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Pain Management Coding Alert

Coding Edits: Pay Attention to New Modifier Indicator Edits for Paraspinous Block Codes

CCI 22.0 edits can get tricky to keep straight.

Version 22.0 of the Correct Coding Initiative (CCI) edits became effective in January, and you'll want to take time to get familiar with certain areas that could change how you submit some claims. Read on for your guide to plowing through the changes that mean the most to you.

Get Used to Having 64461 and 64463 Bundled Into Other Procedure

Hundreds of edits affecting your practice pertain to the new codes for paraspinous blocks:

- 64461 Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)
- 64463 ... continuous infusion by catheter (includes imaging guidance, when performed).

In most edits, the PVB is considered the Column 2 code of the pair, which means you report the other procedure (the Column 1 code) instead of 64461 or 64463. Examples of Column 1 procedures that are paired with the PVB codes include:

- Trigger point injections 20552 (Injection[s]; single or multiple trigger point[s], 1 or 2 muscle[s]) and 20553 (...single or multiple trigger point[s], 3 or more muscle[s])
- Joint injections such as 20600 (Arthrocentesis, aspiration and/or injection, small joint or bursa [e.g., fingers, toes]; without ultrasound guidance) and 20610 (Arthrocentesis, aspiration and/or injection, major joint or bursa [e.g., shoulder, hip, knee, subacromial bursa]; without ultrasound guidance)
- Percutaneous vertebroplasty and vertebral augmentation (codes 22510-22514)
- Epidural or spinal neurostimulator electrode array implantation, replacement, and removal (several codes in the 63650-63688 range)
- Percutaneous lysis of epidural adhesions (62263 and 62264)
- Percutaneous aspiration code 62267 (Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes)
- Epidural patch procedure 62273 (Injection, epidural, of blood or clot patch)
- Neurolytic substance injection or infusion procedures 62280-62282 (Injection/infusion of neurolytic substance [e.g., alcohol, phenol, iced saline solutions], with or without other therapeutic substance ...)
- Discography injections 62290-62291 (Injection procedure for discography, each level ...) and 62292 (Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar)
- Myelography via lumbar injection (codes 62302-62305)
- Destruction by neurolytic agent (most codes in the 64600-64681 range).

Pay attention: "Many of these new edits involving a CPT® surgical procedure code as Column 1 with 64461 or 64463 as Column 2 code carry a '0' modifier indicator which means they can't be bypassed with a modifier," points out **Marvel Hammer, RN, CPC, CCS-P, ACS-PM, CPCO,** owner of MJH Consulting in Denver, Co. "In contrast, the 64461and 64463 are bundled as Column 2 codes into the anesthesia codes, but these edits can be bypassed with a modifier."

The 64461 and 64463 codes are Column 1 codes to most E/M services, particularly the inpatient codes (99221-99223) as these procedures are frequently performed in the hospital setting. You can append a modifier to bypass the edit but the documentation would need to support that the E/M service is indeed separately identifiable and significant from the PVB procedure.

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Don't Miss When PVB Is Reportable as the Main Procedure

Caution: Don't get so accustomed to seeing 64461 and 64462 as Column 2 codes that you assume they can never be reported when paired with another procedure. Some edits in CCI 22.0 actually list the PVBs as the Column 1 code, meaning that's the procedure you file on the claim.

Examples of procedures considered secondary to the PVB include:

- Cervical or thoracic epidurals 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) and 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)
- Intercostal nerve injections 64420 (Injection, anesthetic agent; intercostal nerve, single) and 64421 (... intercostal nerves, multiple, regional block)
- Transforaminal epidurals 64479 (Injection[s], anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance [fluoroscopy or CT]; cervical or thoracic, single level) and +64480 (... cervical or thoracic, each additional level [List separately in addition to code for primary procedure])
- Paravertebral facet joint injections 64490 (Injection[s], diagnostic or therapeutic agent, paravertebral facet [zygapophyseal] joint [or nerves innervating that joint] with image guidance [fluoroscopy or CT], cervical or thoracic; single level), 64491 (... second level [List separately in addition to code for primary procedure]), and +64492 (... third and any additional level[s] [List separately in addition to code for primary procedure]).
- Fluoroscopic guidance 77002 (Fluoroscopic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device]) and 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural or subarachnoid]).

"These edits actually follow the new CPT® parenthetical notes associated with these new codes," Hammer says. "In addition, the new NCCI modifier indicator is '0,' showing that these bundling edits cannot be bypassed with a modifier."

Take note: This list is far from complete, so be sure to check the full list of edits before filing claims.

Percutaneous Annuloplasty Overrides PVB and Sedation

If your pain management specialist performs percutaneous annunoplasty, be sure to report that procedure instead of PVBs or moderate sedation. The Column 1 codes you submit are 22526 (Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level) and 22527 (...1 or more additional levels [List separately in addition to code for primary procedure]).

Procedures that CCI 22.0 considers part of 22526 and 22527 include:

- Paravertebral blocks 64461 and 64462
- Moderate sedation codes 99143 (Moderate sedation services [other than those services described by codes 00100-01999] provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; younger than 5 years of age, first 30 minutes intra-service time); 99144 (... age 5 years or older, first 30 minutes intra-service time); and +99145 (... each additional 15 minutes intra-service time [List separately in addition to code for primary service]).

Once again, the new version of CCI does not allow you to bypass the edits with a modifier.

Don't Get Excited Over Deletions

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CCI updates will occasionally include deletions that reverse previous edits and allow you to submit code pairs that had been banned. The January CCI file does list thousands of deleted edits, but don't get your hopes up for new reimbursement. Each pair includes a code that is no longer valid as of Jan. 1, 2016, such as 64412 (Injection, anesthetic agent; spinal accessory nerve).

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