Pain Management IR Coding

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Pain Management Procedures

Surgical Codes
- Codes are typically found in 6xxxx series
- Some may be found in the 2xxxx series as well as the Category III “T” code section.
- Hospitals (under APCs) may use selected Level II G-codes

Radiological Guidance Codes (CT & Fluoroscopy)
Typically fluoroscopy is defined by one of two choices (77002 or 77003), CT by one option (77012).
- 77002 Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
- 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)
- 77012 Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation
- (Do not report 77012 in conjunction with 10030, 27096, 32554 – 32557, 64479-64484, 64490-64495, 64633-64636, 0232T).
Pain Management Procedures

CPT Guidelines state the following:

- (Injection of contrast during fluoroscopic guidance [77003] and localization is included in 22526, 22527, 27096, 62263, 62264, 62267, 62270-62282, 62302-62305, 62310-62319).
- (Fluoroscopic guidance [77003] for subarachnoid puncture for diagnostic radiographic myelography is included in supervision and interpretation codes 72240-72270).
- (For epidural or subarachnoid needle or catheter placement and injection, see 62270-62282, 62310-62319).
- (For sacroiliac joint arthrography, see 27096).

- (For paravertebral facet joint injection, see 64490-64495. For paravertebral facet joint nerve destruction by neurolysis, see 64633-64636. For transforaminal epidural needle placement and injection, see 64479-64484).
- (Do not report 77002 or 77003 in conjunction with 10030, 22586, 27096, 64479-64484, 64490-64495, 64633-64636, 0195T, 0196T, 0390T).
- (For percutaneous or endoscopic lysis of epidural adhesions, 62263, 62264 include fluoroscopic guidance and localization).
Pain Management Procedures

CPT Guidelines state the following relative to code 77012:

77012 Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation

- (Do not report 77012 in conjunction with 10030, 22586, 27096, 32554 – 32557, 64479-64484, 64490-64495, 64633-64636, 0195T, 0196T, 0232T, 0309T).

Core CPT Information for Injection, Drainage, or Aspiration (Codes 62263-62319)

- Injection of contrast during fluoroscopic guidance and localization is an inclusive component of 62263, 62264, 62267, 62270-62273, 62280-62282, 62302-62305, 62310-62319.
- Fluoroscopic guidance and localization is reported with 77003, unless a formal contrast study (myelography, epidurography, or arthrography) is performed, in which case the use of fluoroscopy is included in the supervision and interpretation codes or the myelography via lumbar injection code. Image guidance and the injection of contrast are inclusive components and are required for the performance of myelography, as described by codes 62302, 62303, 62304, 62305.
- For radiologic supervision and interpretation of epidurography, use 72275. Code 72275 is only to be used when an epidurogram is performed, images documented, and a formal radiologic report is issued.
Pain Management Procedures

Core CPT Information for Injection, Drainage, or Aspiration (62263-62319)

- Code 62263 describes a catheter-based treatment involving targeted injection of various substances (e.g., hypertonic saline, steroid, anesthetic) via an indwelling epidural catheter. **Code 62263 includes percutaneous insertion and removal of an epidural catheter** (remaining in place over a several-day period), for the administration of multiple injections of a neurolytic agent(s) performed during serial treatment sessions (i.e., spanning two or more treatment days). If required, adhesions or scarring may also be lysed by mechanical means. Code 62263 is **not** reported for each adhesiolysis treatment, but should be reported **once** to describe the entire series of injections/infusions spanning two or more treatment days.

- Code 62264 describes multiple adhesiolysis treatment sessions performed on the *same day*. Adhesions or scarring may be lysed by injections of neurolytic agent(s). If required, adhesions or scarring may also be lysed mechanically using a percutaneously-deployed catheter.

- Codes 62263 and 62264 include the procedure of injections of contrast for epidurography (72275) and fluoroscopic guidance and localization (77003) during initial or subsequent sessions.

- The placement and use of a catheter to administer one or more epidural or subarachnoid injections **on a single calendar day** should be reported in the same manner as if a needle had been used, i.e., as a single injection using either 62310 or 62311. Such injections should not be reported with 62318 or 62319.

- Threading a catheter into the epidural space, *injecting substances at one or more levels* and then removing the catheter should be treated as a single injection (62310, 62311). **If the catheter is left in place to deliver substance(s) over a prolonged period (i.e., more than a single calendar day)** either continuously or via intermittent bolus, use 62318, 62319 as appropriate.

- When reporting 62310-62319, **code choice is based on the region at which the needle or catheter entered the body** (e.g., lumbar). Codes 62310-62319 should be reported only once, when the substance injected spreads or catheter tip insertion moves into another spinal region (e.g., 62311 is reported only once for injection or catheter insertion at L3-4 with spread of the substance or placement of the catheter tip to the thoracic region).
Pain Management Procedures

Core CPT Information for Injection, Drainage, or Aspiration (62263-62319)

- Percutaneous spinal procedures are done with indirect visualization (e.g., image guidance or endoscopic approaches) and without direct visualization (including through a microscope). Endoscopic assistance during an open procedure with direct visualization is reported using excision codes (e.g., 63020-63035).

Myelograms - S&I Codes

- 72240 Myelography, cervical, radiological supervision and interpretation
- 72255 Myelography, thoracic, radiological supervision and interpretation
- 72265 Myelography, lumbosacral, radiological supervision and interpretation
- 72270 Myelography, 2 or more regions (e.g., lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation

There are four possible codes for radiographic imaging supervision and interpretation for myelography when component coding is appropriate. Only one of these S & I codes would be assigned per session. If a single region (lumbar, thoracic, or cervical) is imaged, code the region-specific S & I code. If two or three regions are imaged, assign the combination code (72270) instead. Do not assign two individual region codes separately.
Pain Management Procedures

Surgical Code Options

- 61055 Cisternal or lateral cervical (C1-C2) puncture; with injection of medication or other substance for diagnosis or treatment (e.g., C1-C2)
- 62284 Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)
  - There are two code options for the puncture and injection when component coding is appropriate. Assign code 61055 for a cervical injection. If contrast is given by a lumbar injection, assign code 62284. Code 62284 also would be the appropriate injection code for lumbar intrathecal contrast injection for a spinal CT scan.

Pain Management Procedures

Myelography- Complete Procedure Options

- 62302 Myelography via lumbar injection, including radiological supervision and interpretation; cervical
- 62303 Myelography via lumbar injection, including radiological supervision and interpretation; thoracic
- 62304 Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral
- 62305 Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (e.g., lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)
Pain Management Procedures

Myelography

- When one physician performs the complete procedure (injection and imaging) with a lumbar injection of contrast, one of these four combination codes would be chosen. If imaging is performed on only one region, choose 62302, 62303, or 62304 as appropriate. If imaging is performed on two or three regions, choose 62305. Never assign two codes from the 62302–62305 series. Do not also code 62284, or 72240–72270 in addition to 62302–62305.

- When a myelogram is performed via a cervical puncture and injection of contrast, or when one physician performs a lumbar or cervical injection of contrast and another supervises and interprets the imaging, the appropriate component codes would be assigned instead of 62302–62305.

- Based on the new code descriptions, hospitals should always use the new bundled codes (62302–62305) when a myelogram is performed with a lumbar injection regardless of the number of physicians involved.

If CT is Performed Post- R&F Myelogram

- 72126 Computed tomography, cervical spine; with contrast material
- 72129 Computed tomography, thoracic spine; with contrast material
- 72132 Computed tomography, lumbar spine; with contrast material

- If contrast is injected for a CT or MRI of the spine with a spot image or two to confirm needle/contrast location without a full diagnostic study, assign code 77003 for fluoroscopic guidance for the injection instead of 72240–72270. It may be necessary to add modifier -59 (or one of the X modifiers) to 77003 when billed with the injection code prior to an MRI or CT.
Pain Management Procedures

Additionally, if Medically Necessary, Ordered and Documented, 3D Codes may also be assigned:

- 76376 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing **under concurrent supervision**; not requiring image post-processing on an independent workstation

- 76377 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing **under concurrent supervision**; requiring image post-processing on an independent workstation

Surgical code options for ESI’s include:

- 62310 Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic

- 62311 Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)

  - Since January 1, 2015, CCI edits list code 77003 as a Column 2 (ie., component code) to Column 1 codes 62310 – 62319 (ie., comprehensive procedure).
  - The modifier indicator for this edit is “1.”
Pain Management Procedures

Surgical code options for ESI’s include:

- 62318 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic

- 62319 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)
  - Since January 1, 2015, CCI edits list code 77003 as a Column 2 (ie., component code) to Column 1 codes 62310 – 62319 (ie., comprehensive procedure).
  - The modifier indicator for this edit is “1”.

Epidural Blood Patch

- 62273 Injection, epidural, of blood or clot patch
- 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)

Neither CCI or current CPT guidelines have not yet bundled guidance into this surgical code.
Pain Management Procedures

Diskograms

S&I Code options include:
- 72285 Diskography, cervical or thoracic, radiological supervision and interpretation
- 72295 Diskography, lumbar, radiological supervision and interpretation

Surgical Code choices include:
- 62290 Injection procedure for diskography, each level; lumbar
- 62291 Injection procedure for diskography, each level; cervical or thoracic

Post diskography CT’s are coded as without contrast studies.

Is it appropriate to report code 77003 when fluoroscopy is used for discography?

No, it is not appropriate to report code 77003, Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, translaminar epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction, when fluoroscopy is used for discography. The appropriate codes to report for discography are codes 62290 or 62291 for the injection procedure, and codes 72285 or 72295 for imaging guidance. The appropriate codes assigned are based on the spinal level injected (i.e., lumbar or cervical/thoracic). Fluoroscopy is the imaging technique by which images are produced, and the use of fluoroscopy has been valued into the discography imaging codes 72285 and 72295. Therefore, it is not appropriate to report code 77003 in conjunction with codes 72285 or 72295 for discography. A general rule of thumb: if fluoroscopy is always performed as part of the radiological imaging study, fluoroscopy is included in the radiological imaging coded.
Pain Management Procedures

Diskograms

The following can be found in the March 2011, AMA CPT Assistant

- **Question:** What is the proper use of codes 62290, 72285, and 72295 when reporting lumbar discography procedures? When should code 77003 (fluoroscopic guidance) be reported with the discography procedure?

- **Answer:** To respond to your query, it is key to understand that dye injected into the disc space for tissue identification purposes is considered inclusive of the discectomy procedure performed (e.g., 63030) and does not constitute diagnostic discography (62290). When performed for diagnostic purposes, independent of a discectomy, lumbar discography is essentially a two-part procedure. The first component is the placement of the needle into the disc with subsequent injection of contrast. The second component is the visualization of the dye pattern, the interpretation of the disc morphology, and often the interpretation of the pain response.

When performing lumbar discography, code 62290, Injection procedure for discography, each level; lumbar, is the appropriate code to report for the injection procedure for each lumbar level. For cervical or thoracic discography, the appropriate injection code is 62291, Injection procedure for discography, each level; cervical or thoracic. Injection of contrast and localization during the imaging guidance portion (fluoroscopy) is an inclusive component of these injection procedures, and 77003 is not reported separately.

- The radiological supervision and interpretation of lumbar discography is a separately reported service, as a radiologist may perform these services independently from the physician performing the injection procedure. The codes to report these services are code 72295, Discography, lumbar, radiological supervision and interpretation, for the lumbar region and code 72285, Discography, cervical or thoracic, radiological supervision and interpretation, for cervical or thoracic regions.
Pain Management Procedures

Diskograms
The following can be found in the March 2011, AMA CPT Assistant

Because lumbar discography is reported per lumbar level, code 62290 may be reported multiple times during the same session on the same day, depending on the number of levels of lumbar discography performed. Typically, a modifier (e.g., modifier 51) is attached to additional levels in order to avoid duplicating the pre- and postservice components of the work value. Similarly, the supervision and interpretation of the contrast material in the disc is dependent on the total number of discs injected. Therefore, typical coding for a three-level lumbar discography is as follows:

- 62290
- 62290-51 x 2 (three levels)
- 72295
- 72295-51 x 2 (three levels)

MAI = 2  MUE = 5

Some payers do not require a modifier, but instruct providers to list the procedure with the number of levels performed, or multiple units of the same code.

Code 77003 should not be reported in addition to code 72295 for lumbar discography procedure(s). Fluoroscopic guidance is included in the procedure and radiological supervision and interpretation codes. Even when one physician performs the injection and another performs the radiological supervision and interpretation, it is inappropriate for either physician to code the fluoroscopic guidance (e.g., 77003) as the injection of contrast and localization during the imaging guidance portion (fluoroscopy) is an inclusive component of code 62290.
Pain Management Procedures

Diagnostic or Therapeutic Lumbar Punctures
Two surgical code choices are available for assignment:
- 62270 Spinal puncture, lumbar, diagnostic
- 62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)

These codes should not be assigned in addition to 62284 or 61055 during myelography.

Fluoro guidance would be defined by the following code when documented:
- 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)

The following can be found in the 2014 AMA/ACR Clinical Examples in Radiology, Winter, Volume 10, Issue 1:
- A therapeutic spinal puncture differs from a diagnostic lumbar puncture. A diagnostic lumbar puncture is performed to collect samples of CSF to help diagnose infections such as meningitis or encephalitis, subarachnoid hemorrhage, inflammatory conditions of the nervous system (e.g., multiple sclerosis), and malignancy involving the brain, spinal cord, or meninges. Lumbar puncture may also be performed during other diagnostic studies such as myelography. In the case of a diagnostic lumbar puncture, the report would commonly include a statement that the CSF collected was sent to the laboratory for analysis; however, such a statement does not in and of itself determine that the procedure is solely diagnostic. When a therapeutic lumbar puncture is performed in addition to a diagnostic examination done during the same session, the diagnostic study is not separately reportable, as indicated by the National Correct Coding Initiative (NCCI) edits.
Pain Management Procedures

Diagnostic or Therapeutic Lumbar Punctures
The following can be found in the 2014 AMA/ACR Clinical Examples in Radiology, Winter, Volume 10, Issue 1:
A modifier indicator of (1) allows the reporting of codes 62272 and 62270 only when procedures are performed at different times/encounters on the same day of service.

- Lumbar puncture may also be used to inject chemotherapy drugs into the CSF. For intrathecal administration of chemotherapy, code 96450, Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture, is reported. When a lumbar puncture is performed to administer chemotherapy into the CNS, code 62270 is included in the chemotherapy code 96450 and is not separately reportable.

VentriculoPeritoneal (V-P) Shunt Injection
The following codes are to be assigned in a 1:1 fashion when this service is provided:
- 61070 Puncture of shunt tubing or reservoir for aspiration or injection procedure
- 75809 Shuntogram for investigation of previously placed indwelling nonvascular shunt (e.g., LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation
- See code series 78630 – 78650 for Nuclear Medicine Cerebrospinal Fluid (CSF) procedures.
Pain Management Procedures

Intrathecal Chemotherapy
- 96450 Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture
- 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid)

Some payers may disallow code 77003 when assigned with CPT 96450! Closely monitor local payer 3rd party guidelines.

No CCI edits currently preclude this (May 2015).

Neurolytic Epidural Injections
- 62263 Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; **2 or more days**

- 62264 Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; **1 day**

- CCI edits currently show “1” modifier indicator and 62663 & 62664 as Column 1 codes with CPT 77003 as the Column 2 code
Pain Management Procedures

Neurolytic Epidural Injections
- 62280 Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid
  - (code does not include fluoro if utilized and defined)
- 62281 Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic
  - (code does not include fluoro if utilized and defined)
- 62282 Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)
  - (code does not include fluoro if utilized and defined)

Facet Procedures / Injections
Remember the following relative to these procedures:
- Image guidance (fluoroscopy or CT) and any injection of contrast are inclusive components of 64490-64495. Do not submit CPT 77012, 77002 or 77003 with these codes.
- Imaging guidance and localization are required for the performance of paravertebral facet joint injections described by codes 64490-64495.
- If imaging is not used or not documented in report, report CPT 20552 or 20553.
- If ultrasound guidance is instead of fluoro or CT, used, report from Category III codes 0213T-0218T.
- Codes are unilateral in nature. Modify as directed by payer.
Pain Management Procedures

Facet Procedures / Injections

Remember the following relative to these procedures:

- For procedures performed at T12-L1 (i.e., paravertebral facet injection of the T12-L1 joint, or nerves innervating that joint) level:
  - Assign thoracic code, 64490

- Units
  - Code 64492 or 64495 may not be reported more than once per day.

- Primary and Add-On codes
  - You must have submitted code 64490 in order to also submit code 64491 or 64492.
  - You must have submitted code 64493 in order to also submit code 64494 or 64495.
Pain Management Procedures

Facet Procedures / Injections
Cervical/Thoracic (CT or Fluoro Guided)
Codes are bundled to include both guidance and surgical portion of service
- 64490 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
- 64491 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
- 64492 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)

MAI = 2  MUE = 1

Facet Procedures / Injections
Lumbar/Sacral (CT or Fluoro Guided)
Codes are bundled to include both guidance and surgical portion of service
- 64493 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
- 64494 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
- 64495 Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)

MAI = 2  MUE = 1
Facet Procedures / Injections
Cervical/Thoracic (Ultrasound Guided)

- **0213T** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; **single level**

- **0214T** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; **second level** (List separately in addition to code for primary procedure)

- **0215T** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; **third and any additional level(s)** (List separately in addition to code for primary procedure)

  - **MAI = 2**
  - **MUE = 1**

Remember the following relative to these procedures:

- Codes are unilateral in nature. Modify as directed by payer.
- Units
  - Code 0215T may not be reported more than once per day.
- Primary and Add-On codes
  - You must have submitted code 0213T in order to also submit code 0214T or 0215T.
  - For fluoro or CT guided studies, see Category I codes 64490 – 64495.

If any type of imaging is not used/defined, you must default to the following code options:

- **20552** Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
- **20553** Injection(s); Injection(s); single or multiple trigger point(s), 3 or more muscle(s)
Facet Procedures / Injections
Lumbar/Sacral (Ultrasound Guided)

- 0216T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; **single level**
- 0217T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; **second level** (List separately in addition to code for primary procedure)
- 0218T Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; **third and any additional level(s)** (List separately in addition to code for primary procedure)

MAI = 2 MUE = 1

Remember the following relative to these procedures:
- Codes are unilateral in nature. Modify as directed by payer.
- Units
  - Code 0218T may not be reported more than once per day.
- Primary and Add-On codes
  - You must have submitted code 0216T in order to also submit code 0217T or 0218T.
- For fluoro or CT-guided studies, see Category I codes 64490-64495

If any type of imaging is not used/defined, **you must default** to the following code options:
- 20552 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
- 20553 Injection(s); Injection(s); single or multiple trigger point(s), 3 or more muscle(s)
Neurolytic Destruction

Cervical/Thoracic (CT or Fluoro Guided)

- 64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); cervical or thoracic, *single facet joint*
- 64634 Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); cervical or thoracic, *each additional facet joint* (List separately in addition to code for primary procedure)

Remember the following relative to these procedures:
- Codes are unilateral in nature. Modify as directed by payer.
- Units
  - You must have submitted code 64633 in order to also submit code 64634.

Neurolytic Destruction

Lumbar/Sacral (CT or Fluoro Guided)

- 64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); lumbar or sacral, *single facet joint*
- 64636 Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); lumbar or sacral, *each additional facet joint* (List separately in addition to code for primary procedure)
Neurolytic Destruction

From February 2015 AMA CPT Assistant:
- Although two nerves innervate each facet joint, the number of nerves treated does not affect code selection. This is reflected in the term “nerve(s)” which is included in the code descriptors. Therefore, only one unit of service may be reported for each joint regardless of the number of nerves treated. To clarify, the typical patient has two nerves treated for each facet joint. These nerves are at two different vertebral levels; however, the code is reported once per joint treated no matter how many nerves are treated.
- In keeping with other procedures involving the vertebra, the code structure is based on spinal region. Codes 64633 and 64634 specify the cervical and thoracic regions, while codes 64635 and 64636 specify the lumbar and sacral regions.
- Codes 64634 and 64636 are add-on codes. These codes are reported for each additional facet joint at a different vertebral level in the same spinal region. Because each additional level is reported using codes 64634 and 64636, modifier 51, Multiple procedures, is not appended to these codes. If the additional level(s) is treated bilaterally, modifier 50 may be reported. It is important to note that the procedure must be adequately documented in the medical record.

Remember the following relative to these procedures:
- Codes are unilateral in nature. Modify as directed by payer.
- Units
  - You must have submitted code 64635 in order to also submit code 64636
- Contrast Injections
  - Are inclusive in these codes (64633-64636) and should not be charged separately
- Guidance
  - Do not unbundle CT or Fluoro guidance as these services are inclusive in codes 64633-64636
  - If CT or fluoroscopic imaging is not used or not defined as being used in dictated report, assign UPC 64999 (i.e., under US guidance, April 2013 AMA Assistant)
- For procedures performed at T12-L1 (i.e., paravertebral facet destruction by neurolysis, joint, or nerves innervating that joint) level:
  - Assign thoracic code, 64633
Pain Management Procedures

Other Neurolytic Destruction-Nerves

- While not all inclusive, following are additional neurolytic procedures that may additionally be performed by radiology:
  - Injection of other therapeutic agents (e.g., corticosteroids) are considered to be included in CPT codes 64600 – 64681. as such, it would be inappropriate to charge separately for these diagnostic and/or therapeutic injections separately.
  - Chemodenervation codes do not include the drug/material used to perform these procedures. As such, when allowed (ie., hospital versus professional billing) separate charging should be made for this material.

From February 2015 AMA CPT Assistant-

- Do not report these codes for "pulsed radiofrequency" or destruction by neurolytic agent if done with ultrasound guidance. Those procedures should be reported with code 64999, Unlisted procedure, nervous system

- 64600 Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
- 64605 Destruction by neurolytic agent, trigeminal nerve; Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale

  – CCI edits show edits with code 64610 being the Column 1 code to the Column 2 code of 77002. The modifier indicator is “1”.

- 64610 Destruction by neurolytic agent, trigeminal nerve; Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring
Pain Management Procedures

Other Neurolytic Destruction-Nerves

While not all inclusive, here are some additional neurolytic procedures that may also be performed by radiology:

- 64680 Destruction by neurolytic agent, *with or without radiologic monitoring*; celiac plexus
- 64681 Destruction by neurolytic agent, with or without radiologic monitoring; Destruction by neurolytic agent, *with or without radiologic monitoring*; superior hypogastric plexus

Note that codes 64610, 64680 and 64681 are inclusive of fluoro

Codes 64600 and 64605 do not include fluoro

Transforaminal Injections

![Diagram of Transforaminal Injection]

- Steroid medication
- Inflamed nerve root
- Transforaminal Epidural Steroid Injection
Pain Management Procedures

Transforaminal Injections

Cervical/Thoracic (CT or Fluoro Guided)
- 64479 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, **single level**
- 64480 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, **each additional level** (List separately in addition to code for primary procedure)

Remember:
- Codes are unilateral in nature. Modify as directed by payer.
- Use these codes only for CT or Fluoro guided studies. If performed under US guidance, see code 0228T or 0229T.
- Units
  - You must have submitted code 64479 in order to also submit code 64480
- For procedure performed at T12-L1 (i.e., transforaminal epidural injection of an anesthetic agent and/or steroid)
  - Assign thoracic code, 64479

Lumbar/Sacral (CT or Fluoro Guided)
- 64483 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, **single level**
- 64484 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, **each additional level** (List separately in addition to code for primary procedure)

Remember:
- Codes are unilateral in nature. Modify as directed by payer.
- Use these codes only for CT or Fluoro guided studies. If performed under US guidance, see code 0230T or 0231T.
- Units
  - You must have submitted code 64483 in order to also submit code 64484.
Pain Management Procedures

Trigger Point Injections
What are they?
- Steroids and/or anesthetics are injected into muscles to alleviate/relieve pain

How are they coded?
- Code based upon number of muscles injected

Guidance:
- Guidance is not inclusive (see US, Fluoro, MR or CT)

CPT Options:
- 20552 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
- 20553 Injection(s); single or multiple trigger point(s), 3 or more muscle(s)
Tendon Sheath / Ligament Injections

Guidance
- Guidance is not inclusive (see US, Fluoro, MR or CT)

CPT Options:
- 20550 Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar “fascia”)
- 20551 Injection(s); Injection(s); single tendon origin/insertion
- 64455 Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton’s neuroma)
- 64632 Destruction by neurolytic agent; plantar common digital nerve

Remember:
- It is incorrect to submit code 64632 with code 64455
- Note parenthetical “s” when coding/billing

Dry needling (DN) is a technique in which a thin filiform needle is used to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues. The technique is used to treat dysfunctions in skeletal muscle, fascia, and connective tissue, diminish persistent peripheral nociceptive input, and reduce or restore impairments of body structure and function which may lead to an individual’s improved daily activity.

Prior to 2002, CPT code 20550, Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar “fascia”), was used to report injections of various anatomic sites (i.e., tendon sheath, ligament, ganglion, trigger point). However, as new techniques emerged for performing trigger point services, there was some confusion regarding the appropriate reporting of trigger point injections when a “dry needle” technique is used. Consequently, in the June 1998 issue of the CPT Assistant newsletter (p 10), the following frequently asked question was published to address proper reporting of trigger point injections using a “dry needle” technique.
Coding Clarification: Trigger Point Injections Using "Dry Needling" Technique

**Question:** My physician performs a trigger-point injection using a "dry needle" (a syringe which does not contain an injectable). Can I still use 20550, or should another code be reported?

**Answer:** The intent of code 20550 is to identify the procedure of performing the trigger-point injection itself. The supply of the injectable is reported separately, using an appropriate HCPCS code to identify the specific injectable used. Since the injectable supply is not included as part of the 20550 procedure, if a "dry needle" technique is used, code 20550 may be used to identify the procedure performed.

For the 2002 CPT® code set, codes 20551, Injection(s); single tendon origin/insertion, 20552, Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s), and 20553, Injection(s); single or multiple trigger point(s), 3 or more muscle(s), were established to differentiate the techniques associated with multiple muscle group injections for trigger points. In addition, code 20555 was revised to describe only injections of a tendon sheath, ligament, or ganglion cyst, thus excluding trigger point(s). Due to this revision of code 20550, confusion remained regarding the reporting of trigger point injections using a "dry needle" technique. To clarify proper reporting of trigger point services performed using a "dry needle" technique, an article was published in the September 2003 issue of CPT Assistant, stating that codes from the (20550-20553) code range are not intended for reporting a "dry needle" technique, and that dry needling techniques may be reported with the unlisted procedure code 20999. Unlisted procedure, musculoskeletal system, general.

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**Ganglion Cyst**

What is a ganglion cyst?

- Ganglion cysts are noncancerous lumps that most commonly develop along the tendons or joints of your wrists or hands. They also may occur in the ankles and feet. Ganglion cysts are typically round or oval and are filled with a jelly-like fluid.
- Small ganglion cysts can be pea-sized, while larger ones can be around an inch (2.5 cm) in diameter. Ganglion cysts can be painful if they press on a nearby nerve. Their location can sometimes interfere with joint movement.
Pain Management Procedures

Ganglion Cyst
Guidance
- Guidance is not inclusive (see US, Fluoro, MR or CT)

CPT Option
- 20612 Aspiration and/or injection of ganglion cyst(s) any location

Remember:
- Note parenthetical “s” when coding/billing

Joint Aspiration / Injection
Guidance
- Guidance is not inclusive (see US, Fluoro, MR or CT)

CPT Options
- 20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes); without ultrasound guidance
- 20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance
- 20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa); without ultrasound guidance

Examples of procedures that may be defined by these codes:
- Hip aspiration under fluoro guidance- 77002 and 20610
- Toe arthrogram- 77002 and 20600
Pain Management Procedures

Joint Aspiration / Injection

CPT 2015 saw the addition of three (3) new codes for ultrasound guided small, intermediate and major joint procedures mimicking the codes 20600, 20605 and 20610. They are as follows:

- **20604** Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting
- **20606** Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting
- **20611** Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

From the February 2015 AMA CPT Assistant:

- Two parenthetical notes were also added following codes 20604, 20606, and 20611. The initial parenthetical note following these codes restricts reporting of code 76942 in conjunction with codes 20604, 20606, and 20611, and the second parenthetical note following these codes instructs users to report codes 77002, 77012, or 77021 if fluoroscopic, computed tomography (CT), or magnetic resonance imaging (MRI) guidance is performed. In addition, the exclusionary parenthetical note that follows code 20611 restricts its use with code 27370. To maintain consistency and accurate reporting, the exclusionary parenthetical note following ultrasound guidance code 76942 was also revised to include new codes 20604, 20606, and 20611 in the list of codes that may not be reported with code 76942. The instructional note following code 20610 regarding imaging guidance was deleted to support these changes.
- For code 20610, the descriptor was revised to clarify its intended use and to distinguish the reporting for arthrocentesis, aspiration, and/or injection of a major joint (such as the knee) versus injection of contrast agent(s) into the knee for purposes of arthrography (as identified by code 27370).
Pain Management Procedures

Joint Aspiration / Injection

- Codes 20610 and 20611 are reported to identify arthrocentesis procedures for major joints or bursas (e.g., shoulder, hip, or knee). Code 20610 is used when the procedure is performed without the use of ultrasound guidance and code 20611 is used when ultrasound is necessary to guide the needle into the correct location in the joint.
- Both aspiration and/or injection are inherently included as part of the service as noted in the descriptors for these codes. As a result, either code may only be reported once per joint or bursa. Codes 20610 and 20611 are not intended to report the injection of contrast materials into the knee.
- Code 27370 is intended to be used specifically for that purpose. To indicate this intent, the descriptor for code 27370 was revised, adding the phrase "of contrast" to the descriptor to specify use for contrast agent injection only, excluding the use for other injection types or aspiration procedures of the knee.
- To direct users to the appropriate code to identify contrast injection of the knee, an instructional parenthetical note was added. An exclusionary parenthetical note following the listing of codes 20610 and 20611 reflects the intended use of these codes.

What is the correct code to report when needle access is gained into the hip joint and two separate injections are made through this same access point? Each injection is for a separate, full and complete procedure. The first procedure is a magnetic resonance (MR) arthrogram, which is accomplished by instilling gadolinium. This injection of contrast is not merely a positional injection to verify needle placement for the pain management study, but is a true, full and complete procedure. The second injection is of the anesthetic or steroid mixture for the attempted ablation of pain in this area.
Pain Management Procedures

Joint Aspiration / Injection
The following can be found in the Spring 2013 AMA/ACR Clinical Examples in Radiology, Volume 9, Issue 2:

Unless performed at different sessions, the procedure described should be reported with either code 27093, Injection procedure for hip arthrography; without anesthesia, or code 20610, Arthrocentesis, aspiration and/or injection; major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa). There are established National Correct Coding Initiative (NCCI) edits precluding the reporting of codes 27093 and 20610 when both procedures are performed at the same patient encounter. However, the use of modifier 59 is allowed for the reporting of both procedures when the services are performed on the same day but at different sessions. The imaging part of the injection procedure is reported with code 77002, Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device). The MRI is reported with code 73722, Magnetic resonance (e.g., proton) imaging, any joint of lower extremity; with contrast material(s).

Bone Cyst Aspiration/Injection
Guidance
- Guidance is not inclusive (see US, Fluoro, MR or CT)

CPT Option
- 20615 Aspiration and injection for treatment of bone cyst
Pain Management Procedures

Sacroiliac Joint Injection / Aspiration

Guidance
- Since 2012, this code is bundled/collapsed to include guidance (S&I code) and the surgical aspect of the procedure

CPT Option
- 27096 Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
- If no CT or fluoroscopic guidance is used, or no mention is made in dictated report of imaging guidance, CPT 20552 must be assigned

Remember:
- Code is unilateral in nature. If performed bilaterally, modify per payer directives.

The following can be found in the Fall 2011 AMA/ACR Clinical Examples in Radiology, Volume 7, Issue 4:

A sacroiliac joint is injected under fluoroscopic guidance and formal arthrogram is performed and interpreted. What is the appropriate code(s) to report as of January 1, 2012?
Pain Management Procedures

Sacroiliac Joint Injection / Aspiration

The following can be found in the Fall 2011 AMA/ACR Clinical Examples in Radiology, Volume 7, Issue 4:

- The appropriate code to report a sacroiliac (SI) arthrography procedure beginning in 2012 is code 27096, *Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed.* Code 27096 was revised to include imaging guidance (fluoroscopy or computed tomography) and arthrography radiological supervision and interpretation; therefore, code 73542 is no longer required and will be deleted in 2012.

- A parenthetical note following code 27096 in the CPT 2012 codebook specifies that if CT or fluoroscopic image guidance is not performed, code 20552, *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s),* should be reported.
**Pain Management Procedures**

**Sacroiliac Joint Injection / Aspiration**
Hospital billing under OPPS (i.e., APC’s) may choose from the following options:

- **G0259** Injection procedure for sacroiliac joint; arthrography
- **G0260** Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

**Status and Status Indicators** are as follows:

- **G0259** and **G0260** have “E” Status for MPFS
- **G0259** has “N” Status Indicator under OPPS
- **G0260** has “T” Status Indicator under OPPS

**Arthrograms**

- Numerous anatomic site-specific code choices are available for assignment.
- Codes are most often submitted in a 1:1 fashion
- Post arthrogram CT or MR studies would be coded as “with contrast” exams

**Elbow**

- **73085** Radiologic examination, elbow, arthrography, radiological supervision and interpretation
- **24220** Injection procedure for elbow arthrography

**Wrist**

- **73115** Radiologic examination, wrist, arthrography, radiological supervision and interpretation
- **25246** Injection procedure for wrist arthrography
  - For triphasic wrist arthrogram, submit 73115 once and 25246 for each injection (i.e., x3)
Pain Management Procedures

Arthrograms

Shoulder
- 73040 Radiologic examination, shoulder, arthrography, radiological supervision and interpretation
- 23350 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

Ankle
- 73615 Radiologic examination, ankle, arthrography, radiological supervision and interpretation
- 27648 Injection procedure for ankle arthrography

Knee
- 73580 Radiologic examination, knee, arthrography, radiological supervision and interpretation
- 27370 Injection of contrast for knee arthrography

Other Joint not Specifically Defined (i.e., fingers, toes)
- 77002 Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
- 20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes); without ultrasound guidance

Temporomandibular joint (TMJ)
- 70332 Temporomandibular joint arthrography, radiological supervision and interpretation  (MAI = 2  MUE = 1)
- 21116 Injection procedure for temporomandibular joint arthrography  (MAI = 2  MUE = 1)

Hip
- 73525 Radiologic examination, hip, arthrography, radiological supervision and interpretation
- 27093 Injection procedure for hip arthrography; without anesthesia
- 27095 Injection procedure for hip arthrography; with anesthesia
Pain Management Procedures

Arthograms

Hip
- 73525 Radiologic examination, hip, arthrography, radiological supervision and interpretation
- 27093 Injection procedure for hip arthrography; without anesthesia
- 27095 Injection procedure for hip arthrography; with anesthesia

Q&A from Fall 2007 AMA/ACR Clinical Examples in Radiology

Question:
An interventional radiologist administered a lidocaine injection during a hip arthrography procedure. Should CPT code 27093, Injection procedure for hip arthrography; without anesthesia or 27095, Injection procedure for hip arthrography; with anesthesia, be reported?

Answer:
When lidocaine is administered by a radiologist during a hip arthrography procedure, it is appropriate for the radiologist to report this conventional radiographic arthrography procedure with CPT code 27093 to describe the injection and CPT code 73525, Radiologic examination, hip, arthrography, radiological supervision and interpretation, to describe the imaging (radiological supervision and interpretation [RS&I]). In the rare circumstance when hip arthrography is performed with an anesthesiologist providing anesthesia care, CPT code 27095 is the appropriate code for the radiologist to report for the injection. The anesthesia code 01200, Anesthesia for all closed procedures involving hip joint, is the appropriate code for the anesthesiologist to report.

For CPT purposes, anesthesia includes general or regional anesthesia or other supportive services as deemed necessary by the attending anesthesiologist. A local anesthetic, such as lidocaine, administered by the radiologist who performs the arthrography procedure does not fulfill the definition of “with anesthesia” because it is included in the imaging RS&I code.
Pain Management Procedures

Arthrograms
Other Joint not Specifically Defined (i.e., fingers, toes)
- 77002 Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)
- 20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes); without ultrasound guidance

Vertebroplasty
- 22510 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
- 22511 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral
- 22512 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)
Pain Management Procedures

Kyphoplasty

22513 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic

22514 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar

22515 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

Vertebroplasty

- CPT 2015 now provides for use 3 codes for vertebroplasty.
- Codes 22510-22512 describe procedures for percutaneous vertebroplasty of the cervical, thoracic, lumbar, and sacral spine.
- CPT states the following:
  - "Vertebroplasty is the process of injecting a material (cement) into the vertebral body to reinforce the structure of the body using image guidance".
  - "Vertebral augmentation" is the process of cavity creation followed by the injection of the material (cement) under image guidance".
  - "For 0200T and 0201T, "sacral augmentation (sacroplasty)" refers to the creation of a cavity within a sacral vertebral body followed by injection of a material to fill that cavity".
  - "The procedure codes are inclusive of bone biopsy when performed, moderate sedation, and imaging guidance necessary to perform the procedure".
  - "Use one primary procedure code and an add-on code for additional levels".
  - "When treating the sacrum, sacral procedures are reported only once per encounter".
  - Codes are bundled to include CT or fluoroscopic guidance.
Pain Management Procedures

Kyphoplasty (Vertebral Augmentation)

- Codes 22513, 22514, 22515 describe procedures for percutaneous vertebral augmentation of the thoracic and lumbar spine.
- CPT states the following:
  - "Vertebral augmentation" is the process of cavity creation followed by the injection of the material (cement) under image guidance.
  - "For 0200T and 0201T, "sacral augmentation (sacroplasty)" refers to the creation of a cavity within a sacral vertebral body followed by injection of a material to fill that cavity."
  - "The procedure codes are inclusive of bone biopsy when performed, moderate sedation, and imaging guidance necessary to perform the procedure."
  - "Use one primary procedure code and an add-on code for additional levels. When treating the sacrum, sacral procedures are reported only once per encounter."
  - Codes are bundled to include CT or fluoroscopic guidance.

CCI Narrative Information

CCI Narrative instructions (Chapter 4, subsection H, #15) state the following relative to these codes:

- 15. Many spinal procedures are grouped into families of codes where there are separate primary procedure codes describing the procedure at a single vertebral level in the cervical, thoracic, or lumbar region of the spine. Within some families of codes there is an add-on code for reporting the same procedure at each additional level without specification of the spinal region for the add-on code. When multiple procedures from one of these families of codes are performed at contiguous vertebral levels, a physician should report only one primary code within the family of codes for one level and should report additional contiguous levels utilizing the add-on code(s) in the family of codes. The reported primary code should be the one corresponding to the spinal region of the first procedure. If multiple procedures from one of these families of codes are performed at multiple vertebral levels that are not contiguous and in different regions of the spine, the physician may report one primary code for each non-contiguous region.
CCI Narrative Information

CCI Narrative instructions (Chapter 4, subsection H, #15) state the following relative to these codes:

- For example, the family of CPT codes 22532-22534 describes arthrodesis by lateral extracavitary technique. CPT code 22532 describes the procedure for a single thoracic vertebral segment. CPT code 22533 describes the procedure for a single lumbar vertebral segment. CPT code 22534 is an add-on code describing the procedure for each additional thoracic or lumbar vertebral segment. If a physician performs arthrodesis by lateral extracavitary technique on contiguous vertebral segments such as T12 and L1, only one primary procedure code, the one for the first procedure, may be reported. The procedure on the second vertebral body may be reported with CPT code 22534. If a physician performs the procedure at T10 and L4, the physician may report CPT codes 22532 and 22533.

- CPT codes 22510-22512 represent a family of codes describing percutaneous vertebroplasty, and CPT codes 22513-22515 represent a family of codes describing percutaneous vertebral augmentation. Within each of these families of codes, the physician may report only one primary procedure code and the add-on procedure code for each additional level(s) whether the additional level(s) are contiguous or not.
CCI Narrative Information

- From Chapter 8, 6xxxx series of codes

- 20. Fluoroscopy reported as CPT codes 76000 or 76001 should not be reported with spinal procedures unless there is a specific CPT Manual instruction indicating that it is separately reportable. For some spinal procedures there are specific radiologic guidance codes to report in lieu of these fluoroscopy codes. For other spinal procedures, fluoroscopy is used in lieu of a more traditional intraoperative radiologic examination which is included in the operative procedure. For other spinal procedure codes, fluoroscopy is integral to the procedure.

Pain Management Procedures

62267  Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes

- Code 62267 does not include imaging guidance. For use of fluoro, see 77003
- This code can be used to define a diagnostic aspiration of the intervertebral disc or paravertebral tissue
- CPT 62267 should not be assigned with the following codes:
  - 10022 (FNA), 20225 (deep bone biopsy), 62287 (therapeautic disc aspiration procedure), 62290 or 62291 (diskogram injections)
Pain Management Procedures

62287  Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar

- Do not charge separately for fluoro (77003) or CT (77012) guidance when used with 62287
- This code (62287) is for a therapeutic procedure as opposed to diagnostic aspiration defined by 62267
- Do not report CPT 62287 with codes 62267 (diagnostic disk aspiration), 62290 (lumbar diskogram injection), 62311 (ESI) or 72295 S&I for lumbar diskogram when these procedures are performed at the same anatomic level
- Code 62287 includes an endoscopic approach as well

Thank you for your participation!

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