Eli's Rehab Report

Append Correct Modifiers to Diskography Codes To Ethically Optimize Reimbursement

PM&R practices that specialize in back pain are quite familiar with the correct codes for diskography (62290-62291), but these practices still receive denials centering on claims for multiple levels of diskography, or claims for diskography as well as the radiological supervision and interpretation that frequently accompanies it. Knowing which modifiers to append to these codes, along with the codes for radiological supervision and guidance, can help decrease denials.

Most PM&R practices are just beginning to offer diskography, a relatively new procedure that uses pressure to simulate the tension on a patient's vertebral disk while radiographic material is injected into an intervertebral disk. The radiography allows the physiatrist to see any cracks or fissures in the patient's vertebrae.

Coding for diskography would be much easier if the radiography and injection were the only aspects to the procedure. However, diskography billing can become quite involved. The following information can help PM&R practices more accurately code for this service.

Multiple Levels Billed

"It's very rare for our practice to ever bill for just one level of diskography, because the doctor almost always performs several injections during the procedure," says **Vicki Moraaten,** a member of the billing team at the Pain Clinic of Northwestern Wisconsin in Eau Claire, where three physicians perform diskography. "Even though an LMRP will never come out and say that we have to add modifier -51 for multiple procedures, it is necessary to make the claim go through faster and without any problems."

Many PM&R practices have faced the same challenge as Moraaten. Although the code descriptors for 62290 (injection procedure for diskography, each level; lumbar) and 62291 (... cervical or thoracic) state "each level," the practical assumption is that the number of units should be indicated next to the code and that no additional modifier is necessary. For instance, if three injections were performed on the lumbar spine, the coder would enter 62290 x 3. However, many subscribers say they have received denials stating, "Procedural modifiers required."

"The insurer says that their computer system will automatically add modifier -51 (multiple procedures) when necessary," says **Tania Calabrese,** office manager at Indianapolis Sport and Spine, a two-physiatrist practice, "but we had a lot of problems billing for diskography without adding the modifier ourselves. Now we add modifier -51 to the claim, and we don't have any problems."

Some carriers will not return or delay claims lacking modifier -51, but for those practices whose diskography claims for multiple levels are frequently denied, it can help a lot to add the modifier. Practices that use modifier -51 on these claims should enter the diskography code on separate line items with modifier -51 appended next to the subsequent entries. For instance, a claim for two levels of lumbar diskography would read:

62290
62290-51.

Radiological Supervision

Because diskography involves radiography, physiatrists who perform it should also bill 72295 (diskography, lumbar, radiological supervision and interpretation) for the lumbar region or 72285 (diskography, cervical or thoracic, radiological

supervision and interpretation) for the cervical or thoracic regions if the physiatrist performs and interprets the radiological portion. Most PM&R practices perform diskography solely in the lumbar region, so 72295 is almost always the best choice for this service.

Note that 72295 should be reported only once per diskography despite the number of injections that the physiatrist gives to the patient. Although the practice will most likely bill multiple levels of the injection procedure (62290, as discussed above), this is not true for the radiological portion. Therefore, a claim for three levels of a lumbar diskography would read: 72295, 62290 x 3 (with the optional modifier -51 appended).

If the physiatrist does not own the radiological equipment required for 72295, he or she would indicate that the professional component of the code was performed by appending modifier -26 to 72295. Most diskographies are performed in a hospital, and the hospital or other facility normally owns the equipment, so the hospital would report 72295-TC (technical component), while the physiatrist would report 62290 x 3, 72295-26.

Many practices leave the entire radiological portion both the supervision and interpretation to a radiologist and do not use 72295. "We have the option of billing 72295," Moraaten says, "but we have never used it because a hospital radiologist performs the service and the hospital bills the 72295 independently."

If your practice owns the equipment and performs the radiological portion of the 72295, but sends the results to an independent laboratory for interpretation, you would append modifier -TC to your claims for 72295, and the lab would bill the professional component of the code.

Because physiatrists use fluoroscopic guidance to help pinpoint where the needle should be inserted into the patient's disk, some PM&R practices have made the error of billing 76005 (fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures) along with the diskography code. However, 72285 and 72295 include the fluoroscopic guidance, so 76005 should not be reported also.

CCI-Prohibited Diskography Billing

The Correct Coding Initiative (CCI) lists 76005 as a component of 62290 as well. Even in cases such as Moraaten's, where the PM&R practice is billing just the diskography code (62290) and not the radiology code (72295), the fluoroscopy claim will still be denied. The separate charge for the fluoroscopy will be bundled into the diskography code and the claim may be delayed.

Five other codes are also components of 62290 and can't be billed separately:

1. 62311 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; lumbar, sacral (caudal)

2. 62319 injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances lumbar, sacral (caudal)

3. 64483 injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level;

4. 69990 microsurgical techniques, requiring use of operating microscope

5. 76005 fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures including neurolytic agent destruction.