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Pain Management: LCD L33622 and Billing and Coding Article A52863

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Carleen Parker, Consultant
  - JK Provider Outreach and Education
- Christine Obergfell, CPC, CPC-I
  - J6 Provider Outreach and Education

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Objectives

- Improving efficiency and reducing administrative burden by knowing policies prior to submitting claims and avoiding costly appeals.

Agenda

- Pain Management LCD L33622
  - Provider Qualifications
  - General
  - Indications
  - Limitations
  - Coding
  - Documentation
  - HCPCS Drug Codes

Local Coverage Determinations

- Pain Management LCD L33622
- Related terms and codes
  - Spine, spinal, trigger, injection, ganglion
  - 20526, 20550, 20551, 20552, 20553, 20560, 20561, 20612, 27096, 28899, 64451, 64625, G0260
- Look at ICD-10-CM codes that support or do not support medical necessity and submit claim correctly first time

Provider Qualifications

- CMS Internet-Only Manual Publication 100-08, *Medicare Program Integrity Manual*, Chapter 13 states "reasonable and necessary" services are "ordered and/or furnished by qualified personnel"
- Services will be considered medically reasonable and necessary only if performed by appropriately trained providers

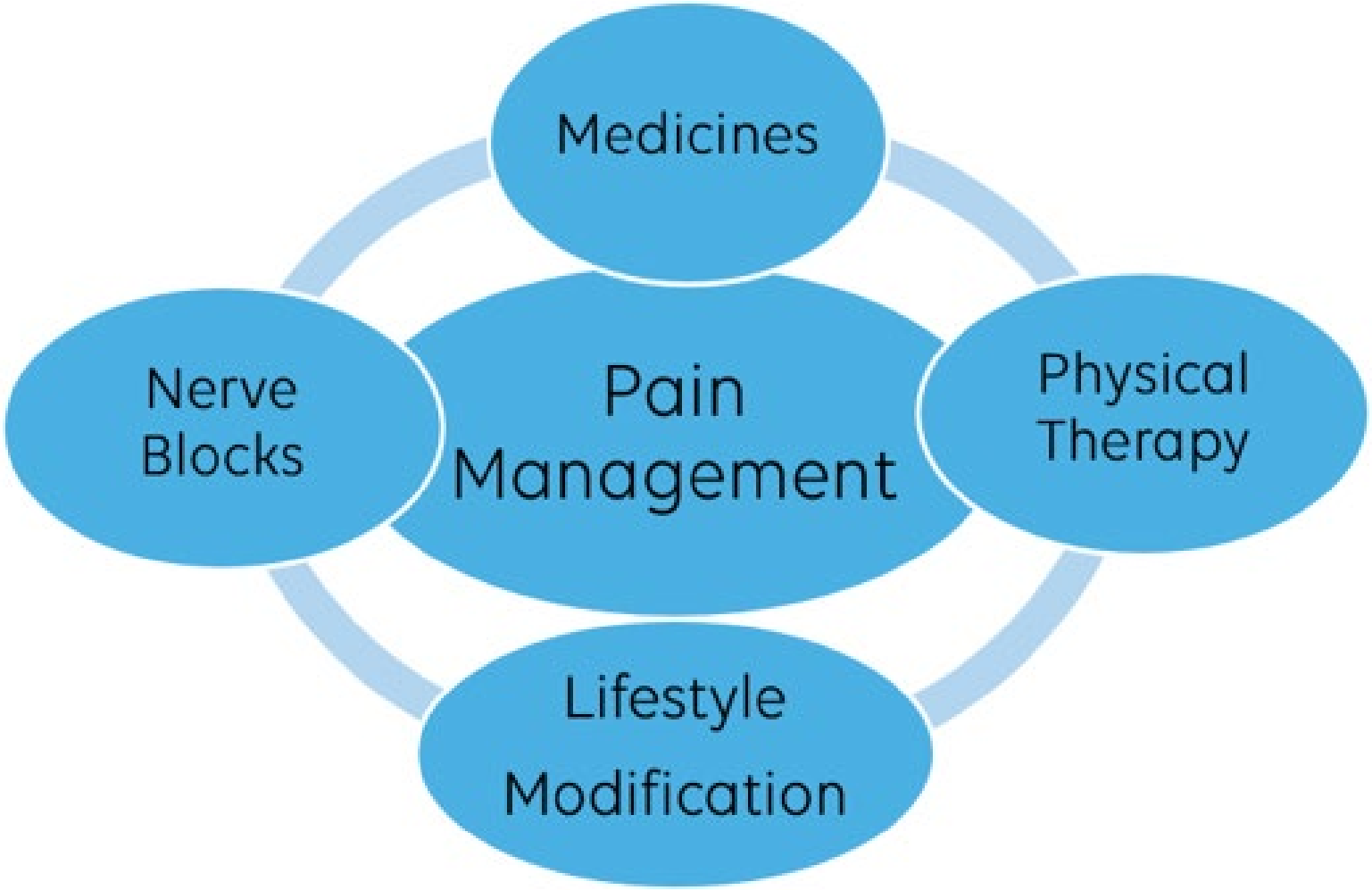
Provider Qualifications

- Healthcare professionals who perform spinal pain management procedures shall be appropriately trained and/or credentialed by a formal residency/fellowship program and/or are certified by either an accredited and nationally recognized organization or by post-graduate training course accredited by an established national accrediting body or accredited professional training program

Provider Qualifications

- Training must cover and develop an understanding of anatomy and drug pharmacodynamics and kinetics as well as proficiency in diagnosis and management of disease, technical performance of procedure and utilization of required associated imaging modalities
- Practitioners who works in hospital or ASC shall be credentialed by facility

Pain Management



General

- Pain most common symptom of potentially thousands of injuries, diseases, disorders and conditions and can result from treatments for conditions
- Acute pain
  - Can last a short time and go away when one heals
- Chronic pain
  - Can last for months or years

Acute Pain

- Elicited by injury of body tissues and activation of nociceptive transducers at site of local tissue damage
- This type of pain is often reason individuals seek health care, and it occurs after trauma, surgical interventions, and some disease processes

Chronic Pain

- Persistent or episodic pain of duration or intensity that adversely affects the function or well-being of patient, attributable to any nonmalignant etiology
- Pain has been refractory to repeated attempts at medical management and usually has been present for at least three to six months

Cancer Pain

- Pain associated with cancer includes
  - Disease progression
  - Can have multiple causes and disease progression and treatment
    - Neuropathic pain resulting from radiation therapy
    - Co-occurring diseases resulting from arthritis
- Regardless of whether pain associated with cancer stems from disease progression, treatment, or co-occurring disease, it may be either acute or chronic

Spinal Pain

- Structures responsible for pain in spine, include but are not limited to
  - Vertebral bodies, intervertebral discs
  - Spinal cord, nerve roots
  - Facet joints, ligaments
  - Muscles, atlanto-occipital joints
  - Atlanto-axial joints
  - Sacroiliac joints

Spinal Pain

- Postlaminectomy syndrome
- Other spinal conditions causing pain include various degenerative disorders such as
  - Spinal stenosis, spondylolysis, spondylolisthesis degenerative scoliosis, idiopathic vertebrogenic sclerosis, diffuse idiopathic spinal hyperostosis, and segmental instability
- Degenerative conditions other than disc disruption and facet arthritis may contribute to approximately five to ten percent of spinal pain

Neural Blockade

- Neural blockade is interruption of neural transmission by the injection of local anesthetic agent or other drug
- Success of nerve block is determined by adequacy of interruption of nerve function, and effect of blockade on patient's pain
- Goal of chronic pain management is to achieve optimal pain control

Pain Management Limitations

- Limitations for all pain management services
  - General anesthesia or monitored anesthesia care is rarely, if ever required for injections addressed in pain management LCD L33622 policy
  - Per medical findings and facts, general anesthesia is contraindicated for diagnostic blocks
  - Monitored anesthesia care or heavy sedation may provide false-positive results

Treatment Decisions

- Must be based on thorough evaluation of patient and include systematic assessment of location, intensity, and pathophysiology of pain
- Detailed pain history that includes prior treatment and response to treatment
- Detailed physical examination and review of all pertinent diagnostic tests

Trigger Point Injection and Injection of Tendon Sheath, Ligament, Ganglion Cyst, Carpal and Tarsal Tunnel

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Trigger Point Injection

- Diagnosis of trigger points requires detailed history and thorough physical examination
  - History of onset of the painful condition, and cause
  - Distribution pattern of pain
  - Restriction of range of motion with increased sensitivity
  - Muscular deconditioning in affected area
  - Focal tenderness of a trigger point

Trigger Point Injection

- Palpable taut band of muscle in which trigger point is located
- Local taut response to snapping palpation or needle insertion
- Reproduction of referred pain pattern upon stimulation of the trigger point

- Effective treatment may be delivered via PT
- For trigger points in acute state of formation, before additional pathologic changes develop

Other Treatment Modalities

- The goal is to treat cause of pain and not just symptom of pain
  - Pharmacologic treatment
    - Analgesics and medications to induce sleep and relax muscles, such as, antidepressants, neuroleptics, or nonsteroidal anti-inflammatory drugs
  - Nonpharmacologic treatment modalities
    - Osteopathic manual medicine techniques, massage, ultrasonography, application of heat or ice, transcutaneous electrical nerve stimulation, spray and stretch technique

Limitations: Trigger Point Injection

- One trigger point injection procedure should be reported on any particular day
- Local anesthetic administered in conjunction with trigger point injection is included in practice expense
- Routine injections used on regular periodic and continuous basis, with chronic nonmalignant pain syndromes are not considered medically necessary

Injection Sites

- Injection into tendon sheaths, ligaments, ganglion cysts, tarsal or carpal tunnel is sometimes indicated to provide relief of pain and to reduce inflammation in structures when response to conservative measures has failed or is not indicated
- Proper use of modality should be part of an overall management plan including diagnostic evaluation to identify and treat

Indication

- Other conservative therapy has not provided acceptable relief
- Injection will significantly improve patient's pain/functional disability
- Injection of carpal tunnel may be indicated for patient w/mild-moderate symptoms when pharmaceutical and other conservative measures have failed

Limitations

- When given specific tendon, ligament, tunnel, or cyst is injected, it will be considered one injection regardless of number of injections administered at specific anatomical location on single date of service

Coding

- Procedure codes may be subject to NCCI edits or OPPS packaging edits
  - Refer to NCCI and OPPS requirements prior to billing Medicare
- Services requiring a referring/ordering physician
  - Name and NPI of referring/ordering physician must be reported on claim

Coding

- Claim(s) submitted without valid ICD-10-CM diagnosis code will be returned to as incomplete claim
- Diagnosis code(s) must best describe patient's condition for which service was performed
- All procedures performed on same day must be billed on same claim

Coding

- For trigger point injection
  - Code 20552: one or two muscle groups injected
  - Code 20553: three or more muscle groups injected
    - Only 20552 or 20553 may be billed, not both
- Number of services for either code is one
  - Regardless of number injections/sites
  - Shall be billed on only one line

Acupuncture Coding

- Effective 1/1/2020, Medicare will cover all types of acupuncture including dry needling for chronic low back pain within specific guidelines in accordance with NCD 30.3.3
  - Dates of service prior to 1/1/2020, dry needling should be reported with CPT code 20999 (Unlisted procedure, musculoskeletal system, general)
  - Dates of service on or after 1/1/2020, dry needling should be reported with CPT code 20560 and/or 20561

Coding

- CPT code 20551 should be used when origin or insertion of tendon is injected, in contrast to an injection of tendon sheath, CPT code 20550
- CPT code 28899 (unilateral procedure, foot or toe) should be billed for injection of tarsal tunnel

Coding

- Injection of separate sites (tendon sheath, ligament or ganglion cyst) during same encounter should be reported on separate line of coding and must have modifier 59 appended
- Bilateral modifier 50
  - Not appropriate with 20551, 20552, 20553 or 20612
  - When appropriate, may be used with 20550 and 20526

Ambulatory Surgical Center Coding

- Ambulatory Surgical Center
  - Appropriate site modifier (RT and/or LT) should be appended to indicate if service was performed unilaterally or bilaterally
  - Bilateral services must be reported on separate lines using an RT and LT modifier
  - 50 modifier should not be used

Coding

- Multiple injections per day, at same site, are considered one injection and should be coded with one unit of service
- Claims for prolotherapy must not be reported with trigger point codes or other injection codes

Documentation Requirements

- Patient's medical record must contain documentation that fully supports medical necessity for services included within the LCD
- Documentation includes, but is not limited to
  - Relevant medical history
  - Physical examination
  - Results of pertinent diagnostic tests or procedures
- Notes must be legible, include sufficient detail

Documentation Requirements

- Required elements of note include
  - Description of techniques
  - Sites(s) of injections
  - Drugs and doses with volumes and concentrations
  - Pre-procedural pain assessments
  - Post-procedural pain assessments

Documentation Requirements

- Treatment of established trigger point, patient's medical record must clearly document
  - Evaluation leading to diagnosis of trigger point in an individual muscle
  - Identification of the affected muscle(s)
  - Reason for selecting trigger point injection as therapeutic option, and whether it is being used as an initial or subsequent treatment for myofascial pain

Documentation Requirements

- Medical record must include a procedural note documenting reason for injection at any particular site
  - If multiple sites are injected, documentation to substantiate that all the injections are reasonable and necessary must be present

Documentation Requirements

- **Trigger Point Injections**
  - Repeat **trigger point injections** may be necessary when there is evidence of persistent pain
    - Generally more than three injections of same trigger point are not indicated
  - Evidence of partial improvements to range of motion in any muscle area after injection
  - Persistent significant pain, would justify repeat injection
  - Medical record must clearly reflect the medical necessity for repeated injections

Documentation Requirements

- Most conditions that require injections into tendon sheaths, ligaments or ganglion cysts should be resolved with one- three injections
- Frequency and number of injections or interventions
- In diagnostic phase, patient may receive injections at intervals of no sooner than one week or preferably, two weeks
  - Diagnostic phase limited to no more than two times

Documentation Requirements

- Once structure is proven to be negative, no repeat interventions should be directed at that structure
  - Unless new clinical presentation with symptoms, signs, and diagnostic studies of known reliability and validity that implicate structure

Documentation Requirements

- Effect of injected corticosteroids may remain for several weeks and benefit attributed to decrease of local inflammation and perhaps some local anesthetic effect
  - It's usually not necessary to repeat an injection if there has been satisfactory response to first injection
- Patients who relapse after satisfactory response may be candidates for another trial after an appropriate interval

Documentation Requirements

- In therapeutic phase
  - Frequency should be two months or longer between each injection
    - Provided that initial pain relief with diagnostic injections of > or equal to 75%–100% with ability to perform previously painful maneuvers
    - Persistent pain relief of > or equal to 50% with continued ability to perform previously painful maneuvers is maintained for at least six weeks
  - Therapeutic frequency must remain at least two months or longer

Documentation Requirements

- Treatment or therapeutic phase, injections should be repeated only as medically necessary
- No more than four per patient per year are anticipated for majority of patients

Sacroiliac Joint Injection

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Sacroiliac Joint Injection

- Sacroiliac joint is diarthrodial, synovial joint which is formed by articular surfaces of sacrum and iliac bones
- Sacroiliac joints bear weight of trunk and as result are subject to development of strain and/or pain

Indications: Sacroiliac Joint Injection

- Considered medically reasonable and necessary for diagnosis and/or treatment of chronic low back pain that is considered to be secondary to suspected sacroiliac joint dysfunction
- Diagnostic and therapeutic injections would not likely be performed unless conservative therapy and noninvasive treatments (i.e., rest, physical therapy, NSAIDs, etc.) have failed

Indications: Sacroiliac Joint Injection

- Diagnostic blocks of sacroiliac joint
- Arthropathy (joint disease) is diagnosed through double-comparative local anesthetic blockade of joint by the intra-articular injection of small volume of local anesthetics of different durations of actions
- A positive response should demonstrate initial pain relief and ability to perform previously painful maneuvers

Indications: Sacroiliac Joint Injection

- Therapeutic sacroiliac joint injection of an anesthetic and/or steroid to block joint for immediate, and potentially long lasting, pain relief are considered medically reasonable and necessary if it is determined that sacroiliac joint is source of pain in lower back
- Local anesthetic used for the procedure should not be billed

Indications: Sacroiliac Joint Injection

- Sacroiliac joint arthrography and/or therapeutic injection of an anesthetic/steroid should only be reported when imaging confirmation of intra-articular needle positioning with applicable radiological and/or fluoroscopic procedures have been performed

Limitations: Sacroiliac Joint Injection

- If previous diagnostic or therapeutic SI injections of anesthetic and/or steroid to block joint for immediate, and potentially long lasting, pain relief have not effectively relieved the pain, further injections would not be considered medically necessary
- Radiofrequency ablation used for sacroiliac joint pain is considered not medically necessary

Coding

- Procedure codes may be subject to NCCI edits or OPPS packaging edits
  - Refer to NCCI and OPPS requirements prior to billing Medicare
- Services requiring a referring/ordering physician, name and NPI of referring/ordering physician must be reported on claim

Coding

- Sacroiliac Joint Injection
  - CPT codes 27096, 64451 and G0260 should not be billed when a physician provides routine sacroiliac injection
    - They are to be used only with imaging confirmation of intra-articular needle positioning
  - Paravertebral Spinal Nerves and Branches – Image guidance (fluoroscopy or CT) and any injection of contrast are inclusive components of 27096
    - Do not report CPT code 27096 or G0260 unless fluoroscopic or CT guidance is performed

Coding

- Sacroiliac Joint Injection
- CPT codes 27096 and 64451 have bilateral surgery indicator of "1"
  - Follow the same guidelines for G0260
    - When injecting a sacroiliac joint bilaterally, bill with modifier 50
    - When injecting a sacroiliac joint unilaterally, file the appropriate anatomic modifier LT or RT
    - Only one unit of service should be submitted for unilateral or bilateral sacroiliac joint/nerve injection

Coding

- Sacroiliac Joint Injection
  - For an Ambulatory Surgical Center, appropriate site modifier (RT and/or LT) should be appended to indicate if service was performed unilaterally or bilaterally
  - Bilateral services must be reported on separate lines using an RT and LT modifier (50 modifier should not be used)
  - CPT code G0260 should be billed by facilities paid by OPPS

Coding

- Sacroiliac Joint Injection
  - CPT code 73542 (Radiologic examination, sacroiliac joint arthrography, radiological supervision and interpretation) is only to be billed for a medically necessary diagnostic study and requires a full interpretation and report
  - Do not bill CPT code 73542 for injection of contrast to verify needle position

Coding

- Sacroiliac Joint Injection
  - Use CPT code 64999 (Unlisted procedure, nervous system) for pulsed radiofrequency and denervation procedures of the sacroiliac joint/nerves
  - Pulsed radiofrequency for denervation is considered investigational and therefore, not medically necessary
  - Dates of service prior to 1/1/2020, sacroiliac joint/nerve denervation procedures using traditional or cooled radiofrequency are also considered investigational and not medically necessary and should be billed with CPT code 64999

Coding

- Sacroiliac Joint Injection
  - Dates of service on or after 1/1/2020, CPT code 64625 - Radiofrequency ablation, nerves innervating sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography) should be used to report radiofrequency ablation whether performed using **traditional or cooled** radiofrequency (<80 degrees Celsius)
  - Radiofrequency ablation for denervation whether performed using traditional, cooled, or pulsed radiofrequency is considered investigational and therefore, not medically necessary

Coding

- Sacroiliac Joint Injection
  - CPT code 72275 epidurography, radiological supervision and interpretation represents a formal recorded and reported contrast study that includes fluoroscopy
  - Epidurography should only be reported when it is reasonable and medically necessary to perform a diagnostic study
    - It may only be performed with a caudal or intrathecal approach and should not be billed for the usual work of fluoroscopy and dye injection that is integral to the sacroiliac injection(s)

Documentation Requirements

- Sacroiliac Joint Injection
- Lists specific requirements
  - Document the total amount of injectate for all medications used
  - Amount of injectate should be such that the synovial lining of the joint is not burst and the injectate does not disperse beyond the confines of the target joint

Documentation Requirements

- Patient's medical record must contain documentation that fully supports medical necessity for services included within the LCD
- Documentation includes, but is not limited to
  - Relevant medical history
  - Physical examination
  - Results of pertinent diagnostic tests or procedures

Documentation Requirements

- Required elements of note include
  - Description of techniques employed
  - Sites(s) of injections
  - Drugs and doses with volumes and concentrations
  - Pre-procedural pain assessments
  - Post-procedural pain assessments

HCPCS Drug Codes

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HCPCS Drug Codes

- Claim(s) for services rendered
  - Off campus outpatient hospital (19)
  - Inpatient hospital (21)
  - On campus outpatient hospital (22)
  - Emergency room, hospital (23)
  - Ambulatory surgery center (24)
  - Skilled nursing facility for patients in a part A stay (31)
  - Comprehensive in/outpatient rehabilitation facility (61, 62)

HCPCS Drug Codes

- Medication being injected, designated by an appropriate HCPCS drug code must be submitted on same claim, same day of service as claim for procedure
- When CPT 20612 is reported for aspiration and not for injection or when the ICD-10-CM codes reported are M77.11 or M77.12 and there is no injection
  - HCPCS drug code and dose is not required

HCPCS Drug Codes

- Claims for local anesthetic should not be reported
  - The exceptions to this guideline are
    - When services are rendered in places of services 19, 21, 22, 23, 61, and 62 there should be no claim for the HCPCS drug code
    - Drugs packaged in ASC payments should not be separately reported

HCPCS Drug Codes

- Claim(s) for services rendered in office or independent clinic, when physician does not bill for injectable, must include
  - Name of the drug and dosage in item 19 or electronic equivalent

Unlisted Drug Codes

- When billing unlisted codes, the unit of service equals one (1), and details must be entered into line Item 19 of the CMS-1500 or electronic claim equivalent
  - Name of the drug
  - Dose administered (mg, cc, etc.)
  - Route of administration (IV, IM, SC, PO, etc.)
  - Invoice price (for new drugs if the WAC is unavailable, or for compounded drugs)

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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