Pain Management Coding Alert

Procedure Spotlight: Get Familiar With Cryoablation and RF Lesioning Coding

Don't forget about these neurolytic destruction options.

Physicians can choose from several different techniques to accomplish the neurolytic destruction represented by codes such as 64600-64647 for somatic nerves and 64650-64681 for sympathetic nerves. You need to be familiar with two important techniques cryoablation and radiofrequency lesioning to code the most accurate claims.

Cryoablation Puts the Freeze on Things

Pain relief from the destruction of nerves following exposure to extreme cold is called cryoanalgesia, or cryoablation. The major advantage of this procedure is the absence of neuritis or neuroma formation, and prolonged analgesia with reversible effects (unlike chemical neurolysis). It has no systemic side effects and produces minimal tissue damage.

Neurologists and pain management specialists frequently use cryoablation to treat Morton's neuroma (G57.6-, Lesion of plantar nerve ...) or conditions affecting peripheral nerves. A few examples include:

- The coccygeal nerve for coccydynia (M53.3, Sacrococcygeal disorders, not elsewhere classified)
- The lateral femoral cutaneous nerve (G57.1-, Meralgia paresthetica), with the fifth character indicating right or left
- The intercostal nerve for chronic post-thoracotomy pain (G89.22).

Cryoablation is performed as an outpatient procedure. The results usually last for six to twelve months.

Radiofrequency Lesioning Heats It Up

Radiofrequency (RF) lesioning is the application of electrical current to promote thermocoagulation and nerve destruction. Physicians use this technique to ablate pain pathways in numerous locations:

- Trigeminal ganglion
- Dorsal root ganglion
- Sympathetic chain
- Facet joints
- Peripheral nerves.

Since RF lesioning causes nerve destruction, physicians resort to this technique only as an "end of the line" therapeutic modality when other measures have failed (such as single or dual diagnostic injections to confirm that a nerve is the source of the patient's pain).

"Many payers require the patient have severe pain-limiting activities of daily living for at least three months despite documented conservative treatments such as structured exercise, formal physical therapy within the past six months, activity modification, weight loss, and/or drug therapy," explains **Marvel Hammer, RN, CPC, CCS-P, ACS-PM, CPCO,** owner of MJH Consulting in Denver, Co.

"The conservative treatment requirements vary depending upon anatomic source of the chronic pain as well as the individual payers," she adds. "It is best to check with the patient's insurance coverage policies to make sure that all requirements are met and documented."

Most physicians must use image guidance during RF lesioning to ensure proper needle placement. Image guidance may or may not be included in the CPT® procedure code, depending upon the anatomic location.

For example, fluoroscopic or CT imaging is included in codes 64633-64636 and not separately billable. The fluoroscopic guidance code 77002 (Fluoroscopic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device]) is included in 64620 for intercostal nerve destruction, but CT guidance code 77012 (Computed tomography guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], radiological supervision and interpretation) is not. In contrast, neither fluoroscopic nor CT image guidance is bundled into the peripheral nerve destruction code 64640.

"Coders need to check the bundling edits for the image guidance used with the specific CPT® code for the RF ablation," Hammer recommends.

Potential complications: As with many procedures, RF lesioning carries some potentially negative outcomes. For example, the patient's pain might be worse after the procedure than beforehand or the patient might experience numbness, motor paralysis, or incomplete pain relief. Always be sure the patient knows these risks and signs a written informed consent prior to the procedure.

Last resort: When neurolytic destruction does not help the patient long-term, the final treatment options involve neurosurgical procedures. The basic intent is to interrupt sensory pathways to the brain or in the brain and brain stem, which alters the transmission or perception of pain. Your physician might refer the patient to a neurosurgeon for one of these invasive treatment modalities, including:

- Neurectomy
- Cranial neurectomy
- Peripheral neurectomy
- Sympathectomy
- Cordotomy
- Commissurotomy
- Mesencephalotomy
- Thalamotomy
- Cingulotomy

The effectiveness of these techniques in providing permanent pain relief varies and, in some instances, wrought with side effects.

Editor's note: For more on chemical neurolysis, see "Build Your Knowledge of Neurolytic Destruction Options" in Pain Management Coding Alert, Vol. 2, N. 12.