Codify
BY AAPC

Eli's Rehab Report

Bone Up on Coding for Epidural Blocks

Physical medicine and rehabilitation practices that administer epidural blocks to reduce pain and inflammation or to confirm diagnoses must first identify the method of injection, the site, and the material injected before determining which codes to assign to these claims.

Epidural injections are commonly used to treat nonsurgical spinal conditions such as sciatica (**722.10**), but they are also effective in managing postsurgical pain or non-spine-related afflictions. The procedures are reported using four code groups, 62280-62282, 62310-62311, 62318-62319 and 64479-64484, depending on the agent and injection method. Within each group, individual codes are differentiated according to the targeted spinal area cervical, thoracic, lumbar or sacral.

The first epidural block code group (62280-62282) is used to report the injection of neurolytic substances. These injections destroy damaged nerves that are the source of a patient's pain, or that affect adhesions following surgery.

The second code group (62310-62311) describes a single injection of substances other than neurolytic agents. For example, suppose a patient has low back pain that physical therapy or other more conservative treatments have not alleviated. The physiatrist performs a steroid injection into the sacral epidural region to relieve the back pain. This procedure is coded with 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]).

Use codes 62318-62319 to report injections via indwelling catheter of substances other than neurolytic agents. Remember that these codes include catheter placement, so it should not be separately reported.

The final code group (64479-64484) describes transforaminal injections. Codes 64479 and 64483 are the primary codes and should be reported for the first injection to the cervical/thoracic or lumbar/sacral levels. Add-on codes +64480 and +64484 designate each additional injection at these levels. As add-on codes, they are modifier -51 (Multiple procedures) exempt, which means fee reduction may result if you append modifier -51.

Sedation Before Epidural

Some physiatrists offer patients the option of intravenous (IV) sedation before performing the epidural injection so the procedure is less painful, but many coders express frustration that payers often deny the IV.

According to **Marvel Hammer, RN, CPC,** owner of MJH Consulting in Denver, "The physician sometimes gives the patient a drug such as Versed (J2250), most often intravenously." Options for coding the sedation are 90784 (Therapeutic, prophylactic or diagnostic injection [specify material injected]; intravenous) or, if the necessary criteria are met, 99141 (Sedation with or without analgesia [conscious sedation]; intravenous, intramuscular or inhalation).

"Many payers, including most Medicare carriers, bundle the sedation code in with the spinal injection code," Hammer says. "However, if your payer considers it bundled, you should still bill for the medication as long as the physiatrist has the invoice showing that he or she paid for the drug." Hammer explains that "whoever purchases the medication should be capturing the reimbursement for it. Even if you know the injection code will be denied, you should still bill for the medication, because they can add up over time."

The only exception to this rule is if another entity, such as a hospital, ambulatory surgery center, or clinic, paid for the medication, Hammer says.

E/M Is OK With Epidural If Medically Necessary

You may charge an E/M service provided on the same date as an epidural block if the E/M service is significant and separately identifiable. You must append modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the appropriate E/M code.

For example, suppose a patient presents for an injection but also complains of symptoms resembling carpal tunnel syndrome (354.0). The physiatrist performs the injection and spends 15 minutes examining the patient because of the new complaint. For this visit, code the injection (e.g., 64479) and the E/M service (e.g., 99213, Office or other outpatient visit for the evaluation and management of an established patient), with modifier -25 appended to 99213. The medical record should reflect the separate nature of the E/M service.