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Eli's Rehab Report

Create Internal Guidelines for Acute, Chronic Neurogenic Pain Diagnoses

Carriers often require physiatrists to demonstrate whether a patient's neurogenic pain (for example, "phantom" pain in an amputated limb or trigeminal neuralgia) is "chronic," but many insurers do not define how a practice can differentiate between acute and chronic conditions. In the absence of local carrier direction, your practice should create internal guidelines to help decide how to categorize chronic neurogenic pain.

Be Sure You Meet the Requirements

Neurogenic pain is usually chronic, caused by a primary lesion, dysfunction or transitory perturbation in the peripheral or central nervous system. In some cases, such as nerve damage, however, physiatrists feel that the patient's pain is simply acute. So why does it matter whether the patient's pain is acute or chronic? Because many insurers' neurogenic pain treatment policies apply only to chronic-pain patients. Cahaba GBA, the Part B carrier for Georgia, Mississippi and Alabama, for instance, covers percutaneous peripheral nerve stimulation "to evaluate a patient with chronic neuralgia secondary to injury to a peripheral nerve or a disease affecting it or chronic neuralgia caused by complex regional pain syndrome in whom permanent electrode placement is being contemplated."

Create Internal Guidelines

Some insurers, such as Arizona Blue Cross and Blue Shield, define chronic pain as a condition "present continuously or intermittently for six months or more, or extending two to three months beyond the expected recovery time for postsurgical patients." Most carriers, however, do not maintain specific acute and chronic pain definitions.

Many practices designate a three-month period for a condition to remain acute, after which they classify it as chronic. This time period varies widely, with some practices allowing only a few days before acute pain turns chronic, while others give patients more than six months before they classify the pain as chronic.

Although CMS does not officially comment on how to differentiate between acute and chronic conditions, Medicare does define the terms from time to time. For example, in a July 23, 2002, decision memorandum announcing coverage of electrical stimulation for chronic wounds, CMS defines a chronic wound as persisting for "longer than one month."

PM&R practices should set general guidelines for determining when acute pain conditions become chronic, based on their most common diagnoses. Physiatrists should review patient medical records to determine an average period during which each type of pain subsides and create a list of those averages as a guideline.

Even if your practice's policy is based on a three-month acute pain period, that won't necessarily be the case with every patient. Some patients may show marked improvement after three months, and the physiatrist will want to continue listing the condition as acute for three more months. Alternatively, some patients' conditions will worsen after one month, causing an upgrade to chronic.

Can't the practice simply upgrade a patient from an acute condition to a chronic one? You can, but your insurer might not recognize it right away without additional documentation, says **Jacqui Jones,** office manager at Klamath Sports Medicine Clinic in Klamath Falls, Ore.

Physicians often conservatively treat acute conditions, such as minor tingling in an amputated stump, and they frequently respond well with no further treatment. But sometimes the conservative treatment fails, she says, and the patient requires additional procedures, at which point the condition would be upgraded to a chronic one. "This could take

as long as a year," Jones says.

Link Correct Dx to E/Mand Tests

When diagnosing neurogenic pain, physiatrists normally perform an evaluation (99201-99205 for new patients, 99211-99215 for established patients) and order neurophysiological studies (for example, electromyo-graphy [95860-95872] or nerve conduction studies [95900-95904]) to assist in their diagnosis, says **Jay Neal,** an independent coding and billing consultant in Atlanta.

"As with most diagnostic tests, you should link the testing code to the symptoms that create the need for the test, such as tingling, numbness or pain," Neal says. "Don't report the assumed diagnosis."

Common diagnoses for neurogenic pain include:

1. 053.10 Herpes zoster, with unspecified nervous system complication
2. 053.12 postherpetic trigeminal neuralgia
3. 053.13 postherpetic polyneuropathy
4. 340 Multiple sclerosis
5. 350.1 Trigeminal neuralgia (tic douloureux, trigeminal neuralgia NOS and trifacial neuralgia)
6. 353.6 Phantom limb (syndrome)
7. 436 Acute, but ill-defined, cerebrovascular disease.

Note that postherpetic trigeminal neuralgia differs from trigeminal neuralgia in that it is defined as "severe oral or nasal pain following a herpes zoster infection (shingles)." Postherpetic neuropathy refers to multiple areas of pain. Other causes of neurogenic pain can include chemotherapy, spinal cord trauma and traumatic brain injuries (TBIs).

Drug Administration Dominates Treatment

Because even the slightest stimulation may cause extreme discomfort for neurogenic pain patients, physicians generally treat them with drugs rather than with more traditional physical therapy methods. The following codes describe common neurogenic pain treatments:

8. 62310 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) epidural or subarachnoid; cervical or thoracic
9. 62311 lumbar, sacral (caudal)
10. 64420* Injection, anesthetic agent; intercostal nerve, single; and 64421*, intercostal nerves, multiple, regional block
11. 64620 Destruction by neurolytic agent, intercostal nerve.

Observe Payer Conditions

Most insurers designate specific guidelines for nerve block and neurolysis codes. For example, Noridian Mutual (a Part B carrier for Alaska, Arizona, Colorado, Hawaii, Nevada, North Dakota, Oregon, South Dakota, Washington and Wyoming) issued a local medical review policy (LMRP) that states, "If neurolysis is performed, i.e., the 646xx series, it follows and includes the nerve block, i.e., the 644xx series."

In other words, the physician should administer intercostal nerve blocks prior to intercostal neurolysis. If the block fails to provide relief, there is no need to continue to neurolysis. To further support Noridian's claim that you should not report nerve block codes 64420 and 64421 in addition to intercostals nerve neurolysis (64620), the National Correct Coding Initiative (NCCI) bundles these procedures.

In addition, physicians who provide more than one nerve block per date of service must provide documentation to justify the multiple injections. Noridian's LMRP says, "More than one nerve block billed per day will require the submission of documentation with the claim.

The claim will be denied when the necessary documentation is not submitted." If the physician performs more than one intercostal neurolysis, payers will usually apply a multiple-procedure payment reduction to the second and subsequent injections.

Note: There are several treatment options for neurogenic pain, depending on the exact diagnosis, and the ICD-9 code(s) you choose may affect the procedures for which you may expect payment. For this reason, be sure to code to the highest level of specificity.