Codify
BY AAPC

Eli's Rehab Report

Code Pain Diagnoses Appropriately to Avoid OIG Scrutiny

Physiatrists are known for their expertise in providing pain management services to patients suffering from chronic and acute pain disorders, and billing for those services is no problem if the patient has an identifiable problem such as sciatica (**ICD-9 724.3**) or fibromyalgia (729.1). But billing for patients who suffer from unspecified pain can be more challenging. Generalized pain (780.9) is often not included on local medical review policies (LMRPs) for pain management procedures, and many practices that offer these services to patients try to alter the diagnoses on their claims to Medicare to ensure payment. This custom should not be continued.

If a patients pain is caused by late effects from another condition, such as a broken bone or back surgery, practices may be able to code using the original condition as the diagnosis. The following tips can help with correct coding.

Be As Specific As Possible

A patient presents to the PM&R office complaining of severe, chronic pain in her lower back, which started two months ago. The physiatrist performs two trigger point injections to relieve the pain. His chart notes indicate that the patient was suffering from back pain.

The coder receives the chart and notes that the physiatrist has performed trigger point injections in the past and coded them as 20550. He recalls that the most recent injections performed on patients backs were for sciatica, and assumes that this patient is also suffering from that, since the doctor did not denote a more specific diagnosis. He bills one unit of 20550 (because both injections were performed on the same site, which would not warrant billing two units) with the diagnosis code 724.3 for sciatica, and the claim is paid accordingly. However, just because the claim is paid does not mean that it was coded correctly.

If a patient does not have a diagnosis listed as acceptable on the LMRP, you cannot create one just to get paid, says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H,** owner of A+ Medical Management and Education, a coding and reimbursement consulting firm and a national CPC training curriculum site in Egg Harbor City, N.J. Is back pain the same thing as sciatica? No. But the practice will probably get paid because sciatica is on the approved list. But if the physician did not document sciatica, you could be in trouble during an audit. This is the kind of thing that the OIG (Office of Inspector General) is targeting.

Some carriers provide reimbursement for backache, unspecified (724.5) for trigger point injections, so its important to read your LMRP as carefully as possible to determine whether the diagnosis fits the payers rules. You have to be as specific as you can, Jandroep says, which may sometimes mean that your physician performs services that are not ultimately going to be reimbursed. If it is anticipated that the injections are not going to be covered based on the diagnoses, the practice can prepare by having the patient sign an ABN (advance beneficiary notice) prior to the injection.

Tip: A good practice is to have a special symbol (i.e., a #) placed next to diagnoses on your superbill that require an ABN. This makes the physician and the office staff aware immediately.

Coding Prior Trauma

Often, patients with conditions such as back or neck pain are actually suffering from effects caused by prior trauma, such as a broken bone. If the pain is caused by a previous condition, that diagnosis can sometimes be used to justify pain management procedures, says **Sheila Belcher,** provider reimbursement consultant at Carilion Professional Billing in Roanoke, Va., who bills for 20 physicians, including three physiatrists. Ninety percent of the pain management procedures that we bill come from some type of trauma, and we can often code the claim using the underlying problem

instead of current symptoms. We look at the reason the patient is in rehabilitation in the first place, and determine whether that is the root of the problem.

For example, a patient presents with chronic pain in her lower back and right thigh. The physiatrist performs a facet joint nerve block at L4/L5, and writes lumbar, thigh pain on the chart.

The coder reads the chart and looks up the code for the facet joint injection, which is 64475. She looks over the approved diagnoses, and neither lumbar nor thigh pain is listed as acceptable.

Belcher recommends discussing the patients condition with the physician, and suggests that more often than not, the coder will learn that the patient is suffering from a more comprehensive problem, such as post-laminectomy syndrome (722.80-722.83). In that case, I would code the patients main condition first, and her symptoms second.

Therefore, this claim would be coded using 722.83 for lumbar postlaminectomy syndrome, along with 724.2 for low back pain and 729.5 for pain in limb.

Other root problems that often cause pain symptoms include carpal tunnel syndrome (354.0), scar conditions (709.2), displaced intervertebral discs (722.2) and rheumatic disorders (725-729).

Preventive or Sick Visit?

Suppose a patient with sciatica is treated by the physiatrist for two months, and her pain eventually subsides. The doctor asks her to return in six weeks to ensure that the symptoms arent returning and that the problem isnt recurring. The patient presents to the six-week visit with no problems and proves to be pain-free. Is this coded as an established patient E/M (99211-99215) or as a preventive medicine visit (99381-99397)?

You would base your coding on the documentation of whether the physiatrist was following up on the patients chronic pain condition, Jandroep says. If the history is related to the same complaint or pain disorder, then you are providing an established E/M service and not a preventive visit. She adds that this is not a black-and-white issue, but states, If I were billing this service, I would not code it as a well visit. Even though the patients condition is not currently flaring up, you are managing her chronic problem and would code as 99211-99215.

Belcher agrees: A preventive visit would be billed if a physician saw a patient with no known chronic conditions who wanted to make sure they werent developing any problems. If a patient had sciatica and they came back to ensure that it was resolved, I would use a V code to designate that the patient is status post to pain.

The introduction to the V codes section of the ICD-9 manual states that they can be used when some circumstance or problem is present which influences the persons health status but is not a current illness or injury.

For this scenario, you would code for the sciatica using 722.10 and V13.5 to demonstrate a personal history of musculoskeletal disorders.

Almost all Medicare policies for pain management procedures include frequency guidelines. For instance, most carriers allow payment for only one pain management procedure per day (e.g., facet joint nerve block only, or trigger point injection only). Also, each carrier dictates its own rules regarding the period during which pain management procedures will be covered. After such a period ends (usually between 30 days and four months), the physiatrist would have to demonstrate to the carrier why the patient required additional care.