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Coding Pain Management Services

Audio Seminar / Webinar

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Practical Tools for Seminar Learning

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The faculty has reported no vested interests or disclosures regarding this presentation.

Faculty

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Ms. Harder has been a consultant with 3M Health Information Consulting Services since November 2002. She is responsible outpatient coding validation audits, coder education, and ambulatory prospective payment billing audits as well as physician service reviews. In addition Michelle answers client questions regarding coding, billing and charging in the outpatient arena. She has fifteen years of specialized coding experience in the areas of emergency medicine, ambulatory surgery, and ancillary services. Her previous professional experience includes coding, data analysis, statistical reporting, and documentation compliance.

Ms. Harder holds a Bachelor of Arts degree in Business Administration from Eastern Washington University and an Associate of Science Degree in Health Information Technology from Spokane Community College. She is a member in good standing with American Health Information Management Association, North Carolina Health Information Management Association and The American Academy of Professional Coders.

Robert C. Holdenwang, RHIA

Rob is a Senior Manager with 3M Health Information Systems, Consulting Services in Atlanta. Rob has greater than 25 years experience in Health Information Management, managing under different levels of management in facilities ranging from 200 beds to 1450 beds for for-profit, non-profit, and teaching institutions.

Rob has experience in Health Information Management Departments including coding, abstracting, transcription, tumor registry, corporate compliance, and quality management. He has also implemented and converted several systems including Transcription, Coding, Master Patient Index, and Hospital Wide Systems. He has prepared for regulatory surveys such as HCFA, Joint Commission and Tumor Registry. He has led teams on Confidentiality, Ethics, and Team Building issues.

Preparation of Seminar Materials

Audrey G. Howard, RHIA

Audrey is a Senior Consultant with 3M Health Information Systems, Consulting Services (3M HIS/CS). She has consulted on numerous healthcare engagements nationally involving coding validations, coding education, coding process improvement, quality and compliance reviews as well as participating in the delivery of 3M's concurrent DRG ASSURANCE™ program. She is responsible for performing coding research and providing support for client coding questions. Audrey resides on 3M HIS/CS coding roundtable and also contributes to 3M HIS/CS Quarterly Newsletter. In addition, she researches and develops numerous training materials and manuals. Audrey also authors coding columns in the *For the Record* publication.

Audrey has over 16 years of experience in Health Information Management. During her professional career, she has functioned as a coder, senior DRG technician, coding supervisor, assistant director of a Health Information Management Department and consultant. Her duties as assistant director included daily operations, managing bill hold, educating coding staff, and supervising release of information. As assistant director, she also computerized the coding process and streamlined the workflow. Her teaching experience includes advanced coding classes and documentation programs related to reimbursement, coding, compliance, severity and risk profiling. Audrey has worked with very large university hospitals, as well as multi-hospital systems to implement documentation improvement programs.

Audrey is a Registered Health Information Administrator. She earned her Bachelor of Science degree in Health Information Management from the University of Kansas in Lawrence, Kansas.

Table of Contents

Objectives

- **Discuss types of conditions that require pain management services**
- **Discuss pain management procedures**
- **Review ICD-9-CM and CPT codes related to pain management**
- **Review coding guidelines related to pain management services**

1

2

Acute vs. Chronic Pain

2

Acute vs. Chronic Pain

- **Acute pain:**
  - **Begins suddenly**
  - **Sharp feeling**
  - **Range from mild to severe**
  - **Lasts a few minutes or a few weeks or months**
    - **Typically does not last longer than six months**
  - **Resolved when the underlying cause of the pain is identified and treated**
  - **May be caused by one of the following:**
    - **Surgery**
    - **Fractured bones**
    - **Dental work**
    - **Burns or cuts**
    - **Labor/childbirth**

3

Acute vs. Chronic Pain

- **Chronic pain:**
  - **May be caused from unrelieved acute pain**
  - **May persist even though the underlying injury has healed**
  - **Common effects of chronic pain may include:**
    - **Tense muscles**
    - **Limited mobility**
    - **Lack of energy**
    - **Change in appetite**
    - **Depression**
    - **Anger**
    - **Anxiety**

4

Codes for Common Pain Conditions

- **Dorsopathies Section**
  - **Categories 720-724 include**
    - **spinal stenosis, herniated intervertebral discs, degenerative disc disease, radiculopathies, and sacroiliitis**
- **RSD reflex sympathetic dystrophy**
  - **337.29**
- **Trigeminal neuralgia**
  - **350.1 Trigeminal neuralgia**
  - **350.2 Atypical face pain**
  - **053.12 Postherpetic trigeminal neuralgia**

5

6

ICD-9-CM Diagnostic Codes

6

ICD-9-CM Diagnostic Codes

- **Conditions classified to category 338, Pain, not elsewhere classified:**
  - **338.0, Central pain syndrome**
    Dejerine-Roussy syndrome
    Myelopathic pain syndrome
    Thalamic pain syndrome (hyperesthetic)
  - **338.11, Acute pain due to trauma**
  - **338.12, Acute post-thoracotomy pain**
    Post-thoracotomy pain NOS

7

ICD-9-CM Diagnostic Codes

- **Conditions classified to category 338, Pain, not elsewhere classified:**
  - **338.18, Other acute postoperative pain**
    Postoperative pain NOS
  - **338.19, Other acute pain**
  - **338.21, Chronic pain due to trauma**
  - **338.22, Chronic post-thoracotomy pain**
  - **338.28, Other chronic postoperative pain**
  - **338.29, Other chronic pain**

8

ICD-9-CM Diagnostic Codes

- **Conditions classified to category 338, Pain, not elsewhere classified:**
  - **338.3, Neoplasm related pain (acute) (chronic)**
    - **Cancer associated pain**
    - **Pain due to malignancy (primary) (secondary)**
    - **Tumor associated pain**
  - **338.4, Chronic pain syndrome**
    - **Chronic pain associated with significant psychosocial dysfunction**

9

ICD-9-CM Diagnostic Codes

- **Generalized pain (780.96) is assigned to classify unspecified pain**

10

Coding Guidelines for Pain

Note:
Applies to all health care settings

11

Coding Guidelines

Pain – Category 338

- **It is appropriate to assign codes from other categories and chapters with codes from category 338 to further identify the acute or chronic pain and the neoplasm-related pain, unless otherwise indicated in these guidelines.**

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12

Coding Guidelines

Pain – Category 338

- **Do not assign codes from category 338 if the pain is not specified as acute or chronic, except for post-thoracotomy pain, postoperative pain, neoplasm related pain, or central pain syndrome.**

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13

Coding Guidelines

Pain – Category 338

- **Do not assign a code from subcategories 338.1 and 338.2 if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/management and not management of the underlying condition.**
- **Note: The term "encounter" is used for all settings, including hospital admissions**

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14

Coding Guidelines

- **A code from category 338 should be sequenced as principal diagnosis or first-listed code when:**
  - **The reason for admission is for pain control or pain management**
    - **Code the underlying cause of the pain as a secondary diagnosis**
  - **The reason for admission is for insertion of a neurostimulator for pain control**
    - **If admission is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted during the same admission, assign a code for the underlying condition should be sequenced as the principal diagnosis or first-listed code**
      - **Assign the appropriate pain code as a secondary diagnosis**

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15

Coding Guidelines

Pain – Category 338

- **A code for the underlying condition will be sequenced as the principal diagnosis or first-listed code when a patient is admitted for a procedure aimed at treating the underlying condition**
  - **Do not assign a code from category 338 in this situation**

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16

Coding Guidelines

Pain – Category 338

- **It is appropriate to assign a code from category 338 with another site-specific code if the code from category 338 provides additional information.**

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17

Coding Guidelines

- **Sequencing of these two codes will depend on the circumstances of admission with the following two exceptions:**
  - **If the reason for admission is for pain control/management, then the code from category 338 is sequenced as principal diagnosis or first-listed code followed by the site-specific pain code.**
  - **If the reason for admission is for any other reason other than pain control/management and a related definitive diagnosis has not been established, then the site-specific pain code will be sequenced as the principal diagnosis or first-listed code with the code from category 338 sequenced as a secondary diagnosis.**

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18

Coding Guidelines

Pain – Category 338

- **Pain due to a device, implant and graft is assigned to the appropriate code from Chapter 17, Injury and Poisoning**
  - **Assign a code from category 338 to identify if pain is acute or chronic**

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19

Coding Guidelines

Pain – Category 338

- **There is no time frame that identifies when the pain can be defined as chronic**
  - **Code assignment is based on physician's documentation**

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20

Coding Guidelines

Pain – Category 338

- **The diagnosis of chronic pain syndrome is not the same as chronic pain. Assign the code for chronic pain syndrome only when that diagnosis has been documented by the physician**

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21

Coding Guidelines

Pain – Category 338

- **Postoperative pain and post-thoracotomy pain not specified as acute or chronic defaults to the code for the acute type.**
  - **Do not assign a code for the postoperative pain if it is routine or expected after surgery**
  - **Assign a code from category 338 when postoperative pain is not associated with a specific postoperative complication**

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22

Coding Guidelines

Pain – Category 338

- **If postoperative pain is associated with a specific postoperative complication, assign the appropriate code from Chapter 17**
  - **Assign a code from category 338 to identify if pain is acute or chronic, if appropriate**

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23

Coding Guidelines

Pain – Category 338

- **Sequence the postoperative pain code as the principal diagnosis or first-listed code when the patient is admitted for postoperative pain control or pain management**
- **Sequence the postoperative pain code as a secondary diagnosis when the patient develops "unusual or inordinate amount of postoperative pain" after outpatient surgery**

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24

Coding Guidelines

- **Neoplasm related pain**
  - **Assign code 338.3, Neoplasm related pain, for a patient that has pain that is related to, associated with, or due to cancer (either primary or secondary) or tumor regardless if the pain is acute or chronic.**
  - **Code 338.3 includes:**
    - **Cancer associated pain**
    - **Pain due to malignancy (primary) (secondary)**
    - **Tumor associated pain**

continued on next slide

25

Coding Guidelines

- **Neoplasm related pain (continued)**
  - **Code 338.3 is sequenced as the principal diagnosis or first-listed code if the reason for admission is for pain control/management**
    - **Assign a code for the malignancy as a secondary diagnosis**
  - **Code 338.3 may be sequenced as a secondary diagnosis if the reason for admission is for management of the neoplasm and the neoplasm related pain is also documented**

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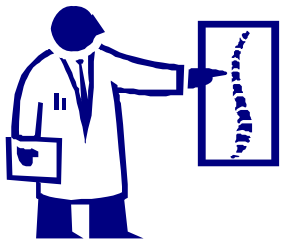
26

Polling Question

A patient is admitted with severe low back pain which has been getting progressively worse over the last 6 months. After study, the physician documents the pain is due to lumbar stenosis. The patient is treated with pain medication during this admission and will be scheduled for surgery soon.



27

Polling Question

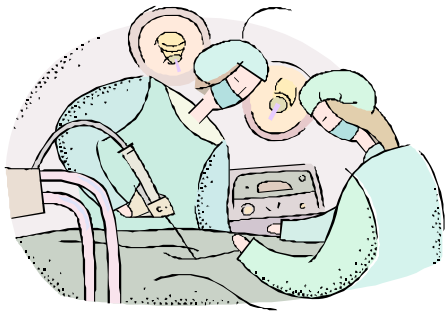
Which of the following codes should be sequenced as the principal diagnosis?

- ***1 724.2, Low back pain (lumbago)**
- ***2 338.19, Acute pain**
- ***3 724.02, Spinal stenosis of the lumbar region**
- ***4 338.29, Chronic pain**

28

29

Pain Management Procedures CPT Coding



29

Pain Management Procedures

- **Injections**
- **Destruction by Neurolytic Agent**
- **Intrathecal Catheters with Subcutaneous Pump Delivery Systems**
- **Spinal Neurostimulators**
- **Epidural Neurolysis**
- **IDET – Intradiscal Electrothermal Therapy**

30

Injections

Questions to ask:

- **When reporting spinal injections keep these key questions in mind and it will help you determine which series of codes to use.**
- **What is the approach?**
  - **Epidural, transforaminal, facet**
- **What is being injected?**
  - **Anesthetic, steroid, contrast, neurolytic agent**
- **What regions are treated?**
  - **Regions: cervical, thoracic, lumbar, sacral**
- **How many levels are treated?**
  - **One or more than one level**
- **Is it a unilateral or a bilateral injection?**

31

Injections

- **Epidural injections**

  The approach for an epidural injection is directly into the epidural space between vertebrae. The purpose is to relieve cervical or neck pain; thoracic or midback pain; lumbar or low back pain.

- **Transforaminal injections**

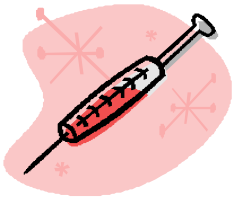
  The approach for a transforaminal injection is by way of the intervertebral foramen. There are two foramen for each vertebra on opposite sides of the spine. The needle is inserted to gain access to the epidural space and nerve root.

- **Facet joint or facet joint nerve injections**

  The approach for facet injections are by way of the intravertebral facets. Each vertebra has four facets. Injections are performed to block the pain signals from the facet joint of the spine and associated nerves to the brain.

32

Injections



Epidural injections

Injection single of diagnostic or therapeutic, epidural or subarachnoid;

62310 **cervical or thoracic**

62311 **lumbar, sacral (caudal)**

- **Medication is administered with needle injection into the epidural space.**
- **Injection procedures are considered unilateral and should be reported once per level per side.**
  Reference: AMA *CPT Assistant,* November 1999.
- **Multiple injections at the same level on the same side are reported one time only**

33

Injections

- **Epidural injections by infusion or bolus**
- **62318 Injection, including catheter placement, continuous infusion or intermittent bolus not including neurolytic substances with or without contrast (for either localization or epidurography) of diagnostic or therapeutic substance(s) (including anesthetic antispasmodic opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic**
- **62319 lumbar, sacral (caudal)**
- **Medication is administered by infusion or bolus**
- **Catheter placement is in included in these codes**

34

Injections
Fluoroscopy and Epidurography

Fluoroscopy

- **77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction**
- **Report any fluoroscopic guidance necessary for placement of the needle.**

Epidurography

- **72275 Epidurography, radiological supervision and interpretation**
- **If epidurography is performed report only if the images are documented and formal radiological report is given. Fluoroscopy would not be reported when performed with the epidurography.**

35

Example

The patient was placed in a prone position. Using fluoroscopic guidance a 18-gage Tuohy needle was placed in the L4 – L5 vertebral interspace. Injected contrast confirmed accurate placement of the needle. Then a mixture of Depo Medrol 80 mg, normal saline 10 cc and lidocaine 1% at 5 cc was injected with good results.

CPT code assignment: 62311, 77003

36

Injections

Transforaminal epidural injections

- **Report modifier 50 for bilateral injections at the same level**
- **Report each level that an injection is given**
- **Report codes appropriate for the treated region of the spine**

Fluoroscopic guidance necessary for placement of the needle (77003) would also be reported.

Physician coding

- **Do not report modifier 51 with the add on codes for additional levels**

Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic	**single level 64479** **each additional level 64480**
Lumbar or sacral	**single level 64483** **each additional level 64484**

37

Example

Patient was placed in prone position. Prepped and draped in usual sterile fashion. Needles were introduced into the left epidural space through the intervertebral foramen at C2-C3 and C3-C4 levels. Fluoroscopic guidance and contrast injection confirmed needle placements. A mixture of Depo-Medrol and lidocaine was injected at both levels with excellent results.

- **Code assignment 64479-LT, 64480-LT, 77003**

38

Injections

Facet joint or joint nerve injection

- Report modifier 50 for bilateral injections at the same level
- Report each level that an injection is given
- Report codes appropriate for the treated region of the spine

Fluoroscopic guidance necessary for placement of the needle (77003) would also be reported.

Physician coding

- Do not report modifier 51 with the add on codes for additional levels

Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic	single level 64470 each additional level 64472
lumbar or sacral	single level 64475 each additional level 64476

39

Polling question

This Medicare patient is given facet joint injections of the lumbar spine at the L2, L3, and L4 levels bilaterally. Fluoroscopic guidance is used. What codes should be reported for the facility?

***1 64483-50, 64484-50, 64484-50, 77003**
***2 64475-50, 64476-50, 64476-50, 77003**
***3 62311-50, 62311-50, 62311-50, 77003**
***4 64475-50, 64476-50-51, 64476-50-51, 77003-26**

40

Injections

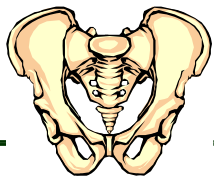
- **Trigger point injections**

  Trigger point is an area of soft tissue or surrounding muscle that is painful. Anesthetic and/or steroid are injected in the area to relieve pain. The description may include "injections administered by fan technique".
- **Injection(s); single or multiple trigger point(s),**
  - **20552 one or two muscles**
  - **20553 three or more muscles**

- **Report one code per session based on the number of muscles injected not the number of injections given.**
- **20552 and 20553 would not be reported together.**
- **Report fluoroscopic needle placement guidance with 77002**

41

Injections



Sacroiliac Joint Injections

- **The sacroiliac joint connects the sacrum to the pelvis. The injection alleviates pain most often produced by sacroiliitis.**
- **In order to report these procedures correctly answer the following questions:**
  - **Is the procedure performed in an OPPS hospital or ASC?**
  - **Is the patient's primary payer Medicare?**
  - **Is the purpose of the injection to inject a steroid or anesthetic (therapeutic) or to perform arthrography (diagnostic)?**
  - **Is the injection unilateral or bilateral?**

42

Injections

Sacroiliac Joint Injections

- **Facility**
  - **Hospitals and ASCs must report these injections for Medicare patients with HCPC level II Codes**

  Injection procedure for sacroiliac joint;
  - **G0259 arthrography**
    - **73542 sacroiliac joint arthrography should also be reported**
    - **Separate fluoroscopic guidance would not be reported in addition to the arthrography**
  - **G0260 provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography**
    - **77003 for the fluoroscopic guidance if performed without arthrography and 73542 if performed with arthrography (77003 would not be reported if arthrography is performed).**
  - **Report modifier 50 for bilateral injections**

43

Injections

Sacroiliac Joint Injections

- **Physician**
  - **27096 Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid**
    - **If the purpose of the injection was for arthrography then the injection code 27096 would be reported with the radiological examination using 73542-26.**
    - **Fluoroscopy would not be reported in addition to the arthrography.**
  - **If the purpose of the injection was for therapeutic purposes report 27096 and the fluoroscopic guidance 77003-26.**

44

Destruction by Neurolytic Agent

- **Radiofrequency ablation procedures are reported with the appropriate destruction codes. "Neurolytic agent" includes chemical, thermal, electrical or radiofrequency.**
- **Paravertebral Facet**
- **Trigeminal**

45

Destruction by Neurolytic Agent

Paravertebral facet radiofrequency ablation.

- **Report modifier 50 for bilateral injections at the same level**
- **Report each level that in injection is given**
- **Report codes appropriate for the region of the spine**

Fluoroscopic guidance necessary for placement of the needle (77003) would also be reported.

Coding for physician do not report modifier 51 with the add on code for additional levels.

Destruction by neurolytic agent; cervical or thoracic	**single level 64626** **each additional level 64627**
lumbar or sacral	**single level 64622** **each additional level 64623**

46

Destruction by Neurolytic Agent

- **Trigeminal rhizotomy may be performed by radiofrequency ablation or by neurolytics.**
- **Trigeminal ablations are performed to treat trigeminal neuralgia or tic douloureux. This is a condition of the fifth cranial nerve thought to be cause by compressive venous or arterial loops in the face. The intense pain caused by this condition is often triggered by activities such as chewing or teeth brushing. It is sometimes referred to as the "suicide disease" because patients are driven to take their own life due to intense pain and failure to obtain effective treatment.**

47

Destruction by Neurolytic Agent

- **Destruction by neurolytic agent trigeminal nerve;**
  - **64600 supraorbital, infraorbital mental or inferior alveolar**
  - **64605 second and third division at the foramen ovale**
  - **64610 second and third division at the foramen ovale with radiologic monitoring**
  - **Report modifier 50 for bilateral injections at the same level**

48

Example

DESCRIPTION: The patient was brought to the general operating room, placed on the table in the supine position, and light general intravenous sedation was established by anesthesia. A lateral fluoroscopic image of the skull was established, and then the right cheek was prepared and draped in the usual sterile fashion for glycerin rhizotomy. The cheek was infiltrated with 1% Xylocaine, and then utilizing external landmarks and an internal finger in the lateral pterygoid wing, a long 20-gauge spinal needle was passed to the level of the foramen ovale. This was done with some degree of difficulty, but eventually it was possible to guide the tip of the needle to the level of the clivus under fluoroscopic control.

The stylette was withdrawn with no initial return of cerebrospinal fluid, and then advanced until there was some cerebrospinal fluid. The head of the bed was then elevated to 60 degrees, and 0.4 cc of anhydrous glycerin slowly injected. There was no bradycardia. The needle was withdrawn and the patient was left in the 60-degree head-up position and taken to the recovery room in satisfactory condition. Code: 64610

49

Intrathecal Catheters and Pain Pumps

Pain pumps deliver anesthetic to the area of pain along the spine. There are two parts to the delivery system. The intrathecal/subdural catheter and the subcutaneous pump.

1) The intrathecal/subdural catheter

- **62350 Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy**
- **62351 with laminectomy**
  - Device code C1755
- **Report 62350, 62351 only if this is a tunneled catheter; percutaneous placement is reported with the injection codes**
- **Report additional codes for pump placement.**

50

Intrathecal Catheters and Pain Pumps

2) The subcutaneous pump device

- **62361 Implantation or replacement of device for intrathecal or epidural drug infusion; non programmable pump**
  - Device code C1891
- **62362 programmable**
  - Device code C1772
- ***Currently there is not a device/procedure edit for the medication pumps and catheter but CMS requires the reporting of HCPCS Level II codes and the charges for those devices by OPPS Hospitals or ASCs if code exists.***
- **Pocket creation is included with the implanted pump placement**

51

Intrathecal Catheters and Pain Pumps

Programmable pump electronic analysis

- **62367 electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming**
- **62368 with reprogramming.**

According to NCCI, programmable pump analysis with or without reprogramming are components of the pump placement (62361, 62362) and therefore not reported together

Refilling of the implantable pump can be reported with CPT codes (95990-95991)

52

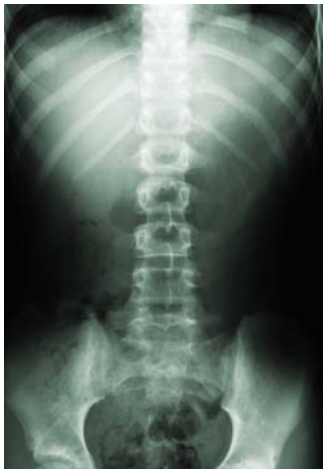
Neurostimulators – Spinal

- **Neurostimulators include a pulse generator, receiver/transmitter, and the lead which may be a plate or paddle or a catheter with multiple contacts (array)**
- **Lead placement**
  - **63650 Percutaneous implantation of neurostimulator electrode array, epidural**
  - **63655 Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural**
- **Generators (implantable)**
  - **63685 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling**

53

Neurostimulators – Spinal

- **Devices**
  - **Lead C1778**
  - **Generator**
    - **C1820 rechargeable**
    - **C1767 non rechargeable**
  - **Receiver transmitter C1816**
  - **Currently there is not a device/procedure edit for the medication pumps but CMS requires the reporting of HCPCS Level II codes and the charges for those devices by OPPS Hospitals or ASCs if they exist**



54

Neurostimulators – Spinal

- **Intraoperative neurostimulator testing and reprogramming of the device.**
  - **When the physician places the neurostimulator and programming is documented the type of programming is dependant on the description of the tested generator. The generator is considered simple or complex if it affects:**
    "pulse amplitude, pulse duration, pulse frequency, 8 or more electrode contacts, cycling, stimulation train duration, train spacing, number of programs, number of channels, phase angle, alternating electrode polarities, configuration of wave form, more than 1 clinical feature (eg, rigidity, dyskinesia, tremor)".
    - **95971 Simple- 3 or less of the above**
    - **95972 Complex- 3 or more of the above**

55

Epidural Adhesiolysis

- **The purpose of epidural adhesiolysis is to dissolve scar tissue around the spinal nerves. Two methods include a direct endoscopic approach or epidural lysis performed by infusion and/or mechanical techniques (i.e. catheter).**
- **Both techniques include:**
  - **Insertion and removal of epidural catheter**
  - **Multiple injections of neurolytics**
  - **Lysis of adhesion by mechanical means**
  - **Fluoroscopic guidance (77003) and epidurography (72275)**

56

Epidural Adhesiolysis

- **62263 Percutaneous lysis of epidural adhesions using solution injection (eg, catheter) including radiological localization (inclusions contrast when administered) multiple adhesiolysis sessions; 2 or more days**
  - **Catheter is placed, multiple injections, performed treatment lasts two days or longer**
  - **code is reported one time**
- **62264 1 day**
  - **Catheter is placed, multiple injections performed, treatment lasts one day**
  - **code is reported one time**
- **0027T Endoscopic lysis of epidural adhesion with direct visualization using mechanical means (eg, spinal endoscopic catheter system) or solution injection (eg, normal saline) including radiologic localization and epidurography**

57

IDET

- **IDET = Intradiscal Electrothermal Therapy Annuloplasty**
- **The application of heat to the intervertebral disc in order to relieve pain. The process collapses the collagen fibers shrinks the disc relieving pressure.**
- **As of January 2007 report these services with codes:**
  - **22526 Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level**
  - **22527 on one or more additional levels (List separately in addition to code for primary procedure)**
- **Unilateral annuloplasty should not be reported with reduced services modifier 52**
- **Fluoroscopic guidance and discography is included and should not be reported separately**

58

Notes/Comments/Questions

IDET

- **Annuloplasty performed by other methods should be reported with temporary codes:**
  - **0062T Percutaneous intradiscal annuloplasty, any method except electro thermal unilateral or bilateral including fluoroscopic guidance; single level**
  - **0063T one or more additional levels (list separately in addition to 0062T for primary procedure)**
- **NCCI policies regard the following procedures as components of the annuloplasty**
  - **cervical or thoracic discography 72285**
  - **lumbar discography 72295**
  - **fluoroscopic guidance 77003**

59

Post Operative Pain Management

- **Postoperative pain blocks may be reported if documentation supports the blocks were performed separately from the anesthesia given during surgery.**
- ***"CPT codes 62310-62311 and 62318-62319 may be reported on the date of surgery if performed for postoperative pain relief rather than as the means for providing the regional block for the surgical procedure. If a narcotic or other analgesic is injected through the same catheter as the anesthetic, CPT codes 62310-62319 should not be billed. Modifier -59 will indicate that the injection was performed for postoperative pain relief but a procedure note should be included in the medical record."***
- **Reference: NCCI General Correct Coding Policies, Chapter II Anesthesia Service and AMA's CPT Assistant, October 2001**

60

Polling question

Patient had an arthroscopic acromioplasty of the right shoulder. Patient was given IV sedation and a brachial plexus block for anesthesia. Postoperatively the patient was given a second block administered through the same catheter.

Postoperative block 64415 should be billed with a modifier 59.

- ***1 True**
- ***2 False**

61

References

- **AMA's *CPT 2008 Professional Addition***
- **AMA's *CPT Assistant***
  - **November 1999**
  - **January 2000**
  - **October 2001**
  - **December 2002**
  - **September 2004**
  - **September 2007**
- **National Correct Coding Initiatives**
- **Epidural Adhesiolysis for the Treatment of Back Pain**
  - Health Technology Assessment ,July 13, 2004 Molly Belozer and Grace Wang, Office of the Medical Director, Washington State Department of Labor and Industries
- **American Society of Pain Physicians**
  - **http://www.painphysicianjournal.com**
- **Other helpful web sites**
  - **http://medical-dictionary.thefreedictionary.com**
  - **http://www.spine-health.com**
  - **http://www.mtdaily.com**

63

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Postponed to April 24, 2008

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Faculty: **Deresa Claybrook, RHIT and Susan Mitchell, RN**

April 10, 2008

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