Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Know What Pain Management Specialists Do to Win the Coding Battle

Brush up on these procedures and codes before OIG comes calling

As pain management continues to grow, your coding accuracy depends on understanding the subtleties between specialties. If your physicians are branching into the area of interventional pain management, the following tips can help you report their services accurately.

Check Differences Between PM and IPM

Pain management specialists are board-certified physicians who study pain and perform manipulations and small injections (such as trigger point injections, 20552, Injection[s]; single or multiple trigger point[s], one or two muscle[s]; and 20553, - single or multiple trigger point[s], three or more muscles) to help relieve patients- pain. An interventional pain management specialist's scope of practice is slightly different.

-Anesthesiologists are most often interventional pain management specialists because their training includes nerve blocks and other invasive techniques like stimulator and opioid pump insertion,- says **Scott Groudine, MD**, an anesthesiologist in Albany, N.Y. -Many patients, however, can be successfully treated with less invasive techniques such as pharmacology, psychiatry and physical therapy.-

Carrier perspective: In the past, CMS recognized pain management and interventional pain management as separate specialties with their own designations. But now you report both specialties under the specialty designation 09 (Interventional pain management) on the 855i application form.

Here's What Is Covered Under the IPM Umbrella

Interventional pain specialists most often perform services related to fluoroscopy or injections. Common procedures include:

1. Fluoroscopy. CPT lists several fluoroscopy 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, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic destruction.

Follow the rules: Use caution when coding fluoroscopy, however. When your physician uses fluoroscopy for needle placement, report 77003 in addition to the code for the epidural, spinal or articular injection. But if your physician performs a RACZ procedure, you shouldn't separately report the services.

Here's why: The RACZ codes (62263, Percutaneous lysis of epidural adhesions using solution injection [e.g., hypertonic saline, enzyme] or mechanical means [e.g., catheter] including radiologic localization [includes contrast when administered], multiple adhesiolysis sessions; 2 or more days; and 62264, - 1 day) include both the RACZ and fluoroscopy services, so you can't unbundle the fluoroscopy.

2. Spinal injections. Your specialist may administer spinal injections to treat chronic pain due to an injury, spinal tumor (benign or malignant), or other problems such as intractable terminal cancer. Report 62280 (Injection/infusion of neurolytic substance [e.g., alcohol, phenol, iced saline solutions], with or without other therapeutic substance; subarachnoid), 62281 (- epidural, cervical or thoracic) or 62282 (- epidural, lumbar, sacral [caudal]), depending on the

injection site.

3. Facet injections. Codes 64470-64476 describe various sites and levels associated with paravertebral facet joint and facet joint nerve injections.

4. Epidural injections. Most epidural injections your provider performs will fall under the codes that distinguish between single-shot or continuous administration, and the injection location:

- 62310--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; cervical or thoracic

- 62311--- lumbar, sacral (caudal)

- 62318--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; cervical or thoracic

- 62319--- lumbar, sacral (caudal).

If your physician administers a transforaminal epidural instead, report the appropriate code from 64479-64484 (Injection, anesthetic agent and/or steroid, transforaminal epidural ...).

5. Sacroiliac joint injections. Report 27096 (Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid) for SI (sacroiliac) joint injections.

Checkpoint: Report 27096, however, only if your physician documents imaging confirmation of intra-articular needle positioning. In the past, some practitioners would inject the SI joint -blindly- in the office, but experts say that approach is nearly impossible to complete accurately.

-Administering SI joint injections without fluoroscopy is risky,- says **Barbara J. Johnson, CPC, MPC**, owner of **Real Code Inc.** in Moreno Valley, Calif. -I would be really concerned if a physician was injecting my SI joint without fluoro.-

-It's difficult to prove you put the needle in the right spot if you don't have x-ray confirmation,- Groudine adds.

Remember to Append Modifiers

Many common interventional pain management procedures qualify for modifiers that help explain special circumstances or give more details about your physician's work. Keep these four common modifiers in mind when filing your next claims:

- **Modifier 25** (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service). Use modifier 25 for situations such as a pain management injection administered during a standard E/M visit. Be sure to append modifier 25 to the E/M code.

- **Modifier 50** (Bilateral procedure). Many carriers require modifier 50 for facet injections, so check your payers-guidelines. Remember that submitting modifier 50 means you should get 150 percent reimbursement for the procedure.

- **Modifier 58** (Staged or related procedure or service by the same physician during the postoperative period). Be sure to add modifier 58 to your claim the first time a patient visits for a pump refill.

- **Modifier 59** (Distinct procedural service). Use modifier 59 when your physician performs two distinct services on the same day, such as when he places a block for postoperative pain management on the same day as the original procedure.

Protect Yourself: You-re Being Watched

With interventional pain management still being a relatively small specialty within the field, why should you worry about knowing the ins and outs of the most common procedures? Because according to the HHS Office of Inspector General's 2008 work plan, Medicare payments for interventional pain management procedures will be on the group's radar screen.

The work plan specifically states, -We will review Medicare payments for interventional pain management procedures.- Knowing the common procedures and being able to code accurately will be your best defense if an OIG team walks through your physician's door.