Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: The Difference Between Nerve Block and Destruction May Be Greater Than You Think

Report only destruction with same session/location block

When coding for facet joint injections, you must read the documentation carefully to determine whether the physician performed a nerve block (64470-+64476) or more extensive nerve destruction (64622-+64627). Additionally, you must know how CPT's definition of -level- varies between the two types of procedures.

Count -Joints- for Nerve Blocks

When reporting nerve blocks, you should focus on the -joint---the area between adjacent nerves--that the physician targets, instructs **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO**, owner of **MJH Consulting** in Denver. Therefore, one nerve block -level- will actually involve two nerves.

Example 1: If the physician provides diagnostic nerve blocks for C2, C3 and C4, he is addressing three nerves but only two levels (the joint at C2/C3 and the joint at C3/C4), notes pain management specialist **Richard Kennedy, MD**.

Example 2: If the physician wishes to block the nerves from L1-L4, he is addressing four nerves (L1, L2, L3 and L4) but only three levels (L1/L2, L2/L3 and L3/L4).

Under CPT rules, you may report one unit of 64470 (Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level) for the initial level the physician addresses in either the cervical or thoracic region. For each additional cervical or thoracic level that the physician targets beyond the first, you may apply +64472 (-cervical or thoracic, each additional level [list separately in addition to code for primary procedure]).

In the first example above, for instance, you would report 64470 for the initial injection (at C2/C3) and one unit of +64472 for the additional injection (at C3/C4).

Similarly, apply 64475 (Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level) for the first lumbar or sacral level, and +64476 (-lumbar or sacral, each additional level [list separately in addition to code for primary procedure]) for each additional lumbar or sacral level.

In our second example above, therefore, you would report 64475 for the initial lumbar level (L1/L2) and +64476 x 2 for the two additional levels (L2/L3 and L3/L4).

Multiple Injections Won't Mean Multiple Code Units

Note that -per level- does not mean per injection. This is an important distinction because the physician may provide more than one injection per level.

For example, the surgeon may provide a left-side C4/C5 intra-articular injection via a single needle puncture, or he may administer two separate injections to the medial branch nerves supplying the C4/C5 facet joint. In either case, you would report a single unit of 64470, Hammer says.

Additionally, the L5/S1 facet joint level receives innervation from three nerves (the L4, L5 and S1 para-vertebral facet joint nerves). If your physician blocks each of these nerves with a separate injection, you will still report only one unit of 64475 (Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single

CPT® 2023 American Medical Association. All rights reserved.

level) because he has addressed just a single level (L5/S1).

Call on Bilateral Modifiers

Be aware that nerve block codes 64470-64476 describe unilateral procedures. That is, the code descriptors assume that the physician targets the joint on either the left or right side. If the physician does address both the left and right side at the same level, CPT and CMS guidelines allow you report a bilateral procedure.

For physician billing, you may apply modifier 50 (Bilateral procedure) or modifiers LT (Left side) and RT (Right side), as appropriate, to describe bilateral nerve blocks, Hammer says.

For example, if the physician targets the C3/C4 and C4/C5 joints on both the left and right, you may report either 64470-50, 64472-50 or--for those payers that prefer the anatomical modifiers--64470-LT, 64470-RT and 64472-LT, 64472-RT.

For Destruction, Count Individual Nerves

When claiming nerve destruction, you should count the actual number of nerves the physician injects. For codes 64622-+64627, therefore, one -level- will equal one nerve.

If the physician documents, for instance, -C4 and C5 facet joint nerve destruction,- you would report 64626 (Destruction by neurolytic agent, paravertebral facet join nerve; cervical or thoracic, single level) for the first nerve/level (C4) and +64627 (-cervical or thoracic, each additional level [list separately in addition to code for primary procedure) for the additional nerve/level (C5), Kennedy notes.

Count only the number of nerves the physician injects, not individual injections. Multiple injections to the same nerve count as a single level.

Additionally, nerve destruction codes, like nerve block codes, describe unilateral procedures. You may report bilateral procedures using modifier 50 or modifiers LT and RT, as appropriate to your payer's preference.

Report Only Destruction With Same-Session Block

If the physician provides facet joint injections for both nerve blocking and destruction at the same location on the same date of service, you should report only the destruction procedure, according to CPT and payer instructions. For instance, a typical local coverage determination (LCD) for facet joint injections from National Government Services, a Part B carrier in New York State, in-structs, -When destruction of the facet joint nerve follows blocking of the same nerve, only the codes for nerve destruction should be billed.-

Finally, if the physician uses fluoroscopic guidance for needle placement with either nerve block or nerve destruction, and also provides the interpretation and report, you may report 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures) separately with modifier 26 (Professional component) appended. You should report this code only once per session, regardless of the number of injections the physician administers.

CPT® 2023 American Medical Association. All rights reserved.