Codify
BY AAPC

Pain Management Coding Alert

Reader Question: Verify Medical Necessity to Combat SCS Analysis Denials

Question: A few months ago, Medicare started denying all our claims for spinal cord stimulator analysis. The reason is "service not covered and not medically necessary." We're reporting codes 95970-95973. What do we need to do to get paid again?

Virginia Subscriber

Answer: There are not any CCI edits between the 95970-95973 codes and the E/M or spinal cord stimulator codes. In addition, this Medicare jurisdiction has an local coverage determination (LCD) for spinal cord stimulators, but it does not include these codes or specifically address analysis or programming. Start by trying to identify the reason for the denial; check with your Medicare contractor for additional information regarding the denial reason.

Ensure that there is medical necessity for the analysis/programming as well as documentation for those codes. Some are time based, which would require documentation of the time spent in programming. Also remember the parameters that were changed/addressed in that simple programming (95971) of the neurostimulator generator includes changes to three or fewer of the following parameters: rate, pulse amplitude, pulse duration, pulse frequency, eight or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, alternating electrode polarities, dose time (stimulation parameters changing in time periods of minutes including dose lockout times), more than one clinical feature (e.g., rigidity, dyskinesia, tremor). In contrast, complex programming (codes 95972 and 95973) include changes to more than three of the parameters.