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The Impact of National Correct Coding Policy on Interventional Pain Management

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Health Care Financing Administration ("HCFA") created the National Correct Coding Council ("NCCC") to help ensure that providers across various jurisdictions received like payment for the same services and use the same codes and provide similar documentation for services performed. As a direct out growth of NCCC's work, HCFA established the National Correct Coding Policy in 1996 and eventually implemented the Medicare "Correct Coding Initiative" to identify and isolate inappropriate coding, unbundling, and other irregularities in coding.

To appropriately implement National Correct Coding Policy in interventional pain management an interventional pain management specialist and their staff must be familiar with correct coding policies as well as understand the physicians current procedural terminology (CPT, medical surgical practice and packages, modifiers, separate procedures, comprehensive and component services, incorrect coding/unbundling and various specific issues relevant to practice of interventional pain management) Comprehensive codes include certain defined services that are separately identifiable by other codes known as component codes. Because component codes are captured by comprehensive codes they man not be listed separately when the complete procedure is done. For example, in interventional pain management, 62279, which is continuous lumbar epidural, is considered a comprehensive code. Various component codes include 62270, 62272 - 62274, 62276 – 62278, 62288 and 62289, among others.

This review describes National Correct Coding Policy, correct procedural terminology, medical and surgical practice and packages, evaluation and management services along with description of most codes used in interventional pain management with correcting coding edits for comprehensive codes and for mutually exclusive codes.

Key words: National Correct Coding Policy, current procedural terminology, comprehensive and component codes, mutually exclusive codes.

Since 1992, Medicare has paid for physician services under the physician fee schedule. The Social Security Act requires that these payments be based on national uniform relative value units determined by the resources used in furnishing a service ("resource-based relative values scales" or "RBRVS"). One goal of the resource-based system is to eliminate payment inequities found in the historic charge-based system of payment because a provider's charges did not necessarily reflect accurately the resources involved in providing a service.

It is the responsibility of the Heath Care Financing Administration ("HCFA") to make certain that uniform payment policies and procedures are followed by all carriers, except those instances where carriers are authorized to make local medical review policy. To help ensure that providers across various jurisdictions receive like payment for the same services (altered only by mandatory geographic adjustments) and use the same codes and provide similar documentation for services performed, HCFA created the National Correct Coding Council ("NCCC"). The purpose of the NCCC was to develop strategies for HCFA's Bureau of Program Operations to control improper coding that leads to inappropriate or increased payments in Part B claims. As a direct outgrowth of NCCC's work, HCFA established the National Correct Coding Policy in 1996 and eventually implemented the Medicare "Correct Coding Initiative" to identify and isolate inappropriate coding, unbundling, and other irregularities in coding. National Correct Coding Policies are available in the form of a National Correct Coding Manual version 5.0, 5.2, and 5.2a, 1999, from the Medical Management Institute (2, 5, 9).

At the core of the Correct Coding Initiative is a list of 83,000 code combinations that Medicare claims physicians sometimes bill incorrectly (1, 3). The coding matrix contains both "unbundled codes" and mutually exclusive coding combinations. In addition, HCFA developed a system of payment denials to be utilized by carriers based on commercial utilization guidelines. These denials are frequently referred to as "black box edits" because carriers refuse to

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give beneficiaries and providers useful, complete information as to the rationale for these denials on the grounds that the guidelines used are "proprietary" and thus, confidential. It is believed that the black box edits are updated frequently, and have become one of the most contentious issues related to Medicare and private insurance reimbursement today. Some suggest that the edits or code pairs may never be released formally to the public. Nevertheless, Medical Management Institute of Alpharetta, Georgia, through research and grass-roots efforts, has discovered over 200 code pairs that it suspects are black box edits. The most recent suspected "black box" edits were published in the July, 1999 issue of Part 'B' News (4, 6). Interestingly, none of the known pairs are identified in the correct coding manual as comprehensive/component or mutually exclusive codes (4).

To appropriately understand and implement National Correct Coding Policy in interventional pain management one must be familiar with correct coding policies (2) as well as understand the physicians' current procedural terminology (CPT), medical surgical practice and packages, modifiers, separate procedures, comprehensive and component services, incorrect coding/unbundling and various specific issues relevant to practice of interventional pain management. This task is made even more complex because CPT has not kept up with the plethora of advances in pain management procedures creating significant coding problems. To reduce the risk of avoidable billing errors, it is strongly suggested that pain management specialists survey or personally meet with insurance carriers and medical directors and obtain a written understanding of coding for new or advanced procedures. At a minimum, every interventional pain management practice should establish and monitor correct coding policies.

CURRENT PROCEDURAL TERMINOLOGY

The physician's Current Procedural Terminology (CPT) developed and routinely updated by the American Medical Association, is a listing of descriptive terms and identification codes for reporting medical services and procedures performed by physicians and other providers (7). HCFA, Medicaid, as well as numerous third party payers have adapted the CPT coding system for use by providers to communicate rendered services. A multitude of codes are necessary in interventional pain management because of the wide spectrum of services provided. For example, a patient encounter at an interventional pain management practice may include one or more of the following procedures during the same session: evaluation and management services, interventional procedures, physical therapy services, and psychological services. Excluded services should never be billed, an issue not addressed by the National Correcting Coding Policy.

MEDICAL SURGICAL PRACTICE AND PACKAGES

As a general principle, all services integral to accomplishing a procedure are considered to be included in a procedure and, therefore, are a component part of a comprehensive code. Some of the services which are considered as part of a comprehensive code include preparation of a patient, establishment of intravenous access, administration of sedatives or regional anesthetics, preoperative, intraoperative, and postoperative documentation, along with surgical supplies unless otherwise classified as a separate item by the policies of HCFA. Thus, medical and surgical packages include pre-procedure and post-procedure work-up and a multitude of other services. For an interventional pain management procedure, the following are typically associated with a standard surgical or medical service package in the CPT manual code description of the service.

1. Intravenous Access. The majority of interventional procedures require the availability of vascular access. Hence, intravenous access with CPT code of 36000 (Introduction of needle or intracatheter, vein) may not be separately reported when performed in conjunction with a more comprehensive procedure. Similarly, maintenance of an infusion or vascular access with use of Heparin Lock or anticoagulant injection with CPT codes 90780 (describing therapeutic or diagnostic infusions or injections) to 90784 are not reportable separately.

2. Cardiopulmonary Monitoring. Most interventional pain management procedures require cardiopulmonary monitoring, including cardiac monitoring, pulse oximetry, and monitoring of vital signs. These services are considered as integral and routine, and as a result the multiple codes describing these services such as 93000, 93005, 93040, or 93041 (describing electrocardiograms) and 94656, 94760, 94761, or 94770 (describing pulmonary services ranging from pulse oximetry, end tidal CO2 monitoring, and airway management may not be separately reported.

3. Successful Service. When one procedure fails or is not possible to perform and a second procedure is performed, only the successful service may be reported.

4. Complications. If a service is performed as a result of complications of the primary procedure such as post lumbar puncture headache, they may

be reported separately. However, modifier –78 may be required to indicate the service was medically necessary to treat the complication if the procedure was repeated within the global surgical period.

Modifiers

An essential part of the CPT coding system is the utilization of modifiers which expand the information provided by the CPT codes. Use of modifiers indicates that the services were performed under circumstances which did not involve "unbundling." However, it is essential to understand the explicit meaning of the modifier by the payer to which a claim is being submitted before using it.

Separate Procedures

The classification of a procedure as a "separate procedure" indicates that the procedure, while it may be performed separately, is generally included in a more comprehensive procedure and the service may not be reported when a related, more comprehensive service is performed. Hence, when a related procedure is performed, a code with a designation of "separate procedure" may not be reported with the primary procedure. The "separate procedure" designation frequently is necessary with interventional pain management procedures, as well as surgical radiology and medical procedures. The most common interventional pain management procedures with a designation of "separate procedure" include:

1. 62289 – lumbar or caudal epidural steroids – Injection of a substance other than anesthetic, antispasmodic, contrast, or neurolytic solutions; lumbar or caudal epidural (separate procedure).
2. 62278 – lumbar or caudal epidural with local anesthetic – Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); epidural, lumbar or caudal, continuous.
3. 62288 – injection of substance other than anesthetic, antispasmodic, contrast, or neurolytic solutions; subarachnoid (separate procedure).
4. 62298 – cervical or thoracic epidural steroids – Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural cervical or thoracic (separate procedure).

Comprehensive and Component Codes

Comprehensive codes include certain defined services that are separately identifiable by other codes known as component codes. Because component codes are captured by comprehensive codes they may not be listed separately when the complete procedure is done. For example, in interventional pain management, 62279, which is continuous lumbar epidural, is considered a comprehensive code. Various component codes include 01996, 20610, 36000, 36140, 36410, 62270, 62272, 62273, 62274, 62276, 62277, 62278, 62288, 62289, 76001, and 76003 (5). Component codes may be billed separately however, if the service they describe is performed independent of the complete procedure or in instances where all the services listed in a comprehensive code were not rendered.

With or Without Contrast and Radiology

Some procedures in interventional pain management are separated into two codes in order to signal whether a procedure included use of contrast or radiology. Hence, both procedure codes cannot be reported. Codes within this category are identified easily in that the code descriptions specify "with or without contrast," or "with or without radiology."

Unlisted Services or Procedures

Codes listed which end in –99 are used to report a service that is not described in any code listed elsewhere in the CPT manual. "99" codes are generally listed in the CPT manual after each section or subsection. Prior to using an unlisted service code for a procedure, providers should make every effort to find the appropriate code to describe the service. Frequent use of these unlisted codes is considered inappropriate and correct code assignment would occur after the documentation has been reviewed and bundling of code pairs would then take place based on the charged code or correctly submitted code. The unlisted service or procedure codes have not been included in the correct coding policy or even the edits because of the multiple procedures that can be assigned to those codes.

In many instances, use of unlisted codes in interventional pain management is necessary because there is a paucity of appropriate codes for numerous procedures such as cervical facet joint nerve blocks, thoracic facet joint nerve blocks, cervical or thoracic radiofrequency neurotomy, or endoscopic or non-endoscopic adhesiolysis. It is important to note, however, that none of the unlisted codes are approved to be performed in ambulatory surgical centers, although it may be reasonable to perform them in hospitals or offices.

EVALUATION AND MANAGEMENT SERVICES

Evaluation and management ("E & M") services refer in large part to cognitive services based on history and ex-

amination, medical decision-making, and non-invasive or minimally invasive (with percutaneous access) procedures. Generally, E & M codes apply to initial and follow-up office visits for new and established patients and initial and follow-up consultations.

The evaluation and management codes are divided to describe the place of service (office, hospital, home, nursing facility, emergency department, or critical care unit), the type of service (new or initial encounter, follow-up, or subsequent encounter, consultation, etc), and various miscellaneous services (prolonged physician service, care plan oversight service, etc). Correct coding primarily involves the determination of the level of history, examination, and medical decision making that was performed rather than reporting multiple codes. In the context of pain management services, the following general rules apply in evaluation and management (5):

1. Only one evaluation and management service code may be billed per day.
2. The prolonged physician service with direct face to face patient contact, (CPT codes 99354 and 99355) represents an exception, and may be used only in conjunction with another evaluation and management code.
3. Certain procedural services that rise directly from the evaluation and management service are included as part of the evaluation and management service. These include cleansing of traumatic lesions, closure of lacerations which does not require a more extensive procedure, counseling, and educational services.
4. CPT codes for psychiatric services include general and special diagnostic services, as well as a variety of therapeutic services. Therapeutic services include psychotherapy and continuing medical diagnostic evaluation. When medical services, other than psychiatric services are provided in addition to psychiatric services, a separate evaluation and management codes cannot be billed. According to Medicare guidelines, the psychiatric service includes the evaluation and management service provided.
5. When the sole purpose of a visit is for the administration of fluids or other medications, a separate evaluation and management service may not be billed, even if a physician interacts with the patient to oversee the injection or infusion. However, if a significant and separately identifiable patient encounter is performed and documented, which involves medical decision making distinct from the injection or infusion, and evaluation and management service may be billed utilizing modifier -257.

INCORRECT CODING AND/OR UNBUNDLING

Unbundling is the billing of multiple procedure codes for a group of procedures that are covered by a single comprehensive code (2). Essentially, there are two types of unbundling, unintentional and intentional. Unintentional unbundling results from a misunderstanding of coding or an honest mistake, whereas intentional unbundling is used to manipulate coding to maximize payment and is considered fraud. Although there are substantial differences of opinion regarding proper coding between physicians and insurers, numerous types of unbundling have been described in interventional pain management some of the examples of unbundling are as follows:

- Fragmenting service into component parts and billing each component part as if it were a separate service.
- Reporting separate codes for related services when one comprehensive code includes all related services.
- Reporting two codes for a bilateral procedures when one code is appropriate.
- Down-coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

CORRECT CODING EDITS FOR COMPREHENSIVE CODES

The following information is compiled from multiple sources (4, 5, 6, 9, 10). The codes are divided into correct coding edits for comprehensive codes and correct coding edits for mutually exclusive codes. As stated previously, pain management physicians are urged to contact their local carriers with coding questions.

i. Injection Codes

	Comprehensive Codes	Component Codes
1.	62273 - Injection, lumbar epidural, of blood or clot patch	36000, 36140, 36410, 62288, 62289, 76001, 76003, G0001
2.	62274 - Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); subarachnoid or subdural	36000, 36140, 36410, 62270, 62272, 62273, 62288, 62289, 62298, 76001, 76003
3.	62275 - Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); epidural, cervical or thoracic, single	36000, 36140, 36410, 62270, 62272, 62273, 62274, 62276, 62277, 62281, 62288, 62298, 76001, 76003
4.	62276 - Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); subarachnoid or subdural, differential	36000, 36140, 36410, 62270, 62272, 62273, 62274, 62288, 62289, 62298, 76001, 76003
5.	62277 - Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); subarachnoid or subdural, continuous	36000, 36140, 36410, 62270, 62272, 62273, 62274, 62276, 62288, 62289, 62298, 76001, 76003
6.	62278 - Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); epidural, lumbar or caudal, single	20610, 36000, 36140, 36410, 62270, 62272, 62273, 62274, 62276, 62277, 62288, 62289, 64440, 76001, 76003
7.	62279 - Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); epidural, lumbar or caudal, continuous	01996, 20610, 36000, 36140, 36410, 62270, 62272, 62273, 62274, 62276, 62277, 62278, 62288, 62289, 76001, 76003
8.	62280 - Injection of neurolytic substance (eg, alcohol, phenol, iced saline solutions); subarachnoid	62270, 62272, 62273, 62288, 62289, 62298
9.	62281 - Injection of neurolytic substance (eg, alcohol, phenol, iced saline solutions); epidural, cervical or thoracic	62270, 62272, 62273, 62288, 62298
10.	62282 - Injection of neurolytic substance (eg, alcohol, phenol, iced saline solutions); epidural, lumbar or caudal	62270, 62272, 62273, 62278, 62279, 62288, 62289
11.	62284 - Injection procedure for myelography and/or computerized axial tomography, spinal (other than C1-C2 and posterior fossa)	62270, 62272, 62273, 62275, 62276, 62277, 62278, 62279, 62282, 62288, 62289, 62298
12.	62287 - Aspiration procedure, percutaneous of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar	62290
13.	62289 - Injection of substance other than anesthetic, antispasmodic, contrast, or neurolytic solutions; lumbar or caudal epidural (separate procedure)	62288
14.	62290 - Injection procedure for diskography, each level, lumbar	62288, 62289

15.	62291 - Injection procedure for diskography, each level, cervical	62288, 62298
16.	62292 - Injection procedure for chemonucleolysis, including diskography, intervertebral disk, single or multiple levels, lumbar	62288, 62289, 62290, 76000
17.	62298 - Injection of substance other than anesthetic, contrast, or neurolytic solutions, epidural, cervical, or thoracic (separate procedure)	62288
18.	62350 - Implantation, revision or repositioning of intrathecal or epidural catheter, for implantable reservoir or implantable infusion pump; without laminectomy	62270, 62272, 62273, 62274, 62275, 62276, 62277, 62278, 62279, 62280, 62281, 62282, 62288, 62298, 62360
19.	64421 - Injection, anesthetic agent, intercostal nerves, multiple, regional block	64420
20.	64441 - Injection, anesthetic agent, paravertebral nerves, multiple levels (eg, regional block)	64440
21.	64573 - Incision for implantation of neurostimulator electrodes; cranial nerve	64553
22.	64580 - Incision for implantation of neurostimulator electrodes; neuromuscular	97014
23.	64600 - Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch	64400
24.	64610 - Destruction by neurolytic agent, second and third division branches at foramen ovale under radiologic monitoring	64605
25.	64612 - Destruction by neurolytic agent (chemodenervation of muscle endplate); muscles enervated by facial nerve (eg, for blepharospasm, hemifacial spasm)	64402
26.	64620 Destruction by neurolytic agent; intercostal nerve	64420, 64421
27.	64622 Destruction by neurolytic agent, paravertebral facet joint nerve, lumbar, single level	64442
28.	64630 - Destruction by neurolytic agent, pudendal nerve	64430
29.	64640 - Destruction by neurolytic agent, other peripheral nerve or branch	64405, 64408, 64410, 64412, 64413, 64415, 64417, 64418, 64425, 64435, 64440, 64441, 64445, 64450
30.	64714 - Neuroplasty; lumbar plexus	11040, 11041, 11042, 64722, 64795, 64862

31.	64727 - Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)	69990
32.	76000 - Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)	36000, 36011, 36410, 36425
33.	20550 - Injection, tendon sheath, ligament, trigger points or ganglion cyst	10160, 11900, 11901, 12032, 12042, 20500, 29075, 29105, 29125, 29130, 29220, 29260, 29405, 29425, 29450, 29515, 29530, 29540, 29550, 29580, 29590, 64405, 64442, 64445, 64450, 64550, 64714, 72240, 72265, 72295, 76000, 76003, 87102, 87163, 90780, 90781, 90782, 95900
34.	20600 - Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (eg, fingers, toes)	10060, 10061, 10140, 10160, 11719, 20500, 20550, 29065, 29075, 29085, 29105, 29125, 29130, 29260, 29280, 29365, 29405, 29425, 29505, 29515, 29540, 29550, 29580, 29590, 64450, 64704, 64708, 72240, 72265, 76000, 76003, 90780, 90782, 95900, G0127
35.	20605 - Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	10060, 10061, 10140, 10160, 11900, 12011, 15852, 20550, 29065, 29075, 29085, 29105, 29125, 29126, 29240, 29260, 29405, 29425, 29445, 29505, 29515, 29540, 29580, 29590, 29705, 64450, 64550, 64704, 76000, 76001 76003, 90780, 90782, 95900
36.	20610 - Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	10060, 10061, 10140, 10160, 11900, 12001, 12002, 12020, 12031, 12044, 15851, 20500, 20501, 20550, 29065, 29075, 29085, 29105, 29125, 29130, 29240, 29260, 29345, 29355, 29365, 29405, 29425, 29505, 29515, 29530, 29540, 29580, 64450, 64550, 64553, 64718, 72255, 72265, 72295, 76000, 76003, 76080, 90780, 90781, 90782, 95900

Note: CPT 76000 – Use of fluoroscopy is a bundled service for injection codes 20600, 20605, and 20610. However, 16 spinal injection codes are okay to bill as per HCFA, effective 7/1/99. These codes are: 62270, 62272, 62273, 62274, 62275, 62276, 62277, 62278, 62279, 62280, 62281, 62282, 62287, 62288, 62289, and 62298. There is no NCC policy for other interventional pain management codes.

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ii. Physical Medicine and Rehabilitation Codes

	Comprehensive Codes	Component Codes
1.	95831 - Muscle testing, manual (separate procedure); extremity (excluding hand) or trunk, with report	95851, 97140, 97530
2.	95832 - Muscle testing, manual (separate procedure); hand, with or without comparison with normal side	95852, 97140
3.	95833 - Muscle testing, manual (separate procedure); total evaluation of body, excluding hands	95831, 95851, 97140
4.	95834 - Muscle testing, manual (separate procedure); total evaluation of body, including hands	95832, 95851, 95852, 97140
5.	95851 - Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section	97530

6.	97001 - Physical therapy evaluation	95831, 95832, 95833, 95834, 95851, 95852, 97112, 97703, 97750, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99261, 99262, 99263, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, 99291, 99295, 99296, 99297, 99301, 99302, 99303, 99311, 99312, 99313, 99321, 99322, 99323, 99331, 99332, 99333, 99341, 99342, 99343, 99354, 99355, 99356, 99357, 99360, 99431, 99432, 99433, 99435, 99440, 99455
7.	97002 - Physical therapy re-evaluation	95831, 95834, 95851, 95852, 97112, 97113, 97504, 97703, 97750, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99261, 99262, 99263, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, 99291, 99295, 99296, 99297, 99301, 99302, 99303, 99311, 99312, 99313, 99321, 99322, 99323, 99331, 99332, 99333, 99341, 99342, 99343, 99354, 99355, 99356, 99357, 99360, 99431, 99432, 99433, 99435, 99440, 99455
8.	97003 - Occupational therapy re-evaluation	95831, 95832, 95833, 95834, 95851, 95852, 97703, 97750
9.	97012 - Application of a modality to one or more areas, traction, mechanical	97018
10.	97014 - Application of a modality to one or more areas, electrical stimulation (unattended)	64550
11.	97016 - Application of a modality to one or more areas; vasopneumatic devices	97018, 97026
12.	97018 - Application of a modality to one or more areas; paraffin bath	99186
13.	97020 - Application of a modality to one or more areas; microwave	97018, 97026, 99186
14.	97022 - Application of a modality to one or more areas; whirlpool	99186
15.	97024 - Application of a modality to one or more areas, diathermy	97018, 97026, 99186
16.	97026 - Application of a modality to one or more areas; infrared	99186
17.	97028 - Application of a modality to one or more areas; ultraviolet	97018, 97026, 99186

18.	97032 - Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes	97014
19.	97034 - Application of a modality to one or more areas; contrast baths, each 15 minutes	97018, 97020, 97022, 97024, 97026
20.	97035 - Application of a modality to one or more areas; ultrasound, each 15 minutes	97018, 97020, 97022, 97024, 97026
21.	97036 - Application of a modality to one or more areas; Hubbard tank, each 15 minutes	97018, 97020, 97022, 97024, 97026
22.	97110 - Therapeutic procedure, one or more areas, each 15 minutes, therapeutic exercises to develop strength and endurance, range of motion, flexibility	99186
23.	97112 - Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, and posture	99186
24.	97113 - Therapeutic procedure, one or more areas, each 15 minutes, gait training (including stair climbing)	97110
25.	97116 - Therapeutic procedure, one or more areas, each 15 minutes, gait training (includes stair climbing)	99186
26.	97124 - Therapeutic procedure, one or more areas, each 15 minutes, massage, including effleurage, pétrissage, and/or tapotement (stroking, compression, percussion)	99186
27.	97140 - Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	97018, 97124, 99186
28.	97150 - Therapeutic procedure(2), group (2 or more individuals)	95831, 95834, 95851, 97124, 97504, 97520, 97535, 97537, 97542
29.	97504 - Orthotics fitting and training, upper and/or lower extremities, each 15 minutes	29044, 29046, 29049, 29055, 29058, 29065, 29075, 29085, 29105, 29125, 29126, 29130, 29131, 29200, 29220, 29240, 29260, 29280, 29305, 29325, 29345, 29355, 29358, 29365
30.	97520 - Prosthetic training, upper and/or lower extremities, each 15 minutes	97016, 97110, 97112, 97116, 97124, 97140, 97504
31.	97545 - Work hardening/conditioning; initial 2 hours	97140
32.	97750 - Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes	95831, 95832, 95833, 95834, 97150
33.	98925 - Osteopathic manipulative treatment (OMT); one to two regions involved	97140
34.	98926 - Osteopathic manipulative treatment (OMT); three to four regions involved	97140, 98925

35.	98927 - Osteopathic manipulative treatment (OMT); five to six regions involved	97140, 98925, 98926
36.	98929 - Osteopathic manipulative treatment (OMT); nine to ten regions involved	97140, 98925, 98926, 98927, 98928

iii. Psychiatry and Biofeedback

	Comprehensive Code	Component Code(s)
1.	90804 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	36640, 90801, 90802, 90862, M0064
2.	90805 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient with medical evaluation and management services	36640, 90801, 90802, 90804, 90862, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99261, 99262, 99263, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, 99301, 99302, 99303, 99311, 99312, 99313, 99321, 99322, 99323, 99331, 99332, 99333, 99341, 99342, 99343, 99347, 99348, 99349, M0064
3.	90806 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	90813, 90814, 90824, 90826, 90827, 90828, 90829, 90845, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99261, 99262, 99263, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, 99291, 99295, 99296, 99297, 99301, 99302, 99303, 99311, 99312, 99313, 99321, 99322, 99323, 99331, 99333, 99341, 99342, 99343, 99354, 99355, 99356, 99357, 99360, 99431, 99432, 99433, 99435, 99440, 99455, 99456
4.	90807 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services	90813, 90814, 90815, 90826, 90827, 90828, 90829, 99291
5.	90808 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient	90814, 90815, 90828, 90829, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99261, 99262, 99263, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, 99291, 99295, 99296, 99297, 99301, 99302, 99303, 99311, 99312, 99313, 99321, 99322, 99323, 99331, 99332, 99333, 99341, 99342, 99343, 99354, 99355, 99356, 99357, 99360, 99431, 99432, 99433, 99435, 99440, 99455, 99456
6.	90809 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services	90815, 90828, 90929, 99291
7.	90845 - Psychoanalysis	90807, 90808, 90809, 90812, 90813, 90814, 90815, 90818, 90819, 90821, 90822, 90826, 90827, 90829, 90847, 99291, 99292
8.	90847 - Family psychotherapy (conjoint psychotherapy) (with patient present)	90801, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90816, 90817, 90818, 90819, 90821, 90822, 90826
9.	90853 - Group psychotherapy (other than of a multiple-family group)	90801, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90826
10.	90911 - Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry	51784, 51785, 51795, 64550, 90901, 95860, 95861, 95863, 95864, 95867, 95868, 95869, 95870, 95872, 97032, 97110, 97112, 97530, 97535, 97750

CORRECT CODING EDITS FOR MUTUALLY EXCLUSIVE CODES

i. Injection Codes

	Code	Mutually Exclusive Code(s)
1.	62275 - Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); epidural, cervical or thoracic, single	62281
2.	62278 - Injection of diagnostic or therapeutic anesthetic or antispasmodic substance (including narcotics); epidural, lumbar or caudal, single	62289
3.	76000 - Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)	76120, 76125
4.	20550 - Injection, tendon sheath, ligament, trigger points or ganglion cyst	11010
5.	20600 - Arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst (eg, fingers, toes)	11010
6.	20605 - Arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)	11010

ii. Physical Medicine and Rehabilitation Codes

	Code	Mutually Exclusive Code(s)
1.	97002 - Physical therapy re-evaluation	
2.	97012 - Application of a modality to one or more areas; traction, mechanical	97140, 99186
3.	97014 - Application of a modality to one or more areas; electrical stimulation (unattended)	99186
4.	97016 - Application of a modality to one or more areas; vasopneumatic devices	99186
5.	97018 - Application of a modality to one or more areas; paraffin bath	97022
6.	97024 - Application of a modality to one or more areas; diathermy	97020
7.	97026 - Application of a modality to one or more areas; infrared	97018, 97022
8.	97028 - Application of a modality to one or more areas; ultraviolet	96910, 96912, 96913, 97022
9.	97140 - Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes	98940, 98941, 98942
10.	97150 - Therapeutic procedure(s), group (2 or more individuals)	97110, 97112, 97113, 97116, 97140, 97530

11.	98925 - Osteopathic manipulative treatment (OMT); one to two regions involved	98940, 98941, 98942
12.	98926 - Osteopathic manipulative treatment (OMT); three to four regions involved	98941, 98942
13.	98927 - Osteopathic manipulative treatment (OMT); five to six regions involved	98942

iii. Psychiatry and Biofeedback

1.	90804 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient	90810, 90811, 90812, 90813, 90814, 90815, 90823, 90824, 90826, 90827, 90828, 90829, 90845, 99201, 99202, 99203, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99261, 99262, 99263, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, 99291, 99295, 99296, 99297, 99301, 99302, 99303, 99311, 99312, 99313, 99321, 99322, 99323, 99331, 99332, 99333, 99341, 99342, 99343, 99354, 99355, 99356, 99357, 99360, 99431, 99432, 99433, 99435, 99440, 99455, 99456
2.	90805 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient with medical evaluation and management services	90811, 90812, 90813, 90814, 90815, 90824, 90826, 90827, 90828, 90829, 90845, 99291
3.	90806 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient	90813, 90814, 90824, 90826, 90827, 90828, 90829, 90845, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99261, 99262, 99263, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, 99291, 99295, 99296, 99297, 99301, 99302, 99303, 99311, 99312, 99313, 99321, 99322, 99323, 99331, 99333, 99341, 99342, 99343, 99354, 99355, 99356, 99357, 99360, 99431, 99432, 99433, 99435, 99440, 99455, 99456
4.	90807 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient; with medical evaluation and management services	90813, 90814, 90815, 90826, 90827, 90828, 90829, 99291
5.	90808 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient	90814, 90815, 90828, 90829, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99261, 99262, 99263, 99271, 99272, 99273, 99274, 99275, 99281, 99282, 99283, 99284, 99285, 99291, 99295, 99296, 99297, 99301, 99302, 99303, 99311, 99312, 99313, 99321, 99322, 99323, 99331, 99332, 99333, 99341, 99342, 99343, 99354, 99355, 99356, 99357, 99360, 99431, 99432, 99433, 99435, 99440, 99455, 99456
6.	90809 - Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient; with medical evaluation and management services	90815, 90828, 90929, 99291

7.	90845 - Psychoanalysis	90807, 90808, 90809, 90812, 90813, 90814, 90815, 90818, 90819, 90821, 90822, 90826, 90827, 90829, 90847, 99291, 99292
8.	90847 - Family psychotherapy (conjoint psychotherapy) (with patient present)	90801, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90816, 90817, 90818, 90819, 90821, 90822, 90826
9.	90853 - Group psychotherapy (other than of a multiple-family group)	90801, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90826

Anesthesia answer book outlined some of the tips from the field of pain management (8). Some of these are as follows:

1. "Murky field" – Chronic pain management is considered a mystery by many payers due to the numerous options of treatment available and inability to quantify the success. Hence, unexplained denials are the norm in some places.

2. "Highest level of specificity" - It is best to use the most recent ICD-9 Codes to the highest specificity in most cases with five digits.

3. "Surgical Billing Practices and Rules" – Some interventional pain management specialists still continue to think in terms of pain management as part of anesthesia. However, Medicare treats all pain management services as surgical or medical procedures. These procedures are not paid for time and payment will be according to the physician RVS fee schedule and rules for surgeons and other specialists. Note the correct modifiers.

4. Multiple Pain Management Procedures – When billing surgical procedures for pain management, if you perform more than one procedure on the same patient on the same day, Medicare reimburses 100% of the global fee for the procedure of the highest value, 50% of the global fee for the second most expensive, and 50% for each of the third and fourth procedures. To be reimbursed for procedures beyond the fifth, one must submit documentation and undergo a special carrier review to determine the payment amount.

5. Know the Rules for Visits Codes – Be prepared to document everything you bill for and expect a wait.

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