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Practice Management

Current Issues in Billing and Coding in Interventional Pain Medicine

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Interventional pain management is a dynamic field with changes occurring on a daily basis, not only with technology but also with regulations that have a substantial financial impact on practices. Regulations are imposed not only by the federal government and other regulatory agencies, and also by a multitude of other payors, state governments and medical boards. Documentation of medical necessity with coding that correlates with multiple components of the patient's medical record, operative report, and billing statement is extremely important.

Numerous changes which have occurred in the practice of interventional pain management in the new millennium continue to impact the financial viability of interventional pain practices along with patient access to these services. Thus, while complying with regulations of billing, coding and proper, effective, and ethical practice of pain management, it is also essential for physicians to understand financial aspects and the impact of various practice patterns.

This article provides guidelines which are meant to provide practical considerations for billing and coding of interventional techniques in the management of chronic pain based on the current state of the art and science of interventional pain management. Hence, these guidelines do not constitute inflexible treatment, coding, billing or documentation recommendations. It is expected that a provider will establish a plan of care on a case-by-case basis taking into account an individual patient's medical condition, personal needs, and preferences, along with physician's experience and in a similar manner, billing and coding practices will be developed. Based on an individual patient's needs, treatment, billing and coding, different from what is outlined here is not only warranted but essential.

Keywords: Interventional techniques, neural blockade, interventional pain management, medical necessity, billing, coding

While multiple issues of documentation, billing, and coding are facts of life for physicians practicing interventional pain management, emphasis continues on the description and definition of what the physician does for and to the patient. Various aspects of appropriate documentation, billing, and coding in interventional pain practice have been described earlier (1). Focus on errors for Medicare program as well as errors in other insurance programs, exclusion and sanction of medical providers, Medicare fraud hotline hits, qui tam cases and recoveries, and sky high settlements from institutions and individual physicians continue to increase. Recent developments include changes in CPT 2000 (2, 3); final rule for 2000, and proposed rule for 2001 on physician payment policies (4, 5); Medicare program prospective payment system for hospital outpatient services (6); program memorandum on the manner in which the Health Care Financing Administration (HCFA) proposed to deal with this those deleted CPT codes for which replacement codes were created in CPT 2000 (7, 8); and HCFA's new position and acknowledgment that it would allow bilateral billing of new facet joint injection and transforaminal codes (2). In addition, the impact of national correct coding policy on interventional pain management (9-13), documentation of medical necessity, and Department of Justice – Health and Human Services (DOJ-HHS) health care fraud and abuse control program, continue to take the center stage.

Medicare program prospective payment system for hospital outpatient services; final rule: Department of Health and Human Services, Health Care Financing Administrations (6) has reduced reimbursement for interventional pain procedures for hospitals in a substantial manner which may have serious impact on patient access to interventional pain procedures (14-16). This is shown in Table 1.

HCFA, in its Ambulatory Surgery center proposal, eliminated all interventional pain medicine procedures, except for epidural and subarachnoid injections (17). However,

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Table 1. *Comparison Payments Under the 2000 and 2001 Medicare Physician Fee Schedules and Hospital Outpatient Payment for 2000*

CPT Code	Abbreviated Description of Procedure	2000 Physician Fee Schedule		2001 Proposed Rule		
		Final Rule CY 2000[i] Nonfacility Total ($)	Final Rule CY 2000[ii] Facility Total ($)	Proposed Rule CY 2001[iii] Nonfacility Total ($)	Proposed Rule CY 2001[iv] Facility Total ($)	Proposed Hospital Outpatient Payment ($)
20550	Trigger-point injection	72.86	41.36	86.77	43.57	102.31
20600	Small-joint injection	56.75	35.51	64.44	38.08	102.31
20605	Intermediate-joint injection	62.60	36.24	73.23	38.81	102.31
20610	Large-joint injection	73.22	41.37	87.87	49.79	102.31
27093	Hip arthrography -without anesthesia	250.44	75.06	354.79	72.50	NA-N
27095	Hip arthrography -with anesthesia	261.78	85.67	370.53	82.38	NA-N
27096	SI-joint injection	408.24	56.75	434.24	58.95	NA-N
62263	Percutaneous epidural adhesiolysis	421.42	332.45	447.79	335.75	176.49
62270	Spinal puncture	124.12	67.36	138.76	65.90	145.46
62272	Spinal puncture-for drainage of spinal fluid	136.20	86.41	147.92	83.11	176.49
62273	Epidural blood patch	128.51	123.75	129.98	124.12	176.49
62280	Neurolytic subarachnoid	197.35	128.88	229.20	129.25	176.49
62281	Cervical/thoracic epidural-neurolytic	184.53	130.71	207.60	128.51	176.49
62282	Lumbar/sacral epidural-neurolytic	221.51	134.37	253.73	123.75	176.49
62284	Myelography	163.29	101.78	190.03	98.49	176.49
62287	Decompression of nucleus pulposus	NA	546.27	NA	529.43	676.88
62290	Lumbar diskography	232.49	173.18	141.70	62.98	NA-N
62291	Cervical/thoracic diskography	229.93	163.38	274.97	162.93	NA-N
62292	Chemonucleolysis-single or multiple levels-lumbar	NA	556.16	NA	508.93	176.49
62310	Cervical/thoracic epidural	198.08	93.36	197.35	94.83	176.49
62311	Lumbar/caudal epidural	199.54	77.62	201.38	78.72	176.49
62318	Continuous epidural-cervical/thoracic	206.86	101.05	206.50	102.88	176.49
62319	Continuous epidural-lumbar/sacral	201.37	91.53	198.08	93.00	176.49
62350	Implantation of catheter	NA	406.41	NA	403.48	307.41
62355	Removal of catheter	NA	334.64	NA	323.67	307.45
62360	Implantation or replacement of drug infusion reservoir	NA	162.56	NA	168.42	1235.45
62361	Implant of non-programmable pump	NA	324.76	NA	325.50	1235.45
62362	Implant of programmable pump	NA	429.84	NA	429.48	1235.45
62365	Removal of reservoir	NA	347.46	NA	340.50	772.88
63650	Implantation of neurostimulator	NA	462.80	NA	440.10	772.88
63660	Removal of neurostimulator	NA	452.55	NA	416.30	772.88
63685	Implantation of pulse generator	NA	511.49	NA	472.32	772.88
63688	Removal of pulse generator	NA	401.65	NA	371.63	772.88
64400	Trigeminal nerve block	91.90	53.08	106.55	56.02	160.98
64402	Facial nerve block	132.54	69.57	155.24	67.37	160.98
64405	Greater occipital nerve block	106.17	64.44	121.19	67.37	160.98

[i]. Information obtained from the November 2, 1999 Federal Register. [ii]. Information obtained from the November 2, 1999 Federal Register. [iii]. Information obtained from the July 17, 2000 Federal Register. [iv]. Information obtained from the July 17, 2000 Federal Register.

Table 1. (cont.) *Comparison Payments Under the 2000 and 2001 Medicare Physician Fee Schedules and Hospital Outpatient Payment for 2000*

CPT Code	Abbreviated Description of Procedure	2000 Physician Fee Schedule		2001 Proposed Rule		
		Final Rule CY 2000[i] Nonfacility Total ($)	Final Rule CY 2000[ii] Facility Total ($)	Proposed Rule CY 2001[iii] Nonfacility Total ($)	Proposed Rule CY 2001[iv] Facility Total ($)	Proposed Hospital Outpatient Payment ($)
64418	Suprascapular nerve block	108.01	65.17	119.00	68.10	160.98
64420	Intercostal nerve block-single	99.22	63.34	112.40	60.05	160.98
64421	Intercostal nerve block-multiple	128.88	88.23	142.79	83.85	160.98
64425	Ilioinguinal nerve block	119.72	86.77	133.27	85.31	160.98
64445	Injection, anesthetic agent; sciatic nerve	121.92	68.47	144.62	72.13	160.98
64450	Peripheral nerve block	88.60	60.77	97.39	64.07	160.98
64470	Facet injection-cervical/thoracic-single	203.93	106.17	204.67	90.44	160.98
64472	Facet injection-cervical/thoracic-additional	170.98	63.34	170.99	64.07	160.98
64475	Facet injection-lumbar/sacral-single	181.23	68.10	181.60	69.20	160.98
64476	Facet injection-lumbar/sacral-additional	171.35	47.23	169.52	47.96	160.98
64479	Transforaminal cervical/thoracic-single	221.51	106.17	221.88	108.38	160.98
64480	Transforaminal cervical/thoracic-additional	199.54	73.59	198.45	74.69	160.98
64483	Transforaminal lumbar/sacral-single	204.30	90.43	204.67	92.27	160.98
64484	Transforaminal lumbar/sacral-additional	188.56	63.70	187.46	64.81	160.98
64505	Sphenopalatine ganglion block	103.61	65.53	115.70	68.83	160.98
64510	Stellate ganglion block	102.51	65.90	113.87	61.88	160.98
64520	Lumbar or thoracic sympathetic block	129.61	72.12	152.31	68.10	160.98
64530	Celiac plexus block	134.73	91.16	145.72	83.48	160.98
64600	Neurolytic-trigeminal-small branches	226.63	206.50	238.36	208.33	160.98
64605	Neurolytic-trigeminal-2/3 division	316.34	296.20	332.08	303.53	160.98
64610	Neurolytic-trigeminal-at foramen ovale	NA	528.33	NA	491.36	160.98
64612	Neurolytic block-muscles of facial nerve	156.70	120.45	163.30	134.74	160.98
64613	Neurolytic block-cervical spinal muscles	139.49	120.82	139.86	133.64	160.98
64620	Intercostal neurolysis	183.43	141.69	197.71	138.77	160.98
64622	Facet neurolysis-lumbar/sacral -single	227.73	166.22	137.67	46.87	160.98
64623	Facet neurolysis-lumbar/sacral -additional	111.67	59.68	129.98	53.82	160.98
64626	Facet neurolysis-cervical/thoracic-single	259.59	161.10	261.42	162.56	160.98
64627	Facet neurolysis-cervical/thoracic-additional	154.87	57.11	155.24	57.48	160.98
64630	Pudenal nerve	201.00	165.86	104.35	47.23	160.98
64640	Peripheral	206.50	142.79	239.45	143.16	160.98
64680	Celiac plexus	178.30	144.25	184.90	136.20	160.98
72265	Myelography, lumbosacral, radiological S&I	202.11	202.11	201.38	NA	160.98
72275	Epidurography-radiological S&I	110.93	110.93	110.57	NA	234.19
72285	Diskography, cervical or thoracic, radiological S & I	384.44	326.93	384.44	NA	234.19
72295	Diskography L/S spine, radiological S & I	349.99	305.69	351.09	NA	234.19
73542	SI-joint arthrography-radiological S&I	107.64	107.64	107.64	NA	132.85
76005	Fluoroscopic guidance	79.45	79.45	20.87	NA	120.73

[i]. Information obtained from the November 2, 1999 Federal Register. [ii]. Information obtained from the November 2, 1999 Federal Register. [iii]. Information obtained from the July 17, 2000 Federal Register. [iv]. Information obtained from the July 17, 2000 Federal Register.

in a later interim action in a program memorandum issued, HCFA delineated certain services with replacement codes for pain management procedures but refused to include new procedures based on various technical limitations (8). We have been told that these services, which include percutaneous lysis of adhesions, transforaminal epidural injections, cervical facet joint nerve blocks, and neurolytic blocks, simply are not available to Ambulatory Surgery center patients, pending the final implementation of the ASC final rule in April 2001. The Association of the Pain Management of Anesthesiologists (AOPMA), now known as the American Society of Interventional Pain Physicians (ASIPP) advised HCFA that the process would take approximately three years or so. Finally, following the numerous requests from the American Society of Interventional Pain Physicians and Congressional membership, HCFA has softened its position somewhat in that the statement that the new procedures will be considered at the time when final rule for outpatient Surgery centers may be issued in November 2000 and comments will be requested (18). While the new rules are pending, this situation creates various issues in billing and coding for interventional pain physicians as well as Ambulatory Surgery centers. Finally, physician payment policies both final rules for 2000 and proposed rules for 2001 (4, 5), and HCFA's acceptance of bilateral coding for procedures also creates some changes in billing and coding for interventional pain procedures in all settings. Table 1 shows the impact of these regulations on various interventional pain procedures.

Issues of correct coding and medical necessity and guidelines with regards to frequency and number of interventions, combination of blocks/interventions, and number per setting continue to remain the same (1, 19).

Various descriptors of interventional pain procedures commonly utilized and examples for many of the situations encountered in interventional pain practices are reviewed here. However, this review will only provide generally accepted practice patterns in a safe and ethical manner. Essentially, these illustrations and the information provide practical considerations for the use of interventional techniques in the management of chronic pain based on the current state of the art and signs of interventional pain management, rules and regulations. However, this article and its descriptions do not constitute practice management or legal advice. In addition, these guidelines also do not constitute inflexible treatment recommendations. It is expected that a provider will establish a plan of care on a case by case basis taking into account an individual patient's medical condition, personal needs, and preferences, and the physician's experience. Thus, based on individual patient's needs, treatments provided, experience of the physician, billing and coding staff, and rules and regulation of local Medicare carriers, and other payors, various types of practice patterns including billing and coding are warranted.

FACET JOINT BLOCKS AND NEUROLYSIS

Procedure (CPT) Codes 2000 (3)

- 64470 – Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve, cervical or thoracic, single level
- 64472 – Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve, cervical or thoracic, each additional level
- 64475 – Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve, lumbar or sacral, single level
- 64476 – Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve, lumbar or sacral, each additional level
- 64626 – Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level
- 64627 – Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level
- 64622 – Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level
- 64623 – Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level
- 27096 – Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
- 73542 – Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation

HCFA continued to propose higher reimbursement for injection procedure for sacroiliac joint arthrography and/or anesthetic/steroid (CPT code 27096), as well as hip arthrography in a nonfacility setting, $434, $355 to $371 consecutively. This probably is an error on the part of HCFA; however, at this point, we are unable to determine the future consequences if and when HCFA realizes that they may have been over-reimbursing for these codes. Similarly, CPT 73542 – radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation is also considered as a radiology code and in-

terventional pain physicians may have difficulty getting reimbursed for this procedure.

Examples

i. Cervical facet joint injection, single level (C5/6 joint)

Physician

- 64470 – C/T facet joint injection, single level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Cervical facet joint injection procedures are not approved for surgery centers.

Other carriers

- 64470 – C/T facet joint injection, single level

ii. Multiple cervical facet joint injections (C4/5 through C6/7)

Physician

- 64470 – C/T facet joint injection, single level
- 64472-51 (two units) – C/T facet joint injection, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Cervical facet joint injection procedures are not approved for surgery centers.

Other carriers

- 64470 – C/T facet joint injection, single level
- 64472 – 51 (two units) – C/T facet joint injection, each additional level

iii. Bilateral cervical facet joint injections (C4/5 through C6/7)

Physician

Medicare

- 64470-50 – C/T facet joint injection, single level (bilateral)
- 64472 – C/T facet joint injection, each additional level (right)
- 64472 – C/T facet joint injection, each additional level (left)
- 76005 – Fluoroscopic guidance

For carriers allowing two levels of bilateral coding

- 64470-50 – C/T facet joint injection, single level (bilateral)
- 64472-50 – C/T facet joint injection, each additional level (bilateral)
- 76005 – Fluoroscopic guidance

For carriers who do not permit bilateral coding

- 64470 – C/T facet joint injection, single level
- 64472 – 51 (two units) – C/T facet joint injection, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Cervical facet joint nerve block procedures are not approved for surgery centers.

For carriers allowing two levels of bilateral coding

- 64470-50 – C/T facet joint injection, single level (bilateral)
- 64472-50 – C/T facet joint injection, each additional level (bilateral)

For carriers who do not permit bilateral coding

- 64470 – C/T facet joint injection, single level
- 64472 -51 (two units) – C/T facet joint injection, each additional level

iv. Cervical facet joint nerve blocks, single joint (C5/6 joint – C5 and C6 medial branch nerves)

Physician

- 64470 – C/T facet joint nerve block, single level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Cervical facet joint nerve block procedures are not approved for surgery centers.

Other carriers

- 64470 – C/T facet joint nerve block, single level

v. Cervical facet joint nerve block, multiple levels (C3/4 and C4/5 joints – C3, C4, and C5 medial branch nerves)

Physician

- 64470 – C/T facet joint nerve block, single level
- 64472 – C/T Facet joint nerve block, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Cervical facet joint nerve block procedures are not approved for surgery centers.

Other carriers

- 64470 – C/T facet joint injection, single level
- 64472 – C/T facet joint injection, each additional level

vi. Cervical facet joint nerve blocks, multiple levels (C3/4 through C6/7 joints - C3 through C7 medial branches)

Physician

- 64470 – C/T facet joint nerve block, single level
- 64472-51 (two units) – C/T facet joint nerve block, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Cervical facet joint nerve block procedures are not approved for surgery centers.

Other carriers

- 64470 – C/T facet joint nerve block, single level
- 64472-51 (two units) – C/T facet joint nerve block, each additional level

vii. Bilateral cervical facet joint nerve blocks (C5/6 and C6/7 joints - C5 through C7 facet joint nerves or medial branches)

Physician

Medicare

- 64470-50 – C/T facet joint nerve block, single level (bilateral)
- 64472 – C/T facet joint nerve block, each additional level (right)
- 64472 – C/T facet joint nerve block, each additional level (left)
- 76005 – Fluoroscopic guidance

For carriers allowing two levels of bilateral coding

- 64470-50 – C/T facet joint nerve block, single level (bilateral)
- 64472-50 – C/T facet joint nerve block, each additional level (bilateral)
- 76005 – Fluoroscopic guidance

For carriers who do not permit bilateral coding

- 64470 – C/T facet joint nerve block, single level
- 64472-51 (two units) – C/T facet joint nerve block, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Cervical facet joint nerve block procedures are not approved for surgery centers.

For carriers allowing two levels of bilateral coding

- 64470-50 – C/T facet joint injection, single level (bilateral)
- 64472-50 – C/T facet joint injection, each additional level (bilateral)

For carriers who do not permit bilateral coding

- 64470 – C/T facet joint injection, single level
- 64472-51 (two units) – C/T facet joint injection, each additional level

viii. Thoracic facet joint injection, single level (T5/6 joint)

Physician

- 64470 – C/T facet joint injection, single level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Thoracic facet joint injection procedures are not approved for surgery centers.

Other carriers

- 64470 – C/T facet joint injection, single level

ix. Multiple thoracic facet joint injections (T4/5 through T6/7)

Physician

- 64470 – C/T facet joint injection, single level
- 64472-51 (two units) – C/T facet joint injection, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

- Thoracic facet joint injection procedures are not approved for surgery centers.

Other carriers

- 64470 – C/T facet joint injection, single level

- 64472-51 (two units) – C/T facet joint injection, each additional level

x. Bilateral thoracic facet joint injections (T4/5 through T6/7)

Physician

Medicare

- 64470-50 – C/T facet joint injection, single level (bilateral)
- 64472 – C/T facet joint injection, each additional level (right)
- 64472 – C/T facet joint injection, each additional level (left)
- 76005 – Fluoroscopic guidance

For carriers allowing two levels of bilateral coding

- 64470-50 – C/T facet joint injection, single level (bilateral)
- 64472-50 – C/T facet joint injection, each additional level (bilateral)
- 76005 – Fluoroscopic guidance

For carriers who do not permit bilateral coding

- 64470 – C/T facet joint injection, single level
- 64472-51 (two units) – C/T facet joint injection, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Thoracic facet joint injection procedures are not approved for surgery centers.

For carriers allowing two levels of bilateral coding

- 64470-50 – C/T facet joint injection, single level (bilateral)
- 64472-50 – C/T facet joint injection, each additional level (bilateral)

For carriers who do not permit bilateral coding

- 64470 – C/T facet joint injection, single level
- 64472-51 (two units) – C/T facet joint injection, each additional level

xi. Thoracic facet joint nerve blocks, single joint (T5/6 joint – T5 and T6 medial branch nerves)

Physician

- 64470 – C/T facet joint nerve block, single level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Thoracic facet joint nerve block procedures are not approved for surgery centers.

Other carriers

- 64470 – C/T facet joint nerve block, single level

xii. Thoracic facet joint nerve blocks, multiple levels (T3/4 through T6/7 joints - T3 through T7 medial branches)

Physician

- 64470 – C/T facet joint nerve block, single level
- 64472-51 (two units) – C/T facet joint nerve block, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Thoracic facet joint nerve block procedures are not approved for surgery centers.

Other carriers

- 64470 – C/T facet joint nerve block, single level
- 64472-51 (two units) – C/T facet joint nerve block, each additional level

xiii. Bilateral thoracic facet joint nerve blocks (T5/6 and T6/7 joints – T5 through T7 facet joint nerves or medial branch nerves)

Physician

- 64470-50 – C/T facet joint nerve block, single level (bilateral)
- 64472 – C/T facet joint nerve block, single level (right)
- 64472 – C/T facet joint nerve block, single level (left)
- 76005 – Fluoroscopic guidance

For carriers allowing two levels of bilateral coding

- 64470-50 – C/T facet joint nerve block, single level (bilateral)
- 64472-50 – C/T facet joint nerve block, each additional level (bilateral)
- 76005 – Fluoroscopic guidance

For carriers who do not permit bilateral coding

- 64470 – C/T facet joint nerve block, single level

- 64472-51 (two units) – C/T facet joint nerve block, subsequent levels
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Thoracic facet joint nerve block procedures are not approved for surgery centers.

For carriers allowing two levels of bilateral coding

- 64470-50 – C/T facet joint injection, single level (bilateral)
- 64472-50 – C/T facet joint injection, each additional level (bilateral)

For carriers who do not permit bilateral coding

- 64470 – C/T facet joint injection, single level
- 64472-51 (two units) – C/T facet joint injection, each additional level

xiv. Lumbosacral facet joint injection, single level (L3/4 joint)

Physician

- 64475 – L/S facet joint injection, single level
- 76005 – Fluoroscopic guidance

Surgery center

- 64475 – L/S facet joint injection, single level

xv. Lumbosacral facet joint injections, multiple levels (L2/3 – L5/S1)

Physician

- 64475 – L/S facet joint injection, single level
- 64476-51 (two units) – L/S facet joint injection, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

- 64475 – L/S facet joint injection, single level
- 64476-51 (two units) - L/S facet joint injection, each additional level

xvi. Bilateral lumbosacral facet joint injections (L3/4 and L4/5 joints)

Physician

Medicare

- 64475-50 – L/S facet joint injection, single level (bilateral)
- 64476 – L/S facet joint injection, each additional level (right)
- 64476 – L/S facet joint injection, each additional level (left)
- 76005 – Fluoroscopic guidance

For carriers allowing two levels of bilateral coding then use

- 64475-50 – L/S facet joint nerve block, single level (bilateral)
- 64476-50 – L/S facet joint nerve block, each additional level (bilateral)
- 76005 – Fluoroscopic guidance

For carriers who do not permit bilateral coding

- 64475 – L/S facet joint nerve block, single level (bilateral)
- 64476-51(two units) – L/S facet joint nerve block, each additional level (bilateral)
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- 64475-50 – L/S facet joint injection, single level (bilateral)
- 64476 – L/S facet joint injection, each additional level (right)
- 64476 – L/S facet joint injection, each additional level (left)

For carriers allowing two levels of bilateral coding

- 64475-50 – L/S facet joint injection, single level (bilateral)
- 64476-50 – L/S facet joint injection, each additional level (bilateral)

For carriers who do not permit bilateral coding

- 64475 – L/S facet joint injection, single level
- 64476-51 (two units) – L/S facet joint injection, each additional level

xvii. Lumbar facet joint nerve blocks, single joint (L3/4 joint – L2 and L3 medial branch nerves or facet joint nerves)

Physician

- 64475 – L/S facet joint nerve block, single level
- 76005 – Fluoroscopic guidance

Surgery center

- 64475 – L/S facet joint injection, single level

xviii. Multiple lumbar facet joint nerve blocks (L4/5 and L5/S1 joints – L3 and L4 medial branch nerves and L5 dorsal ramus)

Physician

- 64475 – L/S facet joint nerve block, single level
- 64476 – L/S facet joint nerve block, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

- 64475 – L/S facet joint nerve block, single level
- 64476-51 – L/S facet joint nerve block, each additional level

xix. Bilateral multiple lumbar facet joint nerve blocks (L3/4 through L5/S1 joints – L2 through L4 medial branch nerves and L5 dorsal ramus)

Physician

Medicare

- 64475-50 – L/S facet joint nerve block, single level (bilateral)
- 64476 – L/S facet joint nerve block, each additional level (right)
- 64476 – L/S facet joint nerve block, each additional level (left)
- 76005 – Fluoroscopic guidance

For carriers allowing two levels of bilateral coding

- 64475-50 – L/S facet joint nerve block, single level (bilateral)
- 64476-50 – L/S facet joint nerve block, each additional level (bilateral)
- 76005 – Fluoroscopic guidance

For carriers who do not permit bilateral coding

- 64475 – L/S facet joint nerve block, single level
- 64476-51 (two units) – L/S facet joint nerve block, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- 64475-50 – L/S facet joint nerve block, single level (bilateral)
- 64476-51 – L/S facet joint nerve block, each additional level (right)
- 64476-51 – L/S facet joint nerve block, each additional level (left)

For carriers allowing two levels of bilateral coding

- 64475-50 – L/S facet joint nerve block, single level (bilateral)
- 64476-50 – L/S facet joint nerve block, each additional level (bilateral)

For carriers who do not permit bilateral coding

- 64475 – L/S facet joint nerve block, single level
- 64476-51 (two units) – L/S facet joint nerve block, each additional level

xx. Cervical paravertebral facet joint nerve neurolysis – single joint (C5/6 joint – C5 and C6 medial branch nerves)

Physician

- 64626 – C/T facet neurolysis, single level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Cervical paravertebral facet joint nerve neurolysis procedures are not approved for surgery centers.

Other carriers

- 64626 – C/T facet neurolysis, single level

xxi. Multiple cervical paravertebral facet joint neurolysis (C4/5 through C6/7 joints – C4 through C7 medial branches)

Physician

- 64626 – C/T facet joint neurolysis, single level
- 64627-51 (two units) – C/T facet joint neurolysis, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Cervical paravertebral facet joint neurolysis procedures are not approved for surgery centers.

Other carriers

- 64626 – C/T facet joint neurolysis, single level
- 64627-51 (two units) – C/T facet joint neurolysis, each additional level

xxii. Bilateral thoracic facet joint nerve neurolysis (T4/5 through T6/7 joints – T4 through T7 medial branches)

Physician

Medicare

- 64626-50 – C/T facet joint nerve neurolysis, single level (bilateral)

- 64627 – C/T facet joint nerve neurolysis, each additional level (right)
- 64627 – C/T facet joint nerve neurolysis, each additional level (left)
- 76005 – Fluoroscopic guidance

For carriers allowing two levels of bilateral coding

- 64626-50 – C/T facet joint nerve neurolysis, single level (bilateral)
- 64627-50 – C/T facet joint nerve neurolysis, each additional level (bilateral)
- 76005 – Fluoroscopic guidance

For carriers who do not permit bilateral coding

- 64626 – C/T facet joint nerve neurolysis, single level
- 64627-51 (two units) – C/T facet joint nerve neurolysis, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Thoracic facet joint nerve neurolytic procedures are not approved for surgery centers.

For carriers allowing two levels of bilateral coding

- 64626-50 – C/T facet joint nerve neurolysis, single level (bilateral)
- 64627-50 – C/T facet joint nerve neurolysis, each additional level (bilateral)

For carriers who do not permit bilateral coding

- 64626 – C/T facet joint nerve neurolysis, single level
- 64627-51 (two units) – C/T facet joint nerve neurolysis, each additional level

xxiii. Thoracic paravertebral facet joint nerve neurolysis – single joint (T5/6 joint – T5 and T6 medial branch nerves)

Physician

- 64626 – C/T paravertebral facet joint neurolysis, single level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Thoracic paravertebral facet joint nerve neurolysis procedures are not approved for surgery centers.

Other carriers

- 64626 – C/T paravertebral facet joint neurolysis, single level

xxiv. Multiple thoracic paravertebral facet joint neurolysis (T4/5 through T6/7 joints - T4 through T7 medial branches)

Physician

- 64626 – C/T paravertebral facet joint neurolysis, single level
- 64627-51 (two units) – C/T paravertebral facet joint neurolysis, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

- Thoracic paravertebral facet joint neurolytic procedures are not approved for surgery centers.

Other carriers

- 64626 – C/T paravertebral facet joint neurolysis, single level
- 64627-51 (two units) – C/T paravertebral facet joint neurolysis, each additional level

xxv. Lumbar paravertebral facet joint neurolysis – single joint (L4/5 joint – L3 and L4 medial branch nerves)

Physician

- 64622 – L/S, paravertebral facet joint neurolysis, single level
- 76005 – Fluoroscopic guidance

Surgery center

- 64622 – L/S, paravertebral facet joint neurolysis, single level

xxvi. Multiple lumbar paravertebral facet joint neurolysis (L3/4 through L5/S1 joints L2 through L4 medial branch nerves and L5 dorsal ramus)

Physician

- 64622 – L/S paravertebral facet joint neurolysis, single level
- 64623-51 (two units) – L/S paravertebral facet joint neurolysis, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

- 64622 – L/S paravertebral facet joint neurolysis, single level
- 64623-51 (two units) – L/S paravertebral facet joint neurolysis, each additional level

xxvii. Bilateral lumbar facet joint neurolysis (L3/4 through L5/S1 joints – L2 through L4 medial branch nerves and L5 dorsal ramus)

Physician

Medicare

- 64622-50 – L/S paravertebral facet joint neurolysis, single level (bilateral)
- 64623 – L/S paravertebral facet joint neurolysis, each additional level (right)
- 64623 – L/S paravertebral facet joint neurolysis, each additional level (left)
- 76005 – Fluoroscopic guidance

For carriers allowing two levels of bilateral coding

- 64622-50 – L/S facet joint nerve neurolysis, single level (bilateral)
- 64623-50 – L/S facet joint nerve neurolysis, each additional level (bilateral)
- 76005 – Fluoroscopic guidance

For carriers who do not permit bilateral coding

- 64622 – L/S facet joint nerve neurolysis, single level
- 64623-51 (two units) – L/S facet joint nerve neurolysis, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- 64622-50 – L/S paravertebral facet joint neurolysis, single level (bilateral)
- 64623-51 – L/S paravertebral facet joint neurolysis, each additional level (right)
- 64623-51 – L/S paravertebral facet joint neurolysis, each additional level (left)

For carriers allowing two levels of bilateral coding

- 64622-50 – L/S facet joint nerve neurolysis, single level (bilateral)
- 64623-50 – L/S facet joint nerve neurolysis, each additional level (bilateral)

For carriers who do not permit bilateral coding

- 64622 – L/S facet joint nerve neurolysis, single level
- 64623-51 (two units) – L/S facet joint nerve neurolysis, each additional level

EPIDURAL INJECTIONS

***Procedure (CPT)* 2000 Codes (3)**

- 62310 – Injection, single (not via indwelling catheter), 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
- 62311 – Injection, single (not via indwelling catheter), 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; lumbar, sacral (caudal)
- 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 – 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; lumbar, sacral (caudal)
- 64479 – Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level
- 64480 – Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, each additional level
- 64483 – Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level
- 64484 – Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level
- 72275 – Epidurography, radiological supervision and interpretation
- 76005 – Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic procedures

The new developments include reduction or elimination of reimbursement for CPT 76005 – Fluoroscopic guidance and localization of needle or catheter tip or paraspinous diagnostic or therapeutic procedures. In addition, carriers across the country have been refusing payment for CPT 72275 – Epidurography, radiological supervision and interpretation stating that this is a radiology code and there are no specific indications for this procedure. Therefore, interventional pain physicians will not be reimbursed for this code.

Examples

i. Cervical interlaminar epidural injection - without fluoroscopy

Physician
- 62310 – C/T epidural

Surgery center
- 62310 – C/T epidural

ii. Cervical interlaminar epidural injection - with fluoroscopy

Physician
- 62310 – C/T epidural
- 76005 – Fluoroscopic guidance

Surgery center
- 62310 – C/T epidural

iii. Thoracic interlaminar epidural injection - without fluoroscopy

Physician
- 62310 – C/T epidural

Surgery center
- 62310 – C/T epidural

iv. Thoracic interlaminar epidural injection - with fluoroscopy

Physician
- 62310 – C/T epidural
- 76005 – Fluoroscopic guidance

Surgery center
- 62310– C/T epidural

v. Lumbar interlaminar epidural injection - without fluoroscopy

Physician
- 62311 – L/S epidural

Surgery center
- 62311– Lumbar epidural

vi. Lumbar interlaminar epidural - with fluoroscopy

Physician
- 62311 – L/S epidural
- 76005 – Fluoroscopic guidance

Surgery center
- 62311– Lumbar epidural

vii. Caudal epidural injection - without fluoroscopy

Physician
- 62311 – L/S epidural
- 76005 – Fluoroscopic guidance

Surgery center
- 62311– Lumbar/caudal epidural

viii. Caudal epidural injection – with fluoroscopy

Physician
- 62311 – L/S epidural
- 76005 – Fluoroscopic guidance

Surgery center
- 62311– Lumbar/caudal epidural

ix. Cervical transforaminal epidural injection, single level (C5 spinal nerve, C4/5 foramen)

Physician
- 64479 – C/T transforaminal epidural, single level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

Cervical transforaminal epidural injection procedures are not approved for surgery centers.

Other carriers
- 64479 – C/T transforaminal epidural, single level (C5)

x. Cervical transforaminal epidural injection, multiple levels (C6 and C7 spinal nerves)

Physician
- 64479 – C/T transforaminal epidural, single level
- 64480 – C/T transforaminal epidural, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare
- Cervical transforaminal epidural injection procedures are not approved for surgery centers.

Other carriers
- 64479 – C/T transforaminal epidural, single level

- ♦ 64480 – C/T transforaminal epidural, each additional level

xi. Thoracic transforaminal or selective epidural injection, single level (T5 spinal nerve, T4/5 foramen)

Physician

- ♦ 64479 – C/T, transforaminal epidural, single level
- ♦ 76005 – Fluoroscopic guidance

Surgery center

Medicare

- ♦ Thoracic transforaminal or selective epidural injection procedures are not approved for surgery centers.

Other carriers

- ♦ 64479 – C/T, transforaminal epidural, single level

xii. Thoracic transforaminal or selective epidural injection, multiple levels (T6 and T7 spinal nerves)

Physician

- ♦ 64479 – C/T, single level
- ♦ 64480 – C/T transforaminal epidural, each additional level
- ♦ 76005 – Fluoroscopic guidance

Surgery center

Medicare

Thoracic transforaminal or selective epidural injection procedures are not approved for surgery centers.

Other carriers

- ♦ 64479 – C/T, single level
- ♦ 64480 – C/T transforaminal epidural, each additional level

xiii. Bilateral thoracic transforaminal or selective epidural injections (T5, T6, and T7 spinal nerves)

Physician

Medicare

- ♦ 64479-50 – CT transforaminal epidural, single level (bilateral)
- ♦ 64480 – C/T transforaminal epidural, each additional level (right)
- ♦ 64480 – C/T transforaminal epidural, each additional level (left)
- ♦ 76005 – Fluoroscopic guidance

For carriers allowing two levels of bilateral coding

- ♦ 64479-50 – C/T transforaminal epidural, single level (bilateral)
- ♦ 64480-50 – C/T transforaminal epidural, each additional level (bilateral)
- ♦ 76005 – Fluoroscopic guidance

For carriers who do not permit bilateral coding

- ♦ 64479 – C/T transforaminal epidural, single level
- ♦ 64480-51 (two units) – C/T transforaminal epidural, each additional level
- ♦ 76005 – Fluoroscopic guidance

Surgery center

Medicare

- ♦ Thoracic transforaminal or selective epidural injections procedures are not approved for surgery centers.

Other carriers

For carriers allowing two levels of bilateral coding

- ♦ 64479-50 – C/T transforaminal epidural, single level (bilateral)
- ♦ 64480-50 – C/T transforaminal epidural, each additional level (bilateral)

For carriers who do not permit bilateral coding

- ♦ 64479 – C/T transforaminal epidural, single level
- ♦ 64480-51 (two units) – C/T transforaminal epidural, each additional level

xiv. Lumbar transforaminal or selective epidural injection (L5 spinal nerve)

Physician

- ♦ 64483 – L/S transforaminal epidural, single level
- ♦ 76005 – Fluoroscopic guidance

Surgery center

Medicare

- ♦ Lumbar transforaminal or selective epidural injection procedures are not approved for surgery centers.

Other carriers

- ♦ 64483 – L/S transforaminal epidural, single level

xv. Lumbar transforaminal or selective epidural injection, multiple levels (L4, L5, and S1 spinal nerves)

Physician

- ♦ 64483 – L/S transforaminal epidural, single level
- ♦ 64484-51 (two units) – L/S transforaminal epidural, each additional level
- ♦ 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Lumbar transforaminal or selective epidural injection codes are not approved procedures for surgery centers.

Other carriers

- 64483 – L/S transforaminal epidural, single level
- 64484-51 (two units) – L/S transforaminal epidural, each additional level

xvi. Bilateral lumbar transforaminal or selective epidural injections (L5, S1)

Physician

Medicare

- 64483-50 – L/S transforaminal epidural, single level (bilateral)
- 64484 – L/S transforaminal epidural, each additional level (right)
- 64484 – L/S transforaminal epidural, each additional level (left)
- 76005 – Fluoroscopic guidance

For carriers allowing two levels of bilateral coding

- 64483-50 – L/S transforaminal epidural, single level (bilateral)
- 64484-50 – L/S transforaminal epidural, each additional level (bilateral)
- 76005 – Fluoroscopic guidance

For carriers who do not permit bilateral coding

- 64483 – L/S transforaminalepidural, single level
- 64484-51 (two units) – L/S transforaminal epidural, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Lumbar transforaminal or selective epidural injection procedures are not approved for surgery centers.

For carriers allowing two levels of bilateral coding

- 64483-50 – L/S transforaminal epidural, single level (bilateral)
- 64484-50 – L/S transforaminal epidural, each additional level (bilateral)

For carriers who do not permit bilateral coding

- 64483 – L/S transforaminal epidural, single level
- 64484-51 (two units) – L/S transforaminal epidural, each additional level

PERCUTANEOUS LYSIS OF EPIDURAL ADHESIONS

Procedure (CPT) Code (3)

- 62263 – Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, spring-wire catheter) including radiologic localization (includes contrast when administered)

Example

Percutaneous lysis of adhesions utilizing Racz catheter

Physician

- 62263 – Percutaneous lysis of epidural adhesions

Surgery center

Medicare

- Percutaneous lysis of adhesions epidural adhesions is not approved for surgery centers.

Other carriers

- 62263 – Percutaneous lysis of epidural adhesions

DISCOGRAPHY AND ANNULOPLASTY

Procedure (CPT) Codes (3)

- 62290 – Injection procedure for discography, each level; lumbar
- 62291 – Injection procedure for discography, each level; cervical or thoracic
- 72285 – Diskography, cervical or thoracic, radiological supervision and interpretation
- 72295 – Diskography, lumbar, radiological supervision and interpretation
- No CPT codes are available for intradiscal thermal annuloplasty. The following code is used with revised description:
  62287 – Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous diskectomy, percutaneous laser diskectomy)

Once again, similar to epidurography and sacroiliac joint discography codes with radiological supervision and interpretation, codes 72285 and 72295 continue to have difficulty getting reimbursed. In addition, intradiscal electri-

cal thermal annuloplasty also has elicited significant controversy. The American Medical Association initially issued an opinion that CPT 62287 (aspiration or decompression procedure) was the appropriate code to utilize. However, later on, the AMA advised to use an unlisted procedure code for the nervous system, namely CPT 22899, and yet another unused code also emerged, i.e. CPT 64999. Further, recent advice was extended to the use of CPT 62292 (injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar). However, none of these codes are approved for Surgery centers at this time. Recently, the AMA has been considering revision of CPT 62287 so that the definition of the code would incorporate intradiscal thermal annuloplasty. Thus, CPT 62287, may be considered as appropriate for continued to use to describe IDET. However, caution must be exercised prior to utilizing this code on any patient. All specialists performing these procedures are requested to obtain pre-approvals with the explicit understanding of the insurer of the procedure to be performed and the code to be utilized. In addition, providers should also obtain in writing the clarification of use of the insurers that they do indeed understand the nature of the procedure i.e. intradiscal thermal annuloplasty and the CPT code 62287 i.e. aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels is being used.

Example(s)

i. Cervical discography – multiple levels (C4/5, C5/6)

Physician

- 62291 – C/T discography, each level
- 62291-51 – C/T discography, each level
- 72285 – C/T discography, radiological supervision and interpretation

Surgery center

Medicare

- Cervical discography procedures are not approved for surgery centers.

Other carriers

- 62291 – C/T discography, each level
- 62291-51 – C/T discography, each level

ii. Thoracic discography – multiple levels (T4/5, T5/6)

Physician

- 62291 – C/T discography, each level
- 62291-51 – C/T discography, each level
- 72285 – C/T discography, radiological supervision and interpretation

Surgery center

Medicare

- Thoracic discography procedures are not approved for surgery centers.

Other carriers

- 62291 – C/T discography, each level
- 62291-51 – C/T discography, each level

iii. Lumbar discography – multiple levels (L3/4, L4/5, L5/S1)

Physician

- 62290 – Lumbar discography, each level
- 62290-51 – Lumbar discography, each level
- 72295 – Lumbar discography, radiological supervision and interpretation

Surgery center

Medicare

- Lumbar discography procedures are not approved for surgery centers.

Other carriers

- 62290 – Lumbar discography, each level
- 62290-51 – Lumbar discography, each level

iv. Intradiscal electric thermal annuloplasty, single or multiple levels

Physician

- 62287 – Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels; or
- 22899 – Unlisted, spine procedure; or
- 64999 – unlisted, spine procedure

Surgery center

Medicare

- Intradiscal electrical thermal annuloplasty procedures are not approved for surgery centers.

Other carriers

- 62287 – Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels; or
- 22899 – Unlisted, spine procedure; or
- 64999 – unlisted, spine procedure

MULTIPLE REGIONS AND/OR COMBINATIONS

Due to various regulations in existence at the present time, when interventional procedures are performed in multiple regions and/or combinations, thus could be utilized for the advantage of the physician in certain cases. It is common to perform blocks in multiple regions in interventional pain practices as it has been shown that involvement of multiple regions in chronic pain patients is more prevalent than assumed (20). It has been shown that in patients suffering with chronic low back pain presenting to interventional pain practice, patients who had three regions being affected were 33% followed by two regions with 46% and the remaining 21% suffered with pain in only one region. In addition, treating multiple regions at one time is not only beneficial to the patient, it is also cost and time saving for the insurer, the facility, and time saving for physician and staff. The most common complication in including multiple regions into the treatment regimen at one time steroid toxicity. However, this has been shown to be negligible when therapy was carried out with a low dose or no steroids (20). Creative billing will only create multiple problems for interventional pain practitioners all across the country as insurers universally blame interventional pain physicians across the board citing examples of 24 charges on one patient, etc. The guidelines here indicate a limitation of 4 procedures or line items for management of a single region and a 5 for multiple regions. Thus, if a bilateral procedure is performed at two levels, that it will constitute 4 procedures, such as needle placement, epidurography, radiological interpretation and supervision, etc. are also considered as a line item. Most carriers of Medicare do not reimburse more than 5 line items, codes, or procedures at one time per patient. In addition, some insurers do not reimburse if a procedure code is repeated following the primary charge as an increase in the number of units. Considering the present situation with the proposed ASC ruling, higher reimbursement may be possible, within legal and ethical parameters without using creative billing techniques, for procedures which are performed in a facility setting which is the same as if it is performed in a nonfacility setting. It may be worthwhile for physicians to pay proper attention to billing and coding practices when multiple regions or combinations are utilized in managing these patients. Once again, these practices should be performed within the limits of the guidelines following the rules, regulations and ethical practices. Benefits may not be realized to the fullest extent if the physician has an agreement with the surgery center to reimburse the surgery center for the facility portion of the reimbursement for nonapproved procedures which is nonfacility total reimbursement minus facility reimbursement; but, still will yield higher reimbursement and is the right thing to do.

Examples

i. Multiple cervical facet joint nerve blocks, (C3/4-C5 6 joints – C3-6 medial branch nerves) and multiple lumbar facet joint nerve block, (L3/4-L5/S1 joints L2-L4 medial branches and L5 dorsal ramus)

Physician

- 64470 – C/T facet joint nerve block, single level
- 64472 – C/T facet joint nerve block, each additional level
- 64475 – L/S facet joint nerve block, single level
- 64476 – L/S facet joint nerve block, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Multiple cervical facet joint nerve blocks are not approved procedures for surgery centers. Hence, the charges for the facility are limited to lumbar facet joint nerve block only:
- 64475 – L/S facet joint nerve block, single level
- 64476-51 (two units) – L/S facet joint nerve block, each additional level

Other Carriers

- 64470 – C/T facet joint nerve block, single level
- 64472-51 – C/T facet joint nerve block, each additional level
- 64475-51 – L/S facet joint nerve block, single level
- 64476-51 – L/S facet joint nerve block, each additional level (may or may not be used considering the charge level of the facility)

ii. Caudal epidural and multiple cervical facet joint nerve blocks (C3/4-C5/6 joints – C3-6 medial branch nerves)

Physician

- 64470 – CT facet joint nerve block, single level
- 64472 – C/T facet joint nerve block, each additional level
- 62311-51 – L/S epidural

- 76005 – Fluoroscopic guidance (may or may not be used)

Surgery center

Medicare

- Cervical facet joint nerve block procedures are not approved for surgery centers.
- 62311 – Lumbosacral epidural

Other Carriers

- 62311 – L/S epidural
- 64470-51 – CT facet joint nerve block, single level
- 64472-51– C/T facet joint nerve block, each additional level

iii. Cervical epidural and multiple lumbar facet joint nerve blocks

Physician

- 62310 – Cervical epidural
- 64475-51 – L/S facet joint nerve block, single level
- 64476 – L/S facet joint nerve block, each additional level; or
- 64476 – 51 (two units) L/S facet joint nerve block, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

- 62311 – L/S epidural
- 64470-51 – CT facet joint nerve block, single level
- 64472-51– C/T facet joint nerve block, each additional level

iv. Multiple cervical transforaminal epidurals and multiple lumbar facet joint nerve blocks

Physician

- 64479 – Cervical transforaminal, single level
- 64481 – Cervical transforaminal, each additional level
- 64475 – L/S facet joint nerve block, single level
- 64476 – L/S facet joint nerve block, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Cervical transforaminal injections are not approved for surgery centers.

Other carriers

- 64475 – L/S facet joint nerve block, single level
- 64476-51 (two units) – L/S facet joint nerve block, each additional level (two units may be billed if a total of at least three levels are performed.

Other carriers

- 64479 – Cervical transforaminal, single level
- 64481-51 – Cervical transforaminal, each additional level
- 64475-51 – L/S facet joint nerve block, single level
- 64476-51 – L/S facet joint nerve block, each additional level

v. Multiple lumbar transforaminal epidurals and multiple cervical facet joint nerve block

Physician

- 64483 – L/S transforaminal epidural, single level
- 64484 – L/S transforaminal, each additional level
- 64470 – C/T facet joint nerve block, single level
- 64472 – C/T facet joint nerve block, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Lumbar transforaminal epidurals and cervical facet joint nerve block codes are not approved procedures for surgery centers.

Other carriers

- 64483 – L/S transforaminal epidural, single level
- 64484-51 – L/S transforaminal, each additional level
- 64470-51 – C/T facet joint nerve block, single level

vi. Percutaneous lysis of adhesions and multiple cervical facet joint nerve blocks

Physician

- 62263 – Percutaneous lysis of epidural adhesions
- 64470 – C/T facet joint nerve block, single level
- 64472-51 (two units) – C/T facet joint nerve block, each additional level
- 76005 – Fluoroscopic guidance

Surgery center

Medicare

- Percutaneous lysis of adhesions **and** multiple cervical facet joint nerve block codes are not approved procedures for surgery centers.

Other carriers

- 62263 – Percutaneous lysis of epidural adhesions
- 64470-51 – C/T facet joint nerve block, single level
- 64472-51 (two units) – C/T facet joint nerve block, each additional level

vii. Bilateral lumbar facet joint nerve blocks and caudal epidural

Physician

Medicare

- 64475-50 – L/S facet joint nerve block, single level (bilateral)
- 64476 – L/S facet joint nerve block, each additional level
- 62311-51 – L/S epidural

For carriers allowing bilateral billing

- 64475-50 – L/S facet joint nerve block, bilateral
- 64476-50 – L/S facet joint nerve block, each additional level
- 62311-51 – L/S epidural

For carriers not allowing bilateral billing

- 64475 – L/S facet joint nerve block, single level
- 64476 – L/S facet joint nerve block, each additional level
- 62311-51– L/S epidural

Surgery center

Medicare

- 64475-50 – L/S facet joint nerve block, single level (bilateral)
- 64476-51 – L/S facet joint nerve block, each additional level
- 62311-51 – L/S epidural

For carriers allowing bilateral billing

- 64475-50 – L/S facet joint nerve block, single level (bilateral)
- 64476-50 – L/S facet joint nerve block, each additional level

For carriers not allowing bilateral billing

- 62311– L/S epidural
- 64475-51 – L/S facet joint nerve block, single level
- 64476-51 – L/S facet joint nerve block, each additional level

CONCLUSION

Similar to death and taxes which are inevitable, ongoing changes in billing, coding and documentation, are also not only definite, but also unavoidable. Once again, it is accepted that CPT descriptive terms and identification of codes currently are the only means of documenting medical necessity and serve a wide variety of important functions in the field of medical practice including interventional pain management. Documentation of interventional pain procedures and subsequent billing and coding are of crucial importance not only in compliance with regulations, but also for good patient care, and finally, last but not least, for survival of the practice itself. This review has provided generally accepted practice patterns in a safe manner. However, caution must be exercised in utilizing the issues and guidelines mentioned in this article in your own practices.

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