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Eli's Rehab Report

ICD-9 Coding Corner: Specificity Is Key to Diagnosing, Treating Radiculopathy

Because diagnosing radiculopathy (722.0-722.2 and 729.2) can require more than one simple test, practices should know just how to justify claims for these diagnostic procedures and to accurately code radicu-lopathy treatments, such as lumbar diskectomies (62287, Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar [e.g., manual or automated percutaneous diskectomy, percutaneous laser diskectomy).

According to the American Academy of Physical Medicine and Rehabilitation (AAPMR), low back pain is the most common form of physical disability and ranks as the second leading cause of work absenteeism in the United States. Physiatrists who treat lumbar radiculopathy often perform a battery of diagnostic tests to pinpoint the diagnosis, followed by injections or more extensive procedures to treat the condition.

"One major problem with billing these services is that we have to list the patient's symptoms as the ICD-9 code for the diagnostic tests, since we haven't yet confirmed radiculopathy," says **Joan Daroy,** coding supervisor at The Pain Center, a two-physician practice in Dallas. "Then if we bill for a significant treatment such as diskectomy, the insurer sometimes asks us to back up the diagnosis, saying that the patient's history doesn't reflect it."

Even if the patient's symptoms support the diagnostic tests, the patient's record must include the radiculopathy confirmation to back up any subsequent treatments.

Diagnosis Starts With E/M

An E/M visit (99201-99205 for new patients, 99211-99215 for established patients) is almost always the first stop for patients with back pain. If the physiatrist suspects radiculopathy, he or she performs further testing, such as ankle and knee jerk reflexes and watching patients walk on their toes and perform squats. No code exists for these tests, which should be included in the E/M service.

Symptoms such as decreased patellar reflex, foot sensation loss, quadriceps muscle weakness and anterior leg pain can indicate nerve root compression problems at the L4-L5 level, where about 90 percent of all lower-extremity radiculopathy due to disk herniation occurs, says **Gloria Tomlin, RN,** office manager at the office of Frederick Tomlin, MD, a physiatrist in Ocean City, Md.

"These symptoms are usually enough to show the insurer that we suspect radiculopathy, allowing us to perform some more extensive tests such as nerve conduction studies (NCS, 95900-95904)." In addition, most carriers allow spinal computed tomography (CT) scans (72125-72133) or magnetic resonance imaging (MRI) testing (72141-72158) to pinpoint which disk has radiculopathy.

Watch EDX Test Frequency Guidelines

The American Association of Electrodiagnostic Medicine (AAEM)'s Recommended Policy for Electrodiagnostic (EDX) Testing, which is a recommendation on the "maximum number of tests necessary in 90 percent of cases" followed by most carriers, advises that up to three motor (95900) and two sensory (95904) NCS and two needle electromyography (EMG, 95860-95870) tests may be necessary to diagnose radiculopathy. Most payers follow the AAEM's recommendations for electrodiag-nostic tests, so you should study these guidelines.

If the physiatrist cannot pinpoint a diagnosis using EDX testing such as NCS, some carriers allow practices to perform somatosensory studies (95925-95927), but do not make these tests part of your normal radiculopathy diagnosis regimen. According to Palmetto GBA's (the Part B carrier for Ohio, South Carolina and West Virginia) local medical review policies (LMRP), somatosensory testing is "covered only when standard methods (i.e., nerve conduction velocities) are not effective for the individual patient. It is not covered for routine evaluation of radiculopathy or autonomic neuropathy."

Other insurers, such as Blue Cross and Blue Shield of Arkansas, allow paravertebral nerve blocks (64479-64484) to diagnose radiculopathy if "the neurodiagnostic studies fail to provide a structural explanation." The medical record must reflect which neurodiagnostic tests failed.

Diagnosis Dictates Treatment Options

Once you confirm radiculopathy, your procedure coding becomes significantly easier because most carriers are very specific about which treatment options they cover for radiculopathy and those they don't cover.

For instance, Cahaba GBA, Georgia's Part B carrier, requires physicians to rule out radiculopathy before performing paravertebral facet joint denervation (64622-64627). TrailBlazer Health Enterprises, the Part B carrier for Delaware, Maryland, Texas, Virginia and Washington, D.C., has a similar requirement for physicians who perform lumbosacral paravertebral facet joint blocks (64475-64476), which they do not cover for radiculopathy.

Just the opposite is true for TrailBlazer's diskectomy (62287) policy, which states that the service is not medically necessary "without evidence of radiculopathy." "

This just shows you how seriously these carriers take the radiculopathy diagnoses," Daroy says. "You have to document everything for these patients to prove either that they have radiculopathy when it's required for payment, or that they don't for services where it must be ruled out."

Some carriers require a waiting period before allowing radiculopathy treatment to ensure that it is a persistent or chronic problem. Unfortunately, "chronic pain" is a subjective term, and although some carriers define it as pain persisting longer than one month, others consider pain acute only until six months has passed. Always ask your insurer for its definition of chronic pain in these circumstances.