Eli's Rehab Report

Sort Through Spinal Injection Coding Maze to Optimize Reimbursement

One of the most confusing aspects of billing for pain management is assigning the proper codes for spinal injections. Because these injections range from epidurals to nerve blocks to facet joint injections, determining exactly which code to assign can be difficult. Knowing when to bill separately for fluoroscopy or additional levels can help practices more accurately code for these injections.

Stellate Ganglion/Nerve Blocks

Nerve blocks are listed in CPT Codes 2000 as codes 64400-64530, which cover injections using anesthetic agents (such as lidocaine, sometimes injected with epinephrine) to the somatic and sympathetic nerves. For example, the physiatrist performs four stellate ganglion injections on a patient with limb pain (729.5) in her arm. The physician uses a single syringe and does not refill it between injections, he simply moves the needle and injects through adjacent skin at the C-6 vertebral level.

This injection would be billed using 64510 (injection, anesthetic agent; stellate ganglion [cervical sympathetic]). With 64510, the stellate ganglion block is used to provide anesthesia to the face, neck and upper extremity, says **Sylvia Albert, CPC,** president of the Tidewater Chapter of the American Academy of Professional Coders, and a customer support manager at the AcSel Corporation, a physician reimbursement firm in Virginia Beach, Va. Code 64510 is based on the number of injections. If multiple injections are done, it is appropriate to report the code and change the units to refer to the number of nerves injected. Coding 64510 with modifier -51 (multiple procedures), however, would not be appropriate, says Albert. Modifier -51 is applicable when multiple related procedures are performed and there is no single inclusive code available.

Albert says that if fluoroscopic guidance was performed in conjunction with the injection to guide needle placement, services would warrant a separately reportable procedure, code 76005 (fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures, including neurolytic agent destruction). No modifier is necessary to bill 76005.

Although 64510 should be reported with the number of units injected (and does not have any add-on codes), some other nerve block codes require the use of an add-on when billing for more than one level. For example, if the physiatrist performs two injections of lidocaine and triamcinolone on C3 and C4 of a whiplash (847.0) patient, the physician would bill 64470 (injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic single level) and 64472 (cervical or thoracic; each additional level).

A lot of times, the doctor will write the code, then x2 or x3 to reflect that he performed the injection on two or three levels, says **Maribel Ortega, CPC,** a coding supervisor at Per Se Inc., a medical billing firm in Miami. But that doesnt mean you should automatically bill the initial code with two or three units. You should look first and make sure there isnt a separate add-on code for each additional level, and if there is, you should use that one instead.

Physiatrists should note that the add-on codes for the spinal injections refer to each additional level injected, not the number of units injected. The physical medicine and rehabilitation (PM&R) provider would have to move from one level (e.g., C3) to another level (e.g., C4) to justify the use of an add-on code.

Codes 64470 through 64476 were added in 2000 and are unilateral procedures, meaning that if injections are performed on both the right and left paravertebral facet joints or facet joint nerves, modifier -50 can be used (bilateral procedure). Fluoroscopy is not included in these codes, so 76005 can be billed if fluoroscopy is used with the injection (no modifier is necessary when billing 76005 and the injection code together), but there is no requirement stating that fluoroscopy must

be used with these codes.

Epidural Injections

CPT 2000 deleted several subarachnoid injection and epidural narcotic injection codes and replaced them with codes 62310-62319. Although these new codes generally have made coding easier because they are more comprehensive, they have caused many questions in PM&R practices.

For example, some coders were using 62289 in 1999 to report injections of antispasmodic drugs into the lumbar region. Code 62289 was a starred procedure, however, while the code that replaced it, 62311 (injection, single, not including neurolytic substances, with or without contrast, of diagnostic or therapeutic substances, epidural or subarachnoid, lumbar, sacral) is not starred.

Codes 62310 (injection, single, not including neurolytic substances, with or without contrast, of diagnostic or therapeutic substances, epidural or subarachnoid, cervical or thoracic) and 62311 are not starred procedures but are site specific codes, says Albert. Therefore, if both injections (62310 and 62311) are done in the cervical or thoracic area and in the lumbar sacral area on the same day, both are reportable with modifier -59 (distinct procedural service) on the second procedure. Fluoroscopy can be reported separately without the use of a modifier.

Editors Note: CPT 2000 contains an error that was clarified in the American Medical Associations CPT 2000 Errata publication, which states, The cross-reference following code 64450 inadvertently directs users to the translaminar epidural injection codes 62310-62319. The correct codes for phenol injections are the neurolytic destruction codes 64622-64627.

Codes 64479 through 64484 were added in CPT 2000 to represent epidural injections and their accompanying add-on codes. These procedures also are considered unilateral, so modifier -50 can be added if the injections are performed on both sides of the spine. Fluoroscopy (76005) can be reported separately if used with these codes.

According to CPT 2000, injection of contrast during fluoroscopic guidance is an inclusive component of codes 62270-62273, 62280-62282, and 62310-62319, and therefore cannot be reported separately on those procedures.