Pain Management Coding Alert

Medication Therapy: Don't Miss the Required Documentation for Long-term Opioid Treatment

Starting with the basics should be your foundation for each visit.

Thorough documentation is your key to getting any reimbursement for your provider, but certain services have specific documentation requirements you don't want to miss. Such is the case with chronic opioid therapy, where making notes of certain things help providers maintain high-quality care by following a structured protocol. Know you're on the right path by keeping three expert steps in mind.

Step 1: Focus on 4 A's Every Time

Because the patient is having opioid therapy for pain relief, that should be a primary focus for your provider at each visit. An easy way to remember the domains of pain that should be addressed and documented at each visit is with four A's:

- **Analgesia** (the effectiveness of pain control): "Realistic analgesia goals can be set in the treatment plan," says **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO,** of MJH Consulting in Denver, Co. "The patient's log of pain levels achieved with various treatments can then inform management decisions."
- **Activities** (functional and daily living): Patient goals might include the ability to work, to be active in one's home, to develop and maintain relationships, to engage in hobbies, to complete therapy, or to make progress toward life goals. The patient helps choose the functional activities being evaluated, and then the provider structures a plan based on the treatment goal.
- **Adverse effects** (side effects from medications): This domain is particularly important, Hammer says, as opioids can cause constipation, sedation, respiratory depression, and other adverse effects that can lead to dangerous complications.
- **Aberrant drug-related behaviors:** Providers must consistently assess and document any unusual behaviors in all chronic pain patients. Tests (such as urine drug screenings) can provide evidence for or against diversion and use of other substances of abuse and a review of the state's controlled substance database. If available, the database can provide evidence for or against "doctor shopping." Periodic use of objective and/or subjective validated screening tools can help stratify patient risk assessment.

Step 2: Follow Medical Necessity Guidelines

Many payers will have policies regarding monitoring chronic opioid therapy (COT) and medical necessity requirements. For example, Palmetto's "Controlled Substance Monitoring and Drugs of Abuse Testing" states that, "Ongoing testing may be medically reasonable and necessary based on the patient history, clinical assessment, including medication side effects or inefficacy, suspicious behaviors, self-escalation of dose, doctor-shopping, indications/symptoms of illegal drug use, evidence of diversion, or other clinician documented change in affect or behavioral pattern."

Drug screening test frequency must be based on a complete clinical assessment of the patient's risk potential for abuse and diversion using a validated risk assessment interview or questionnaire. Keep these tips in mind when evaluating the patient:

- The assessment should include the patient's response to prescribed medications and any medication side effects.
- The clinician should perform random UDT (urine drug testing) at random intervals, in order to properly monitor a patient. UDT testing does not have to be associated with an office visit.

- Patients with specific symptoms of medication aberrant behavior or misuse may be tested in accordance with the payer's guidance for monitoring patient adherence and compliance during active treatment (<90 days) for substance use or dependence.

Step 3: Verify Appropriate Diagnosis Codes

Appropriate ICD-9 codes that support medical necessity must be included in your claim. Palmetto offers the following guidance:

- For monitoring of patient compliance in a drug treatment program, use ICD-9-CM code V71.09 (Observation of other suspected mental condition) as the primary diagnosis and the specific drug dependence diagnosis as the secondary diagnosis. Examples of possible secondary diagnoses might include 304.21 (Cocaine dependence, continuous use), 304.32 (Cannabis dependence, episodic use), or 304.71 (Combinations of opioid type drug with any other drug dependence, continuous use).
- For the monitoring of patients on methadone maintenance and chronic pain patients with opioid dependence, suspected of abusing other illicit drugs, use code V58.69 (Long-term [current] use of other medications).

Remember that the physician should select the most appropriate diagnosis code. And, remember that labs are not to pre-populate requisition forms with a diagnosis. LCDs will prohibit "hard coding" a single ICD-9 code for every lab requisition, such as V58.83 (Encounter for therapeutic drug monitoring), rather than reporting a diagnosis specific to the patient.

Important update: A recent revision to the CCI Manual included information regarding validity testing on urine specimens. According to CCI, providers who perform validity testing on urine specimens used for drug testing should not separately bill the validity tests.

For example, the Manual states, "if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed. The Internet-Only Manual, Publication 100-04, Medicare Claims Processing Manual, Chapter 16 (Laboratory Services), Section 10 (Background) indicates that a laboratory test is a covered benefit only if the test result is utilized for management of the beneficiary's specific medical problem. Testing to confirm that a urine specimen is unadulterated is an internal control process that is not separately reportable."

"Not all of the Medicare contractors specifically addressed validity testing billing in their drug screen coverage policy," Hammer notes. "Now this addition will make it nationwide Medicare non-coverage."