Part B Insider (Multispecialty) Coding Alert

Reader Questions: Stick With Correct Code, Even if Non-covered

Question:

Our payer included codes 64470-64476 on the 2009 physician fee schedule, but dropped them in 2010 as non-covered services. The latest schedule also does not include new codes 64490-64495. I have enough documentation to determine an acceptable E/M service level. Can I report and E/M code instead of the facet injection so our provider gets paid something?

Answer:

Coding guidelines direct you to code the service your physician provided and documented, whether you expect payment or not. Choose the appropriate code from 64490-64495 (Injection[s], diagnostic or therapeutic agent, paravertebral facet [zygapophyseal] joint [or nerves innervating that joint] with image guidance [fluoroscopy or CT]...) and submit to your carrier. Appeal any denials and exhaust all reimbursement efforts before adjusting the service and writing off the fee.

Check related codes: Confirm whether the fee schedule includes 64622-64627 (Destruction by neurolytic agent, paravertebral facet joint nerve ...). Physicians often perform a facet block as a precursor to determine whether radiofrequency ablation of the facet joint nerves would be a suitable treatment option. If the carrier covers 64622-64627, you could begin the process of lobbying for coverage of 64490-64495.

Communicate: Talk with your physicians and the staff member who handles precertification about the denials, so everyone knows the situation. Education helps everyone share correct information with your patients before the procedure. The patient and physician might discuss alternative treatments, or the patient might agree to pay for the procedure himself.