Codify
BY AAPC

Outpatient Facility Coding Alert

Pain Management: Prevent Denials of Interlaminar Injections by Pinning the Levels

You can drop the bilateral modifier.

If your interventional physician performs more than one interlaminar epidural injection in the same spinal region, you should not append modifier 50 (Bilateral procedure) or modifiers RT (Right side) and LT (Left side) to 62310-62311 (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 ...).

Here's why: When your provider injects a substance into the epidural space via an interlaminar approach, the drug diffuses into the entire area, explains CPT® Assistant (November 2008). The spreading eliminates the need to inject medication into both sides of the space to achieve the desired results. Therefore, you won't need to include modifier 50 on your claim or in any way report 62310-62311 more than once to document that the provider treated the complete space.

The Medicare Physician Fee Schedule backs up this interpretation of the code and service by indicating that the 150 percent fee adjustment for bilateral procedures does not apply for these codes. Instead, if you append 50 or RT/LT, you will receive the lower of:

- the total actual charge for each side; or
- the fee schedule amount for one unit of the reported code.

Keep Track of Levels, Not Injections

By the same token, multiple attempts to reach the same epidural space don't equal multiple procedures, CPT® Assistant states. This is because the codes are defined by region, not by vertebral segment or interspace:

- 62310 -- ... cervical or thoracic
- 62311 -- ... lumbar, sacral (caudal).

In other words: Code descriptions for interlaminar epidural injections do not include the term "level." In contrast, transforaminal epidural injection code descriptions refer to "single level" or "each additional level," and "level" refers to an individual vertebral segment.

Codes 62310 and 62311 (as well as related procedures 62318- 62319, Injection, including catheter placement, continuous infusion or intermittent bolus ...) describe injections to an anatomic region (cervical, thoracic, lumbar, or sacral) rather than levels, or individual segments. Therefore, you only report 62310 and 62311 once per date of service.

Caution: Verify that you and your payer speak the same language when discussing spinal anatomy.

For example, the physician might note that he injected the needle at L4 when the payer had preapproved the claim for an injection to L3. If the payer denies the claim saying it wasn't the approved level, you need to clearly explain that the injection wasn't to treat that exact level, but was treating the whole lumbar region.

Remember Fluoro Is Now Included

Per the 2015 Medicare Physician Fee Schedule (MPFS) final rule, fluoroscopy is considered inherent to interlaminar

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epidural injections and should not be billed separately:

"After considering comments received, we are finalizing CPT® codes 62310, 62311, 62318, and 62319 as potentially misvalued, finalizing the proposed RVUs [relative value units] for these services, and prohibiting separate billing of image guidance in conjunction with these services."

Assign the Correct Diagnosis

Many conditions can lead to a patient having interlaminar epidural injections, so be sure to choose the most accurate diagnosis. Common options include:

- Reflex sympathetic dystrophy/CRPS Type I (G90.50)
- Spondylosis without myelopathy (M47.817)
- Disc displacement without myelopathy (M51.26)
- Disc degeneration (M51.34)
- Postlaminectomy syndrome (M96.1)
- Sciatica (M54.3)
- Radiculitis (M50.10)
- Spinal stenosis (M48.06).

Check the individual payer's coverage policy for ICD-10 codes that meet their medical necessity requirements. For example, many payers don't cover interlaminar epidural injections for spondylosis with myelopathy (such as M47.14, Thoracic or lumbar spondylosis with myelopathy). Remember, however, to always report the patient's condition as documented by the physician, regardless of your expectations of coverage.

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