayuse paravertebral facet joint denervation to treat back or neck pain following whiplash/post-traumatic injury and to relieve the pain of associated cervicogenic headache.

CPT includes two codes for denervation in these cases:

- 64626 -- Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level
- +64627 -- ... each additional level [list separately in addition to code for primary procedure].

As with nerve blocks, physicians often perform the therapeutic destructive procedures as unilateral procedures. If your specialist performs a bilateral procedure, append modifier 50 and document which joint levels he treated.

Bottom line: With the prevalence of whiplash injury and the range of treatment options for whiplash and related disorders, physicians and coders need to know what payers cover -- and what they don't.