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Outpatient Facility Coding Alert

Pinpoint Correct Epidural Coding Following Instruction and Payment Changes

Be clear on difference between fluoroscopy and contrast.

Code descriptors aren't the only things that might change each year to affect your reporting. Instructions for submitting codes might also change, which happened with epidural injections in 2012. Watch those instruction changes - and updates to payment rates - to ensure your ASC gets the appropriate reimbursement every time.

Dig Into the Codes
The descriptors for epidural codes 62310-62319 underwent slight revisions in CPT® 2012. The updated descriptors are as follows:

- 62310 - Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
- 62311 - ... lumbar or sacral (caudal)
- 62318 - Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
- 62319 - ... lumbar or sacral (caudal).

The differences: Two revisions were made to the descriptors for 62310 and 62311. First, the terminology no longer states "not via indwelling catheter." Second, the descriptor is now plural - "Injection(s)" - and specifies "including needle or catheter placement." For codes 62318 and 62319, the change comes through adding "indwelling" to describe the type of catheter placement. Therefore, you should report 62318 and 62319 only when the catheter is left is place (more than a calendar day) to continuously deliver substance(s) or to deliver substance(s) by intermittent bolus.

Don't Miss 3 Instruction Changes
Your instructions for reporting 62310-62319 also saw some changes when the revised descriptors became effective.

Region watch: When selecting from 62310-62319, remember that your code choice is based on the region where the catheter enters the body. Each code specifies either cervical/thoracic or lumbar/sacral. This coincides with the AMA advice in CPT Assistant, November 2008. 62311 should not be reported more than once on a given date of service because any injected substance(s) would diffuse into the entire area, therefore making it unnecessary to inject both sides or multiple levels, according to the CPT Assistant Q&A (Surgery/Nervous System, 61793; pg. 11).

Multiple use equals injection: Sometimes a provider will place a catheter to administer one or more epidurals or injections on the same day. In this situation, submit 62310 or 62311 as if the provider used a needle - don't report the service as a continuous infusion with 62318 or 62319. The same holds true when the provider threads a catheter into the epidural space, injects substances at one or more levels, and then removes the catheter. Treat the procedure as a single injection by reporting 62310 or 62311.

Separate fluoroscopy: Providers may use fluoroscopic guidance to help with localization before administering an epidural, but fluoro is not required. If your provider opts for guidance, don't confuse that service with the contrast used.

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Codes 62310-62319 include the contrast substance used for localization. Some payers allow separate physician reimbursement for fluoro with 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural, or subarachnoid]). The ASC, however, will not be paid additionally for the fluoroscopic guidance under Medicare as it is considered a packaged service (status indicator N1, Packaged service/item; no separate payment made).

Keep Up With Payment Rates
Payment values for epidural services 62310-62319 changed in the last quarterly update, so verify that your systems are up-to-date.

The current national ASC facility rate for codes 62310-62318 is $301.95, with national physician rates ranging from $52.42 to $69.44. The current national facility rate for 62319 is $521.08 for an ASC and $63.65 for the physician.