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Pain Management Coding Alert

Procedure Focus: Remember 4 Things Before Coding Interlaminar Epidural Injections

Tip: Pay more attention to levels than frequency.

Pain management specialists frequently perform interlaminar epidural injections - but just because you code a procedure regularly doesn't mean you're doing it correctly. Read on for a refresher on what's important with these claims, and you can be confident you're distinguishing them from other common spinal injections.

1. Skip the Bilateral Modifier

If your interventional physician performs more than one interlaminar epidural injection in the same spinal region, you should not automatically append modifiers.

Here's why: When your provider injects a substance into the epidural space via an interlaminar approach, the drug diffuses throughout the epidural space. Depending upon the volume injected, the spread can be also be up or down one or more levels. The spreading eliminates the need to inject medication into both sides of the epidural space or at multiple consecutive levels to achieve the desired results. Therefore, you should not need to include modifier 50 (Bilateral procedure) on your claim to document that the provider treated the complete space.

2. Pay More Attention to Levels Than Injections

By the same token, multiple attempts to reach the same epidural space don't equal multiple procedures. You learn this because of the procedure descriptor for interlaminar epidural injections:

62311 - 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; lumbar or sacral (caudal).

Explanation: Code descriptions for interlaminar epidural injections do not include the term "level." The verbiage differs from transforaminal epidural injection code descriptions ("single level" or "each additional level"), because "level" refers to an individual vertebral segment. Code 62311 and related procedures (62310, 62318, and 62319) describe injections to an anatomic region (cervical, thoracic, lumbar, sacral, or caudal) rather than levels, or individual segments. Therefore, you only report 62311 once per date of service.

3. Verify Whether Separate Fluoro Is Acceptable

Most physicians use fluoroscopic guidance to pinpoint the injection site and ensure they inject medication into the correct location.

"CPT® continues to allow the fluoroscopic guidance to be reported with codes 62310 through 62319," says **Marvel J.Hammer, RN, CPC, CCS-P, ACS-PM, CPCO,** owner of MJH Consulting in Denver, Co. "However, that is not the case with Medicare."

Remember: As of Jan. 1, 2015, Medicare considers fluoroscopic image guidance to be part of the reimbursement for the epidural injection and not separately billable.

"Even though the NCCI edit allows a modifier to be used to bypass the edit, the only time a modifier should be used is when the image guidance is used with a different procedure," Hammer notes. "For this code set, it would be quite rare

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that the 77003 code would be used with a different procedure that would allow it to be separately billed. For many other spinal injection procedures that may be performed at the same setting as the epidural injection, their code descriptors already include image guidance and don't allow it to be separately billed."

One rare example of reporting both codes would be if the provider administers an epidural injection in the morning and then later in the day finds the need to do a diagnostic aspiration of the disc because of potential infection. The code for the aspiration would be 62267 (Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes), which does allow image guidance to be separately billed.

"The provider could use the 59 modifier with the 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural or subarachnoid]) because the image guidance was used with the different procedure from the epidural injection," Hammer says. "Again, this would be pretty rare."

4. Assign the Correct Diagnosis

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

- Chronic pain syndrome (G89.4)
- Low back pain (M54.5)
- Sciatica (M54.31 and M54.32)
- Disc displacement (M51.26-M51.27)
- Disc degeneration (M51.36-M51.37)
- Disc disorder with radiculopathy (M51.16-M51.17)
- Spinal stenosis, lumbar region (M48.06).

Check with the individual payer's coverage policy for diagnosis codes that meet their medical necessity requirements. For example, many payers don't cover interlaminar epidural injections for spondylosis with myelopathy. Remember, however, to always report the patient's condition and the physician's diagnosis, despite your expectations of coverage.

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