Health Policy Review

A Seamless Navigation to ICD-10-CM for Interventional Pain Physicians: Is a Rude Awakening Avoidable?

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Since October 1, 2015, the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) was integrated into U.S. medical practices. This monumental transition seemingly occurred rather unceremoniously, despite significant opposition and reservations having been expressed by the provider community. In prior publications, we have described various survival strategies for interventional pain physicians.

The regulators and beneficiaries of system – CMS, consultants, and health information technology industry are congratulating themselves for a job well done. Nonetheless, this transition comes at an immeasurable financial and psychological drain on providers. However, a rude awakening may be making its way with expiration of initial concessions from government and private payers.

This manuscript provides a template for interventional pain management professionals with multiple steps for seamless navigation, including descriptions of the most commonly used codes, navigation through ICD-10-CM manual, steps for correct coding, and finally, detailed coding descriptions for various interventional techniques.

Key words: ICD-9-CM (International Classification of Diseases, Ninth revision, Clinical Modification), ICD-10, ICD-10-CM (International Classification of Diseases, 10th Revision), Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology (HIT)

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Implementation of International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) started on October 1, 2015. This occurred against a backdrop of anxiety and concern for independent practitioners, including interventional pain management (IPM) physicians who have faced numerous regulatory burdens and reimbursement cuts in recent years (1-9). The deleterious effects of ICD-10-CM and other regulations on independent practices have been well described in recent years (1-21). With the October 1, 2015 implementation, ICD-10 became another in a series of unfunded mandates requiring independent practitioners to invest their time, personnel, and energies in this extremely complicated and challenging classification system. (22-29).

Since October 1, 2015, practitioners are feeling the aftershocks, in varying degrees, of this seismic event (30-32). Experience from other countries that have implemented ICD-10 might theoretically provide some insights into issues which are facing US providers (1,3,30-32). In fact, in some countries, without so much billing and coding and with universal health care systems with very little independent practice, providers have suffered significant losses, seemingly associated with the use of ICD-10 (30-32). The United Kingdom switched to ICD-10 in 1995, France in 1996, Australia in 1998, and Canada in 2004. However, none of these countries have increased their codes by ten-fold, as has been done in the United States (Fig. 1). Further, these countries have utilized ICD-10 as prepared by

the World Health Organization (WHO). In contrast, the United States has utilized an extremely bureaucratic approach, largely keeping physicians out of loop with management by 4 non-physician groups, described as cooperating parties, which have included primarily the American Health Information Management Association (AHIMA), an inconspicuous organization which has become powerful and extremely profitable and the American Hospital Association (AHA), with its own interests as active partners. The Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) were, by comparison, relatively nominal partners in the overall process (1). Others involved have included Blue Cross Blue Shield Association and 3M, as coalition partners, both deriving substantial benefits. Specifically, 3M has made substantial profits from the development of the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) codes, with a rather poorly designed ambulatory payment classification (APC) software, which is proliferating nationwide (1). Thus, the implementation in other countries has very few similarities to that of the United States. The agency with the most, albeit limited impact, the CDC, has been using ICD-10 since 1999 (24). It is feared that now with expansion, data may actually become unusable (24). Canada with its universal health care system demonstrates the best examples of the aftershocks (30-32). It followed a staggered transition to the ICD-10 modification system, known as the International Classification of Diseases, 10th Revision, Canada (ICD-10-CA) from 2001 to 2005. Canada decided in 1995 for an adaptation of the ICD-10, and planned for transition. The Canadian productivity has dropped by 50% immediately following implementation and it took several years to return to the pre ICD-10 levels. Despite the fact that it does not involve billing and coding for practices as in the United States. Ironically, by some accounts Canada is still recovering from implementation of ICD-10.

Understanding that criticism of ICD-10-CM will not yield results, it is our goal to not only develop survival strategies (1) but, rather, to describe seamless navigation for interventional pain management. Bearing that in mind, experts are already predicting a rude awakening on its way (10). Providers might be developing a false sense of security which will be challenged as CMS and private insurers start becoming more aggressive in their coding expectations and requirements.

The purpose of this manuscript is to provide critical and important information to the interventional pain physicians by identifying the most commonly used procedures and codes; to describe steps to navigating through ICD-10-CM for correct coding; and finally, to clearly present important strategies to deal with denials and survive into the future with the minimization of damage to your practice.

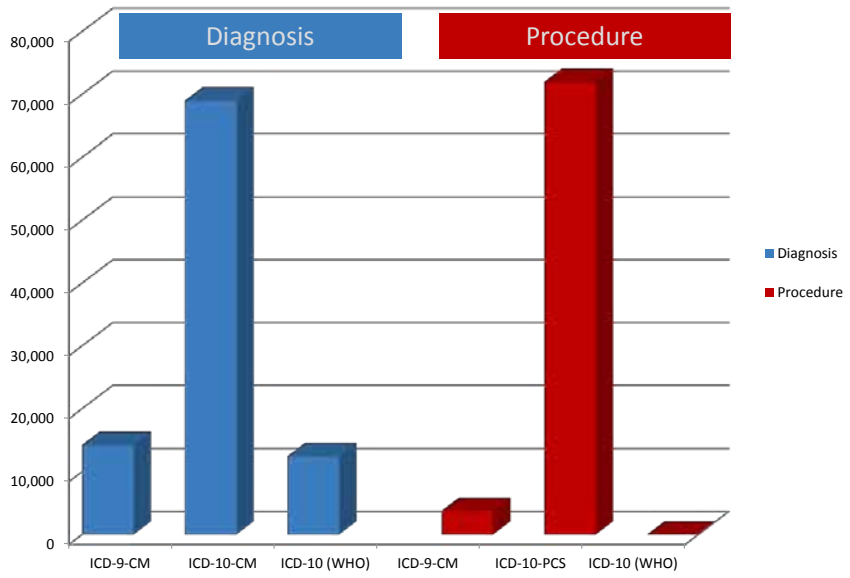

Fig. 1. *ICD-10-CM/PCS growth of codes.*

Seamless Navigation

The foremost essentials for a seamless navigation are as follows:

1. Direct Participation

It is essential not only to purchase ICD-10-CM manuals, but to study and carefully review these manuals.

2. Evolving and Dynamic Process

ICD-10-CM implementation is an evolving and dynamic process. Consequently, practices must continue training their physicians and staff for success with ICD-10-CM coding.

3. Documentation, Documentation, Documentation

Documentation is even more important now in the era of ICD-10-CM with the current appetite for denials, levels of scrutiny, and fraud and abuse investigations. In fact, among the top 5 stressors to physicians, 4 of them are related to documentation including meaningful use, value-based payments, alternate payment systems, and now ICD-10-CM. The documentation is also important for value-based purchasing with the Physician Quality Reporting System (PQRS) and meaningful use for EMR compliance (9,10,33).

- The essence of proper documentation incorporates PC RC TC, in addition to legibility.
  1. PC: Precision and clarity
  2. RC: Reliability and consistency
  3. TC: Timely completion and comprehensive information

4. Most Commonly Used Codes

It is crucial to develop a strategy with identification of the most commonly performed procedures and their related ICD-10-CM codes. Based on utilization patterns as shown in Table 1 and Fig. 2 (34), spinal procedures constitute over 90% of the procedures and other types of nerve blocks constitute 9%. Among these, epidural procedures, including adhesiolysis pro-

Table 1. *Utilization of frequency of interventional techniques in the Medicare population from 2000 to 2013.*

	Medicare Beneficiaries (Thousands)	Epidural procedures		Adhesiolysis procedures		Facet joint interventions		SI joints blocks		Disc Procedures (discography& disc decompression)		Other types of nerve blocks		Total	
		Services	*Rate*	Services	*Rate*	Services	*Rate*	Services	*Rate*	Services	*Rate*	Services	*Rate*	Services	*Rate*
2000	39,632	852,009	2,150	8,778	22	375,242	947	49,554	125	14,983	38	168,929	426	1,469,495	3,708
2001	40,045	1,002,586	2,504	10,966	27	457,845	1,143	85,664	214	17,229	43	186,166	465	1,760,456	4,396
2002	40,503	1,184,170	2,924	15,154	37	606,437	1,497	101,749	251	20,194	50	255,348	630	2,183,052	5,390
2003	41,126	1,353,946	3,292	16,916	41	755,171	1,836	128,864	313	24,362	59	280,064	681	2,559,323	6,223
2004	41,729	1,620,714	3,884	16,780	40	1,181,538	2,831	172,704	414	24,263	58	319,048	765	3,335,047	7,992
2005	42,496	1,757,789	4,136	18,364	43	1,312,616	3,089	188,606	444	27,950	66	355,374	836	3,660,699	8,614
2006	43,339	1,852,537	4,275	17,903	41	1,684,760	3,887	211,928	489	27,432	63	351,564	811	4,146,124	9,567
2007	44,263	1,923,120	4,345	17,334	39	1,607,206	3,631	213,489	482	25,688	58	324,290	733	4,111,127	9,288
2008	45,412	2,024,387	4,458	16,768	37	1,746,312	3,845	228,687	504	27,735	61	389,522	858	4,433,411	9,763
2009	45,801	2,119,542	4,628	16,493	36	1,882,754	4,111	228,946	500	25,929	57	372,015	812	4,645,679	10,143
2010	46,914	2,210,936	4,713	15,550	33	1,699,677	3,623	237,905	507	22,003	47	392,906	838	4,578,977	9,760
2011	48,300	2,294,584	4,751	15,322	32	1,811,573	3,751	252,654	523	19,104	40	422,436	875	4,815,673	9,970
2012	50,300	2,310,103	4,593	14,460	29	1,892,293	3,762	266,764	530	18,017	36	446,337	887	4,947,974	9,837
2013	51,900	2,265,000	4,364	13,790	27	1,931,123	3,721	266,643	514	15,394	30	441,000	850	4,932,950	9,505
Change	31%	166%	103%	57%	20%	415%	293%	438%	311%	3%	-22%	161%	99%	236%	156%
GM	2.1	7.80%	5.6%	3.5%	1.4%	13.4%	11.1%	13.8%	11.5%	0.2%	-1.8%	7.7%	5.4%	9.8%	7.5%

GM - Geometric average annual change. * - From 2003 to 2013. Rate: Services per 100,000 Medicare beneficiaries. Epidural procedures: (62310, 62311, 64479, 64480, 64483, 64484, 62280, 62281, 62282). Adhesiolysis Procedures: 62263,62264). Facet Joint interventions: (64470, 64472, 64475, 64476, 64490, 64491, 64492, 64493-new, 64494, 64495, 64622, 64623,64626, 64627, 64633, 64634, 64635, 64636). SI joint blocks: 27096. Discography and Disc decompression: (62290, 62291, 62287). Other type of nerve blocks (64400, 64402, 64405, 64408, 64410, 64412, 64413, 64417, 64420, 64421, 64425, 64430, 64445, 64505, 64510, 64520, 64530, 64600, 64605, 64610, 64613, 64620, 64630, 64640, 64680)

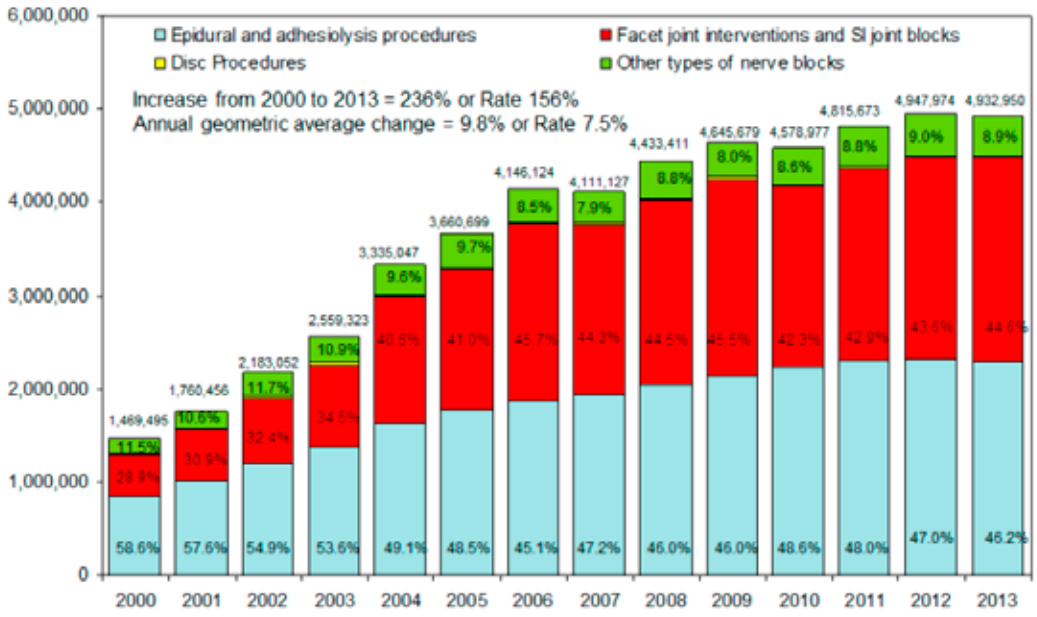

Fig. 2. *Distribution of procedural characteristics by type of procedures from 2000 to 2013.*

cedures (46%) are the majority, followed by facet joint interventions and sacroiliac joint blocks (44%), other types of nerve blocks (9%), and disc procedures, including disc decompression less than 1%. Table 2 shows a listing of the 20 interventional procedures which are most commonly performed by interventional pain physicians. This top 20 constitutes 95% of the total volume of IPM procedures.

5. Dealing with Denials

Dealing with insurance denials is an important aspect of current practice. Almost by definition, denials can create significant cash flow issues for practices. As a consequence, IPM providers must analyze all the inefficiencies in documentation, coding, and billing systems. The documentation should include appropriate indications, medical necessity and be completed in a timely fashion. Coding and billing should incorporate matching codes, avoiding numerous intricacies of ICD-10-CM codes, which may not find equal coding in ICD-10-CM compared to ICD-9-CM, even though multiple codes may seemingly be available, but in some regions accurate codes may not be available, one may have to be careful in using codes defined as "other" and "unspecified."

Navigating Through the ICD-10-CM Manual

Navigation through ICD-10-CM requires understanding the official conventions, official guidelines, organization, and steps to correct coding. ICD-10-CM is organized as follows (35):

1. ICD-10-CM Conventions and Guidelines

This section provides an explanation of the conventions and guidelines regulating the appropriate assignment and reporting of ICD-10-CM codes. This coding guidance is based on the ICD-10-CM manual presented by the National Center for Health Statistic (NCHS), a governmental agency of the CDC.

2. Alphabetic Index to Diseases and Injuries

The alphabetic Index to Diseases is arranged in alphabetic order by disease, by specific illness, injury, eponym, abbreviation, or other descriptive diagnostic term. In addition, the index lists diagnostic terms for other reasons for encounter with health care professionals.

- Table of Neoplasms
- Table of Drugs and Chemicals
- Index to External Causes

3. Tabular List of Diseases and Injuries

The tabular list of diseases and injuries with ICD-10-CM codes and descriptors are arranged within 21 separate chapters according to body system or nature of injury and disease.

- Previous supplemental classifications to ICD-10-CM are also incorporated into the tabular list of ICD-10-CM as individual chapters. In the tabular list of diseases chapter 20 describes external cause of morbidity and 21 factors influencing health status and contact with health services including chapter specific guidelines.

4. Appendices

The appendices show multiple additional resources designed to further instruct the users on the appropriate application of the ICD-10-CM code set. Appendix A includes 10 steps to correct coding. Appendix B shows valid 3 character ICD-10-CM codes, Appendix C shows the pharmacology list for 2016, Appendix D shows Z codes for long-term drug use with associated drugs, and Appendix E shows Z code only as a principle diagnosis list.

Steps to Navigating Through ICD-10-CM

Table 3 shows 8 steps to navigating through ICD-10-CM as described in ICD-10-CM The Official Codebook. These steps include education and understanding of ICD-10-CM coding guidelines, finding the appropriate codes and modifiers, understanding various instructions, and finally confirming and assigning the correct code (35).

Steps to Correct Coding

Ten steps to correct coding are shown in Table 4 derived from Appendix A in the ICD-10-CM The Official Codebook (35). These steps include identifying the reason for the encounter, consulting the index of ICD-10-CM, cross referencing, reviewing entries for modifiers, interpreting various abbreviations, cross references, etc., and choosing and determining the appropriate code leading to assignment of individual or multiple codes.

Intricacies of ICD-10-CM Coding

ICD-10-CM coding is quite different from ICD-9-CM coding. The multitude of intricacies for a physician to understand including unreliable crosswalk and con-

Table 2. *Illustration of the most commonly utilized interventional procedures.**

1.	Caudal epidural injections
2.	Lumbar interlaminar epidural injections
3.	Lumbar/sacral transforaminal epidural injections
4.	Cervical epidural injections
5.	Thoracic epidural injections
6.	Percutaneous epidural adhesiolysis
7.	Lumbar/sacral facet joint injections and nerve blocks
8.	Cervical facet joint injections and nerve blocks
9.	Thoracic facet joint injections and nerve blocks
10.	Lumbar/sacral facet joint nerve radiofrequency neurolysis
11.	Cervical medial branch radiofrequency neurolysis
12.	Thoracic medial branch radiofrequency neurolysis
13.	Sacroiliac joint injections
14.	Cervical sympathetic blocks
15.	Lumbar paravertebral sympathetic blocks
16.	Hypogastric plexus blocks
17.	Celiac plexus blocks
18.	Lumbar discography
19.	Intercostal nerve blocks
20.	Spinal cord stimulation

*Not described in order of utilization.

Table 3. *Steps for navigating through ICD-10-CM.*

Step 1:	Prior to start coding, the physician and staff should review conventions for the ICD-10-CM and general coding guidelines.
Step 2:	ICD-10-CM manual directs looking up the main term in the alphabetic index and scan the subterm entries as appropriate.
Step 3:	All parenthetical terms (nonessential modifiers) that help in code selection, but do not affect code assignment, should be noted. • Shaded vertical guidelines in the index are provided to help determine the indentation level for each subterm in relation to the main terms.
Step 4:	Physicians and staff must pay close attention to various instructions in the index such as "see," "see also," "see category," "with"/"without notes, "omit code," "due to" subterms, and various other instructions such as "code by site," etc.
Step 5:	However, physicians and staff should not code directly from the alphabetic index without verifying the accuracy of the code from the tabular list.
Step 6:	All involved should read instructional materials in the tabular list: "includes" and both types of "excludes" notes, "use additional code," "code also," and age and sex symbols.
Step 7:	Users should always consult the ICD-10-CM guidelines, which govern the use of specific codes.
Step 8:	Finally confirm and assign the correct code.

Table 4. Ten steps to correct coding.

Step 1:	Identify the reason for the encounter (i.e., a sign, symptom, diagnosis and/or condition).
Step 2:	After determining the reason for the encounter, consult the alphabetic index before verifying code selection in the tabular section.
Step 3:	Locate the main term entry in the alphabetic index
Step 4:	Read cross-references listed with the main term or the subterm.
Step 5:	Review entries for both essential and non-essential modifiers.
Step 6:	Interpret abbreviations, cross-references, default codes, additional characters, and brackets.
Step 7:	Choose a potential code and locate it in the tabular list.
Step 8:	Determine whether the code is at the highest level of specificity.
Step 9:	Assign the code.
Step 10:	Sequence codes correctly.

version, unreliable and not always available bilateral coding, titles such as "other," "other specified," "unspecified," and dual coding including "with" and "due to" describing a condition and resultant effect. Combination codes such as intervertebral disc disorder with radiculopathy or Type II diabetes mellitus with polyneuropathy, essentially merge 2 ICD-9-CM codes and remove the use of multiple other codes such as disc herniation and radiculopathy and Type II diabetes and diabetic neuropathy and merge them into a single code.

1. Crosswalk and Conversion

There has been significant hype in reference to crosswalking and general mapping through the use of general equivalence mappings (GEMS). It has been shown that crosswalk may be only 50% or 60% accurate. Consequently, GEMS are not reliable and they are not true crosswalks. There are multiple issues related to new ICD-10-CM codes.

2. Bilateral Codes

Multiple conditions in the Musculoskeletal system ICD-10-CM chapter, frequently used in IPM, have codes describing each side, as well as bilateral codes; whereas several others in the Nervous system chapter do not have this facility. Consequently, it will be important to remember when bilateral codes are available and when they are not. ICD-10-CM Guidelines instruct when no bilateral code is available; both the right and left unilateral codes need to be utilized if bilateral procedures are performed.

3. Codes Titled "Other" or "Other Specified" or "Unspecified"

These codes are meant to be utilized when a specific code does not exist. While "other" or "other specified" are used for when specific codes do not exist, "unspecified" codes are used when the information in the medical record is insufficient to assign a more specific code. Unfortunately, multiple insurers have already issued guidelines to deny codes title other or other specified or unspecified.

Some codes do not have crosswalk codes such as post-surgery syndrome for each region, which is defined by only one code, down from the previously available 4 codes. Consequently, one may not be able to perform 2 procedures on a patient with cervical post laminectomy syndrome and lumbar post laminectomy syndrome and be reimbursed for both.

"With" and "due to" codes are important as the new codes combine intervertebral disc disorder with radiculopathy.

Coding For Interventional Techniques

As described in Table 1 and Fig. 1, the majority of the procedures consist of spinal interventions, while other types of nerve blocks constitute less than 10% of the procedures. We describe the coding for epidural injections and percutaneous adhesiolysis, coding for facet joint interventions, coding for sacroiliac joint interventions, coding for sympathetic blocks and coding for other types of nerve blocks. Table 5 shows a comprehensive and consolidated coding table, which can be used in daily practice, describing various spinal and some non-spinal codes. This table does not illustrate multiple fractures, which are extremely voluminous for description, but it does show a space for coding. This table also includes coding for sacroiliac joint pain. Table 6 shows the coding for complex regional pain syndrome or previously known as reflex sympathetic dystrophy, phantom limb syndrome, and peripheral neuropathy. Other codes pertaining to chronic pancreatitis, pelvic pain, occipital neuralgia, occipital neuritis, intercostal neuritis, and pudendal neuritis are also included.

Table 5. *Comprehensive ICD-10-CM spinal coding with commonly used codes.*

CERVICAL	THORACIC	LUMBAR
1. Disc disorder with radiculopathy (Disc disorder includes both disc displacement and disc degeneration)		
M50.11 - High cervical - C2-3, C3-4	M51.14 - Thoracic	M51.16 - Lumbar
M50.12 - Mid-cervical C4-5, C5-6, C6-7	M51.15 - Thoracolumbar	M51.17 - Lumbosacral
M50.13 - Cervicothoracic C7-T1		
2. Disc displacement (722.0, 722.11, 722.10)		
M50.21 - High cervical - C2-3, C3-4	M51.24 - Thoracic	M51.26 - Lumbar
M50.22 - Mid-cervical C4-5, C5-6, C6-7	M51.25 - Thoracolumbar	M51.27 - Lumbosacral
M50.23 - Cervicothoracic C7-T1		
3 Radiculopathy (723.4, 724.4, 724.4)		
M54.12 - Cervical	M54.14 - Thoracic	M54.16 - Lumbar
M54.13 - Cervicothoracic	M54.15 - Thoracolumbar	M54.17 - Lumbosacral
4. Spinal stenosis or Neural canal stenosis (723.0, 724.01, 724.02, 724.03)		
M48.02 - Cervical	M48.04 - Thoracic	M48.06 - Lumbar
M48.03 - Cervicothoracic	M48.05 - Thoracolumbar	M48.07 - Lumbosacral
M99.21 - Subluxation stenosis	M99.22 - Subluxation stenosis	M99.23 - Subluxation stenosis
M99.31 - Osseous stenosis	M99.32 - Osseous stenosis	M99.33 - Osseous stenosis
M99.41 - Connective tissue stenosis	M99.42 - Connective tissue	M99.43 - Connective tissue stenosis
M99.51 - Intervertebral disc stenosis	M99.52 - Intervertebral disc stenosis	M99.53 - Intervertebral disc stenosis
M99.61 - Foraminal: Osseous and subluxation stenosis	M99.62 - Foraminal: Osseous and subluxation stenosis	M99.63 - Foraminal: Osseous and sublux-ation stenosis
M99.71 - Foraminal: Connective tissue and disc stenosis	M99.72 - Foraminal: Connective tissue and disc stenosis	M99.73 - Foraminal: Connective tissue and disc stenosis
5. Disc degeneration (722.4, 722.51, 722.52)		
M50.31 - High cervical - C2-3, C3-4	M51.34 - Thoracic	M51.36 - Lumbar
M50.32 - Mid-cervical C4-5, C5-6, C6-7	M51.35 - Thoracolumbar	M51.37 - Lumbosacral
M50.33 - Cervicothoracic C7-T1		
6. Spondylolysis or Spondylolisthesis (738.4, 756.11, 756.12)		
M43.02 - Spondylolysis, cervical	M43.04 - Spondylolysis, thoracic	M43.06 - Spondylolysis, lumbar
M43.03 - Spondylolysis, cervicothoracic	M43.05 - Spondylolysis, T/L	M43.07 - Spondylolysis, L/S
M43.12 - Spondylolisthesis, cervical	M43.14 - Spondylolisthesis, thoracic	M43.16 - Spondylolisthesis, lumbar
M43.13 - Spondylolisthesis, cervicothoracic	M43.15 - Spondylolisthesis, T/L	M43.17 - Spondylolisthesis, L/S
Q76.2 - Congenital spondylolisthesis	Q76.2 - Congenital spondylolisthesis	Q76.2 - Congenital spondylolisthesis
7. Facet joint arthropathy (spondylosis W/O myelopathy or radiculopathy) (721.0, 721.2, 721.3)		
M47.812 - Cervical	M47.814 - Thoracic	M47.816 - Lumbar
M47.813 - Cervicothoracic	M47.815 - Thoracolumbar	M47.817 - Lumbosacral
8. Disc disorder with myelopathy (722.71, 722.72, 722.73)		
M50.01 - High cervical - C2-3, C3-4	M51.04 - Thoracic	M51.06 - Lumbar
M50.02 - Mid-cervical C4-5, C5-6, C6-7	M51.05 - Thoracolumbar	G83.4 - Cauda equina syndrome
M50.03 - Cervicothoracic C7-T1		
9. Spondylosis with myelopathy (721.1, 721.41, 721.42)		
M47.12 - Cervical	M47.14 - Thoracic	M47.16 - Lumbar
M47.13 - Cervicothoracic	M47.15 - Thoracolumbar	
10. Post laminectomy syndrome / Epidural fibrosis		
M96.1 - Postlaminectomy syndrome	M96.1 - Postlaminectomy syndrome	M96.1 - Postlaminectomy syndrome
G96.12 - Meningeal adhesions	G96.12 - Meningeal adhesions	G96.12 - Meningeal adhesions

Table 5 (cont.). *Comprehensive ICD-10-CM spinal coding with commonly used codes.*

G96.19 – Unspecified meningeal fibrosis	G96.19 – Unspecified meningeal fibrosis	G96.19 – Unspecified meningeal fibrosis
G03.9 - Meningitis, unspecified	G03.9 - Meningitis, unspecified	G03.9 - Meningitis, unspecified
11. Ankylosing spondylitis		
M54.1 - Ankylosing spondylitis of occipito-atlanto-axial region	M45.4 - Thoracic	M45.6 - Lumbar
M45.2 - Cervical	M45.5 - Thoracolumbar	M45.7 - Lumbosacral
M45.3 - Cervicothoracic		M45.8 - Sacral and sacrococcygeal
M08.1 - Juvenile Ankylosing spondylitis	M08.1 - Juvenile Ankylosing spondylitis	M08.1 - Juvenile Ankylosing spondylitis
12. Pain		
M54.2 Cervicalgia	M54.6 - Pain in thoracic spine	M54.5 - Low back pain
R51 Headache	R07.82 - Intercostal	M53.3 - Coccydynia
	M94.0 - Costochondral (Tietze's dis.)	R10.2 Pelvic and perineal pain
	N64.4 - Mastodynia	
13.SacroiliitisM46.1		
14. Sciatica M54.31 - Right sideM54.32 - Left side		
15. Lumbago with sciatica M54.41 - Right sideM54.42 - Left side		

1.0 Coding for Epidural Injections

Epidural injections is the most common modality of treatment in interventional pain management (34,36-56); however, the rules differ not only for Medicare contractor payers in multiple jurisdictions, but also Medicaid and private payers have their own rules and regulations. The most well-documented coding is for lumbar epidural injections from Medicare in multiple jurisdictions. Table 7 presents a consolidated list of codes commonly approved in multiple jurisdictions; however, it is essential to check each individual jurisdiction and the LCDs with their covered CPT codes in that jurisdiction (36-41).

Some of these codes, such as low back pain and other acute post procedural pain and other reaction to spinal and lumbar puncture, may not meet medical necessity criteria. Consequently, it is also presumed that other carriers may follow suit.

1.1 Spinal Disorder Coding

Pain in spinal regions includes neck pain or cervicalgia (M54.2), pain in the thoracic spine (M54.6), and low back pain (M54.5); however, these codes exclude spinal pain related to intervertebral disc disorder, and disc disorder with radiculopathy, etc. Even though LCDs show low back pain as a covered condition for epidural injections, we do not believe that it will meet the medical necessity criteria and will generate denials.

1.1.1 Disc Disorder with Radiculopathy

A new set of codes has been introduced to show a combination of disc disorder with radiculopathy. These are described as intervertebral disc disorder with radiculopathy with a total of 7 codes. Disc disorders include disc displacement and disc degeneration. Essentially these conditions may include annular disruption, disc bulging, disc protrusion, herniation, and extrusion. They also includes simple intervertebral disc degeneration. These codes are combination codes which include radiculopathy. These codes, M51.11, M51.12, and M51.13, describe disc disorder with radiculopathy in the cervical spine, in the high and mid-cervical, and the cervicothoracic regions. In the thoracolumbar region, these are M51.14 and M51.15. In the lumbosacral region, these are M51.16 and M51.17. Corresponding new codes describing disc disorder, both other category and unspecified category, have not been listed under covered procedures by CMS. Coding must be performed to the most superior level of a disorder. Other disc displacement codes include the M50.2 series in the cervical spine, M51.2in the thoracolumbar and lumbosacral re-

Table 6. *Commonly used ICD-10-CM codes for non-spinal procedures.*

CRPS I (RSD)
G90.513 Bil. UE G90.511 RUE G90.512 LUE
G90.523 Bil. LE G90.521 RLE G90.522 LLE
CRPS II (Causalgia)
G56.41 RUE G56.42 LUE
G57.71 RUE G57.72 LUE
Phantom limb syndrome
G54.6 With pain G547 Without pain
Peripheral neuropathy
G62.0 - Polyneuropathy Drug-induced
G62.1 - Polyneuropathy -Alcoholic
G60.2 - Neuropathy in association with hereditary ataxia
G60.3 - Progressive neuropathy - Idiopathic
G99.0 Autonomic neuropathy in diseases classified elsewhere (Code 1st underlying disease)
E10.41 - Type 1 diabetes mellitus with diabetic mononeuropathy
E10.42 - Type 1 diabetes mellitus with diabetic polyneuropathy
E10.43 - Type 1 diabetes mellitus with diabetic autonomic (poly) neuropathy
E11.41 - Type 2 diabetes mellitus With diabetic mononeuropathy
E11.42 - Type 2 diabetes mellitus With diabetic polyneuropathy
E11.43 - Type 21 diabetes mellitus With diabetic autonomic (poly) neuropathy
G50.0 Trigeminal neuralgia
M54.81 - Occipital neuralgia
G56.01 Carpal tunnel syndrome, RUE G56.02 LUE
G58.8 - Pudendal neuropathy
G58.0 - Intercostal neuropathy
G57.01 Meralgia paresthetica RLE G57.02 LLE
G89.4 Chronic pain syndrome
B25.2 - Cytomegaloviral pancreatitis
K86.0 - Alcohol-induced chronic pancreatitis
K86.1 - Other chronic pancreatitis
G89.3 – Pain due to malignancy (primary) (secondary)

gions. Other cervical disc disorders are the M50.8 series in the cervical spine, the M51.8 series in the thoracic and thoracolumbar region, and unspecified disc disorder codes with M50.9 in the cervical region and 51.9 in the thoracic, thoracolumbar, and lumbosacral regions are not covered by LCDs, consequently, they are not listed here. In addition, disc disorders with myelopathy in the cervical spine with M50.0 in thoracic, thoracolumbar, and lumbosacral intervertebral region with M51.0 are not described here due to noncoverage in LCDs and the epidural injections may not be indicated in these patients.

Table 7. *Consolidated description of ICD-10-CM codes for lumbar epidural injections approved by Medicare.*

ICD-10-CM CODE	DESCRIPTION
B02.23	postherpetic polyneuropathy
B02.7	disseminated zoster
B02.8	z oster with other complications
B02.9 z	oster without complications
G89.18	other acute postprocedural pain
G97.1	other reaction to spinal and lumbar puncture
M48.06	s pinal stenosis, lumbar region
M48.07	spinal stenosis, lumbosacral region
M51.15	intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	intervertebral disc disorders with radiculopathy, lumbar region
M51.17	intervertebral disc disorders with radiculopathy, lumbosacral region
M51.26	other intervertebral disc displacement, lumbar region
M51.27	other intervertebral disc displacement, lumbosacral region
M51.36	other intervertebral disc degeneration, lumbar region
M51.37	other intervertebral disc degeneration, lumbosacral region
M54.15	radiculopathy, thoracolumbar region
M54.16	radiculopathy, lumbar region
M54.17	radiculopathy, lumbosacral region
M54.18	radiculopathy, sacral and sacrococcygeal region
M54.31	sciatica, right side
M54.32	sciatic, left side
M54.41	lumbago with sciatica, right side
M54.42	lumbago with sciatica, left side
M54.5	low back pain
M99.23	subluxation stenosis of neural canal of lumbar region
M99.33	osseous stenosis of neural canal of lumbar region
M99.43	connective tissue stenosis of neural canal of lumbar region
M99.53	intervertebral disc stenosis of neural canal of lumbar region
M99.63	osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.73	connective tissue and disc stenosis of intervertebral foramina of lumbar region

Source: Multiple MACs.

1.1.2 Sciatica

In ICD-9-CM there was only one code for sciatica; however, now there are now 4 sciatica codes, indicating laterality and combination with lumbago.

1.1.3 Disc Displacement

Disc displacement codes in the past have been some of the main codes utilized in interventional pain management. The new codes describe displacement of intervertebral disc without myelopathy and must be coded to the most superior level of disorder. These are M50.21, M50.22, and M50.23 for the cervicothoracic region, M51.24 and M51.25 for the thoracolumbar region, and M51.26 and M51.27 for the lumbosacral region. These codes are described as other disc displacement, but are covered by Medicare and hopefully by all other insurers. These codes generally describe disc displacement with bulging, protrusion, herniation, and extrusion; however, without radiculopathy or myelopathy.

1.1.4 Disc Degeneration

Disc degeneration has been used as a general code for all patients with spinal pain. Disc degeneration leads to disc displacement and also spinal stenosis.

1.1.5 Spinal Stenosis

Spinal stenosis has been described with extensive specificity along with location as well as causation with multiple codes in each region. There are also general codes provided for the cervicothoracic, thoracolumbar, and lumbosacral regions; however, there are no codes for spinal stenosis with neurogenic claudication in the lumbar spine. In each region codes describe subluxation stenosis, osseous stenosis, connective tissue stenosis, intervertebral disc stenosis, and foraminal stenosis (osseous and subluxation and connective tissue, and disc stenosis secondary to osseous and subluxation) and connective tissue and disc stenosis.

1.1.6 Spondylolysis, Spondylosis, or Spondylolisthesis with or without Radiculopathy

A number of codes have been provided to describe spondylosis and spondylolisthesis in multiple spinal regions with or without radiculopathy and myelopathy; however, LCDs do not provide provision for spondylolysis or spondylolisthesis with or without myelopathy for reimbursement.

1.1.7 Post Laminectomy Syndrome

The major issues with post laminectomy syndrome, epidural fibrosis, and arachnoiditis coding are that post laminectomy has been converted from 4 codes into one code, epidural fibrosis is described in all areas as meningeal adhesions, and the arachnoiditis code has been converted to a nonspecific code.

Consequently, if a patient suffers with cervical post laminectomy syndrome and lumbar post laminectomy syndrome and epidurals are performed in both regions only one epidural will be considered as medically necessary; the other one will be excluded because of use of the same code more than once.

2.0 Percutaneous Adhesiolysis

Percutaneous adhesiolysis codes will translate into use of the post laminectomy syndrome code, epidural fibrosis code, spinal stenosis code, or any other codes utilized for epidural injection codes (56-60). While percutaneous adhesiolysis is most commonly performed in post laminectomy syndrome, epidural fibrosis, and spinal stenosis mainly in the lumbar region, any other codes described in the epidural injections section may be used for percutaneous adhesiolysis; however, it should be cautioned that at present LCDs are lacking, but in multiple states they are under development.

3.0 Facet Joint Interventions

Facet joint interventions are the second most common procedures performed by interventional pain physicians as shown in Table 1 and Fig. 2. Facet joint interventions include intraarticular injections and medial branch blocks with the same CPT codes, and facet joint neurolysis, in the cervicothoracic and lumbosacral regions with the same codes (48,61-65). Table 8 shows general approval in LCDs for facet joint interventions by multiple Medicare jurisdictions. Even though these codes include anterior spinal artery compression syndrome, vertebral artery compression syndromes, other spondylosis with myelopathy, other spondylosis with radiculopathy, only the codes for spondylosis without myelopathy are recommended and meet medical necessity criteria.

4.0 Sacroiliac Joint Interventions

Even though sacroiliac joint interventions are rapidly increasing, they constitute a minor proportion of interventions (48,66). Sacroiliitis is coded with the following diagnosis: M46.1. Various other diagnosis describing sacroiliac joint pain may also be utilized.

5.0 Sympathetic Nerve Blocks

Multiple sympathetic nerve blocks or blockade of

Table 8. *ICD-10-CM coding for facet joint interventions in multiple Medicare jurisdictions.*

ICD-10-CM CODE	DESCRIPTION
M47.811	Spondylosis without myelopathy or radiculopathy, occipto-atlano-axial region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M53.81*	Other specified dorsopathies, occipito-atlanto-axial region
M62.830*	Muscle spasm of back
M71.30#	Other bursal cyst, unspecified site

Group I medical necessity ICD-10 codes asterisk explanation: *M53.81* Use for occipital headache with CPT codes 64490 and 64633 only
M62.830* Use for facet syndrome only
#Only in some jurisdictions

the sympathetic nervous system include cervical sympathetic blocks (stellate ganglion block, lumbar sympathetic blocks, hypogastric plexus blocks, and celiac plexus blocks). There are no LCDs available at the present time. Table 6 shows the recommended ICD-10-CM coding for sympathetic interventions. The main indication continues to be chronic regional pain syndrome (CRPS) or reflex sympathetic dystrophy (RSD), and causalgia as described in the past. However, these procedures are also performed in peripheral neuropathy, chronic pancreatitis, and phantom limb pain.

6.0 Other Types of Nerve Blocks

Among various other types of nerve blocks, occasionally performed interventions include occipital nerve blocks, intercostal nerve blocks, and pudendal nerve blocks. These nerve blocks are coded by occipital neuralgia and pudendal neuralgia.

Conclusion

On October 1, 2015, ICD-10-CM coding arrived. Even though there is an increased workload for physicians with potential disruption of cash flow, the descriptions provided here will help ensure a more seamless ICD-10-CM navigation.

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Conflict of Interest

Dr. Manchikanti has provided limited consulting services to Semnur Pharmaceuticals, Incorporated, which is developing nonparticulate steroids. Ms. Hammer is a consultant for Boston Scientific. Dr. Kaye is a speaker for Depomed, Inc. Dr. Hirsch is a consultant for Medtronic.

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