Welcome to Practice Management Institute’s Webinar and Audio Conference Training. We hope that the information contained herein will give you valuable tips that you can use to improve your skills and performance on the job. Each year, more than 40,000 physicians and office staff are trained by Practice Management Institute. For 30 years, physicians have relied on PMI to provide up-to-date coding, reimbursement, compliance and office management training. Instructor-led classes are presented in 400 of the nation’s leading hospitals, healthcare systems, colleges and medical societies.

PMI provides a number of other training resources for your practice, including national conferences for medical office professionals, self-paced certification preparatory courses, online training, educational audio downloads, and practice reference materials. For more information, visit PMI’s web site at www.pmiMD.com

Please be advised that all information in this program is provided for informational purposes only. While PMI makes all reasonable efforts to verify the credentials of instructors and the information provided, it is not intended to serve as legal advice. The opinions expressed are those of the individual presenter and do not necessarily reflect the viewpoint of Practice Management Institute. The information provided is general in nature. Depending on the particular facts at issue, it may or may not apply to your situation. Participants requiring specific guidance should contact their legal counsel.

CPT® is a registered trademark of the American Medical Association.
Welcome to PMI’s Webinar Presentation

Brought to you by:
Practice Management Institute®
pmiMD.com

Meet the Presenter…

On the topic:

Pain Management Coding and Reimbursement

Maxine Collins
MBA, CPA, CMC, CMIS, CMOM
Faculty
Practice Management Institute
Today, CMS released the first proposed update to the physician payment schedule since the repeal of the Sustainable Growth Rate through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The proposal includes a number of provisions focused on person-centered care, and continues the Administration’s commitment to transform the Medicare program to a system based on quality and healthy outcomes.

"CMS is building on the important work of Congress to shift the Medicare program toward a system that rewards physicians for providing high quality care," said Andy Slavitt, Administrator of CMS. "Thanks to the recent landmark Medicare and children’s health insurance program legislation, CMS and Congress are working together to achieve a better Medicare payment system for physicians and the American people."

In the proposed CY 2016 Physician Fee Schedule rule, CMS is also seeking comment from the public on implementation of certain provisions of the MACRA, including the new Merit-based Incentive payment system (MIPS). This is part of a broader effort at the Department to move the Medicare program to a health care system focused on the delivery of quality care and value.
Anesthesia and Pain Management:
- E&M changes:
  - Addition of “military history” to the social-history element in the E/M guidelines
  - Revised to include determination of any history of military service:
    - Addition of element to assist with assessing, diagnosing, and treating service members, veterans and families
  - Section title change from “Complex Chronic Care Coordination” to “Care Management Services”
    - Addition of new 99490
    - Addition of new subsection “Chronic Care Management Services” with deletion of 99488 and revisions of two codes 99487 and 99489
    - Guidelines significantly revised because of two new subsections.
    - New subsection, guidelines and codes 99497 and 99498 added for advance care planning
  - Update on Medicare payment of these codes -
• CPT code **99490** - Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.
This fact sheet provides background on the newly payable chronic care management (CCM) service, identifies eligible providers and patients, and details the Medicare PFS billing requirements.

Examples of chronic conditions include, but are not limited to, the following:
- Alzheimer’s disease and related dementia;
- Arthritis (osteoarthritis and rheumatoid);
- Asthma;
- Atrial fibrillation;
- Autism spectrum disorders;
- Cancer;
- Chronic Obstructive Pulmonary Disease;
- Depression;
- Diabetes;
- Heart failure;
- Hypertension;
- Ischemic heart disease; and
- Osteoporosis.

COMPLEX CHRONIC CARE MANAGEMENT
CPT CODES 99487 AND 99489 PLACED UNDER NEW SUBSECTION

- **99487** – Complex chronic care management services
- **+99489** – each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
ADVANCE CARE PLANNING
New E/M subsection, guidelines and codes

- Involves counseling and discussing advance directives – a document that appoints an agent and/or records wishes of a patient pertaining to his/her medical treatment for future care should patient lack decisional capacity at time of treatment.
- **99497** – Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.
- **+99498** – each additional 30 minutes (List separately in addition to code for primary procedure).

MUSCULOSKELETAL SYSTEM CHANGES

- **Arthrocentesis** –
  - CPT code descriptions revised to indicate “without imaging guidance”
  - New codes added to be reported when ultrasound guidance is used for procedure
  - CPT codes **20600, 20605, and 20610 revised** as parent codes and restricted to arthrocentesis procedures performed w/o imaging guidance
  - CPT codes **20604, 20606, and 20611 require ultrasound guidance** to be performed with arthrocentesis procedure.
    - 2 parenthetical notes added to the codes to restrict reporting 76942 in conjunction with codes 20604, 20606, and 20611 and instructing coders to report codes 77002, 77012, or 77021, if fluoroscopic computed tomography (CT) or magnetic resonance imaging (MRI) guidance is performed.
NERVE BLOCKS, DIAGNOSTIC OR THERAPEUTIC

• Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System:
  – 4 codes (64486-64489) established to report administration of local anesthetic for postoperative pain control and abdominal wall analgesia, including imaging guidance when performed:
    • 64486 – Transverse abdominis plane (TAP) block (abdominal plane block, rectus sheath block, unilateral, by injection(s) (includes imaging guidance when performed)
    • 64487 – by continuous infusion(s) (includes imaging guidance when performed)
    • 64488 – Transverse abdominis plane (TAP) block (abdominal plane block, rectus sheath block, bilateral, by injection(s) (includes imaging guidance when performed)
    • 64489 – by continuous infusion(s) (includes imaging guidance when performed)

DRUG ASSAYS
5 new codes and deletion of 2014 drug screening codes

• In addition, 58 new drug codes for quantitative drug testing and 2 new therapeutic drug assay codes:
• Drug assays, presumptive drug class screening (Codes 80300-80304)
  – Drug testing section revised to update drug procedures
  – Same three subsections retained – Drug Assay, Therapeutic Drug Assay (TDA) and Chemistry
  – Detailed instructions under the “Drug Assay” section
  – Addition of a definition and acronym conversion listing table to assist in various drug terminology
  – AMA list of drug classes, Class A and Class B and a definitive drug testing table to assist in assignment of appropriate code(s) for a given drug(s) for that methodology.
    • Class A – usually performed by methods such as direct observation (e.g. dipsticks, cards, etc.) or by instrumented test systems such as immunoassay analyzers.
    • Class B – methods that require more resources to perform service
PRESUMPTIVE DRUG CLASS

• Procedures performed to identify possible use or non-use of a particular drug/drug class.
  – Test generally followed by a definitive test in order to specifically identify particular drug(s) or its metabolite(s).

DEFINITIVE DRUG CLASS

• Procedures are qualitative or quantitative — used to identify possible use or non-use of a drug.
  – Test identify specific drugs and associated metabolites, if performed.
  – A presumptive test is not required prior to a definitive drug test.
• May 6, 2015 - U.S. Food and Drug Administration News Release:
  - Approved the Senza spinal cord stimulation (SCS) system (Senza System):
    • As an aid in the management of chronic intractable pain of the trunk and/or limbs, including:
      - Pain associated with failed back surgery syndrome
      - Low back pain, and
      - Leg pain
  • Senza system can reduce pain without producing a tingling sensation called parathesia by providing high frequency stimulation (at 10KHz) and low stimulation amplitudes.
THE OIG 2015 WORKPLAN:
2 TARGETS – ANESTHESIOLOGY AND PAIN MANAGEMENT

– Anesthesiology – 2nd year in a row
  • Appropriate use of “AA” and “QK” modifiers
  • “Payments to any service provider are precluded unless the provider has furnished the information necessary to determine the amounts due” (Social Security Act P.1833(e)).

– Pain management being reviewed
  • Retroactive and current reviews for compliance
    • Source: “The OIG 2015 Workplan: 2 Targets are Anesthesiology and Pain Management,  
http://blog.abeo.com
AETNA – BACK PAIN – NON-INVASIVE TREATMENTS

Note – source: All Aetna information on policies come from www.aetna.com website under Providers resources.

*Number: 0232

1. Quantitative Muscle Testing Devices
   - Aetna considers experimental and investigations when used for muscle testing because of insufficient evidence that use of devices improves assessment of muscle strength over standard manual strength testing.
   - Isokinetic devices (e.g. Biodex, Cybex, and Kin-Com) and other exercise and testing machines (e.g. Isostion B-2000 and MedX) are considered acceptable alternatives for provision of medically necessary exercise in physical therapy.
   - In addition to use in muscle testing, the MedX and other machines have also been used for administering exercise therapy. These devices can be used as exercise machines for administering physical therapy. However, these particular brands of exercise devices have not been proven to be superior to standard brands of exercise equipment (e.g., Nautilus, etc.) when used for administering physical therapy.

2. Orthotract Pneumatic Vest – Aetna considers experimental and investigational.

AETNA – BACK PAIN – NON-INVASIVE TREATMENTS FOR BACK PAIN

- “3. Back School – Aetna considers medically necessary for treatment of chronic or recurrent back pain:
  - When such a program is prescribed by member’s doctor and
  - Program is conducted by Physical Therapist or other appropriate recognized healthcare profession.

- 4. Spinal Adjusting Instruments – See CPB 0107 – Chiropractic Services

- 5. Khan Kinetic Treatment – Aetna considers experimental and investigational for treatment of back pain or any other indications because its effectiveness has not been established.

  - See also CPB 0011 – Electrical Stimulation for Pain; CPB 0016 – Back Pain – Invasive Procedures; CPB 0135–Acupuncture; CPB 0180–Vertebral Axial Decompression; CPB 0204–Manipulation Under General Anesthesia; CPB 0207–Prolotherapy; and CPT 0569– Lumbar Traction Devices.
  - Aetna considers manual muscle testing to be sufficiently reliable for clinical practice. There is insufficient peer-reviewed published scientific evidence that computerized muscle testing leads to better patient outcomes.”
AETNA – CPT/HCPCS CODES/ICD-9 CODES

<table>
<thead>
<tr>
<th>CPT CODES COVERED IF CRITERIA ARE MET</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>97110</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility</td>
</tr>
<tr>
<td>97140</td>
<td>Manual therapy technique (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 min.</td>
</tr>
<tr>
<td>97530</td>
<td>Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 min.</td>
</tr>
</tbody>
</table>

*CPT codes not covered for indications listed in CPB: 95861 – Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk 95851 – Range of motion measurements and report; (separate procedure); each extremity (excluding hand) or each trunk section (spine) 97545 – Work hardening/conditioning; initial 2 hours 97546 – Each additional hr 97750 – Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 min,*

AETNA – NON-INVASIVE TREATMENT FOR BACK PAIN COVERAGE

<table>
<thead>
<tr>
<th>HCPCS CODES COVERED IF SELECTION CRITERIA ARE MET</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>59117</td>
<td>Back school, per visit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER ICD–9 CODES RELATED TO CPB:</th>
<th>DESCRIPTION</th>
<th>OTHER ICD–9 CODES RELATED TO CPB:</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>720.0-7249</td>
<td>Dorsopathies</td>
<td>756.11</td>
<td>Spondylolysis, lumbosacral region</td>
</tr>
<tr>
<td>907.2</td>
<td>Late effect of spinal cord injury</td>
<td>907.3</td>
<td>Late effect of injury to nerve root(s), spinal plexus(es), and other nerves of trunk</td>
</tr>
<tr>
<td>V57.1</td>
<td>Other physical therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
AETNA – CHRONIC PAIN PROGRAMS – 
“MAGIC WORDS” IN DOCUMENTATION

• “Number 0237: Policy – Aetna considers a screening examination medically necessary for members who are being considered for admission into a chronic pain program.

• I. Outpatient Pain Management Programs:
  – Aetna considers outpatient multi-disciplinary pain management programs medically necessary when all of the following criteria are met:
    • If a surgical procedure or acute medical treatment is indicated, it has been performed prior to entry into pain program; and
    • Member has experienced chronic non-malignant pain (not cancer pain) for 6 months or more; and
    • Member has failed conventional methods of treatment; and
    • Member has undergone a mental health evaluation, and any primary psychiatric conditions have been treated, where indicated; and
    • Member’s work or lifestyle has been significantly impaired due to chronic pain; and
    • Referral for entry has been make by the primary care physician/attending physician; and
    • The cause of the member’s pain is unknown or attributable to a physical cause, i.e. not purely psychogenic in origin.”

• Aetna considers entry into an outpatient multi-disciplinary chronic pain program of no proven benefit for members with any of the following contraindications:
  – Member exhibits aggressive and/or violent behavior; or
  – Member exhibits imminently suicidal tendencies; or
  – Member has previously failed an adequate multi-disciplinary (e.g. Commission on Accreditation of Rehabilitation Facilities (CARF) accredit) chronic pain management program; or
  – Member has unrealistic expectations of what can be accomplished from program (i.e. member expects an immediate cure); or
  – Member is medically unstable (e.g. due to uncontrollable high blood pressure, unstable congestive heart failure, or other medical conditions); or
  – Member is unable to understand and carry-out instructions.

• Pain is considered chronic if it results from a chronic pathological process, has recurred periodically over months or years, or persists longer than expected after an illness or injury. Typically, pain is considered chronic if it has persisted for 6 months or more.

• Modality-oriented pain clinics and single disciplinary pain clinics are considered not medically necessary and inappropriate for comprehensive treatment of members with chronic pain.

• Note: Dependence or addiction to narcotics or other controlled substances is frequently part of presentation of a member with chronic pain. Issues surrounding addiction, detoxification must be considered and evaluated prior to enrollment of a member into a pain management program.”
AETNA – CHRONIC OUTPATIENT MULTI-DISCIPLINARY PAIN PROGRAMS

• CPT Codes/HCPCS Codes/ICD-9 Codes:
  – Not covered for indications in the CPB:
    • 96118-96120 Neuropsychological testing (e.g. Halstea-Reitan, Weschsler Memor Scales, Wisconsin Card Sorting Test).
  – Other CPT codes related to CPB:
    • 64550-64595 Neurostimulators
    • +90785 Interactive complexity (List separately in addition to the code for the primary procedure)
    • 90791-90792 Psychiatric diagnostic evaluation with or without medical services
    • 90832-90840 Psychotherapy
    • 96150 Health and behavior assessment (e.g. health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires) , each 15 minutes face-to-face with patient; initial assessment
    • 97010-97546 Therapeutic procedures

AETNA – ICD-9- COVERED CODES FOR OUTPATIENT CHRONIC PAIN PROGRAM

<table>
<thead>
<tr>
<th>ICD-9 CODES COVERED IF CRITERIA MET</th>
<th>DESCRIPTION</th>
<th>ICD-9 CODES COVERED IF CRITERIA MET</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>338.21-338.29</td>
<td>Chronic pain</td>
<td>338.4</td>
<td>Chronic pain syndrome</td>
</tr>
<tr>
<td>290.0-319</td>
<td>Mental disorders</td>
<td>337.20-337.29</td>
<td>Reflex sympathetic dystrophy</td>
</tr>
<tr>
<td>338.3</td>
<td>Neoplasm related pain (acute) (chronic)</td>
<td>346.00-346.93</td>
<td>Migraine headache</td>
</tr>
<tr>
<td>354.4</td>
<td>Causalgia of upper limb</td>
<td>335.71</td>
<td>Causalgia of lower limb</td>
</tr>
<tr>
<td>401.0-405.99</td>
<td>Hypertensive disease</td>
<td>428.0</td>
<td>Congestive heart failure, unsp.</td>
</tr>
<tr>
<td>710.-733.9</td>
<td>Arthropathies and related disorders, dorsopathies, rheumatism, osteopathies, and chondropathies</td>
<td>800.0-999.9</td>
<td>Injury and poisoning</td>
</tr>
<tr>
<td>905.0-908.9</td>
<td>Late effects of injuries</td>
<td>V15.51-V15.59</td>
<td>Personal history of injury</td>
</tr>
</tbody>
</table>
AETNA – BACK PAIN INVASIVE PROCEDURES

“Number: 0016 – Policy – Aetna considers any of the following injections or procedures medically necessary for treatment of back pain; provided, however, that only 1 invasive modality or procedure will be considered medically necessary at a time.

I. Facet joint injections (intra-articular and medial branch blocks) – considered medically necessary:
   a. In diagnosis of facet pain in persons with chronic back or neck pain
   b. Pain lasting more than 3 months despite appropriate conservative treatment.

Note: Facet joint injection (intra-articular or medial branch blocks) are considered experimental and investigational as therapy for back and neck pain and for all other indications because their effectiveness for these indications has not been established.

   c. A set of facet joint injections means:
      1. Up to 6 such injections per sitting, and
      2. Can be repeated once at the same levels and side to establish the diagnosis.
      3. Additional sets of facet injections or medial branch blocks at the same levels and side are considered experimental and investigational.

   d. Aetna considers ultrasound guidance of facet injections experimental and investigational.”

FACET JOINT INJECTIONS

Source: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3107686/
**INDICATIONS FOR FACET INJECTION**

- Imaging findings are of little help in diagnosing the facet syndrome. It is usually a diagnosis of exclusion that is arrived at, after excluding mimics like nerve entrapment syndrome, discogenic pain, spinal stenosis and osseous abnormalities.
- In patients with facet joint syndrome, distension of the joint with saline or contrast will reproduce the pain, and injection of a local anaesthetic agent will relieve the pain [62, 63].
- This response pattern is the current gold standard for diagnosing the facet syndrome [38, 60, 61, 64–66].
- Provocation of pain from a joint injection is an unreliable criterion, but relief of pain is a prima facie evidence for making the diagnosis [22].

The diagnostic injection permits testing of the hypothesis that the target structure (facet joint) is the source of a patient’s pain. Revel et al. [67] found that clinical signs are unsuitable for making a diagnosis, but may be of value in selecting patients for diagnostic block of the facet joint. Hence, the interventional/musculoskeletal radiologist and rheumatologist/spine specialist will need to work in close consultation to select the appropriate candidate for facet injection.

- Indications may be classified as: (a) diagnostic and (b) therapeutic.

[http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3107686](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3107686)

---

**AETNA – BACK PAIN INVASIVE PROCEDURES - TPIs**

- II. Trigger point injections of corticosteroids and/or local anesthetics, are considered medically necessary for:
  - A. Treating members with chronic neck or back pain or myofascial pain syndrome, when all of the following selection criteria are met:
    - 1. Conservative therapies such as bed rest, exercises, heating or cooling modalities, massage, and pharmacotherapies such as non-steroidal anti-inflammatory drugs, muscle relaxants, non-narcotic analgesics, should have been tried and failed, and
    - 2. Symptoms have persisted longer than 3 months, and
    - 3. Trigger points have been identified by palpation: and
    - 4. Trigger point injections are not administered in isolation, but are provided as part of a comprehensive pain management program, including physical therapy, patient education, psychosocial support, and oral medication where appropriate.
  - Note: Trigger point injections are considered experimental and investigational for all other indications.
Aetna Policy on Trigger Point Injections – Continued -

B. A trigger point is defined as a specific point or area where, if stimulated by touch or pressure, a painful response will be induced.

C. A set of trigger point injections means injections in several trigger points in one sitting.

D. It is not considered medically necessary to repeat injections more frequently than every 7 days.

E. Up to 4 sets of injections are considered medically necessary to diagnose the origin of a patient's pain and achieve a therapeutic effect; additional sets of trigger point injections are not considered medically necessary if no clinical response if achieved.

F. Once a diagnosis is established and a therapeutic effect is achieved, it is rarely considered medically necessary to repeat trigger point injections more frequently than once every 2 months.

G. Repeated injections extending beyond 12 months may be reviewed for continued medical necessity.
• “III. Sacroiliac joint injections – are considered medically necessary to relieve pain associated with lower lumbosacral disturbances in members who meet both of the following criteria:
  – A. Member has back pain for > (3) months; and
  – B. The injections are not used in isolation, but are provided as part of a comprehensive pain management program, including physical therapy, patient education, psychosocial support, and oral medication where appropriate.

• Note: Sacroiliac joint injections are considered experimental and investigational for all other indications because their effectiveness for indications other than the ones listed above has not been established.”
  – C. Up to (2) SI injections are considered medically necessary to diagnose the patient’s pain and achieve a therapeutic effect.
  – D. It is not considered medically necessary to repeat these injections more frequently than once every (7) days.
  – E. If the member experiences no symptom relief or functional improvement after (3) SI injections, additional SI injections are not considered medically necessary.
  – F. Once a diagnosis is established, it is rarely medically necessary to repeat SI injections more frequently than once every (2) months.
  – G. Repeat injections extending beyond (12 months) may be reviewed for continued medical necessity.
  – H. Ultrasound guidance of SI injections is considered not medically necessary.
IV. Epidural injections – of corticosteroid preparations (e.g. Depo-Medrol), with or without added anesthetic agents, are considered medically necessary in the outpatient setting for the management of persons with radiculopathy or sciatica when all of the following are met:

- A. Intraspinal tumor or other space-occupying lesion, or non-spinal origin for pain, had been ruled out as the cause of pain; and
- B. Member has failed to improve after (2) or more weeks of conservative measures (e.g. rest, systemic analgesics and/or physical therapy); and
- C. Epidural injections beyond the first set of (3) injections are provided as part of a comprehensive pain management program, which includes physical therapy, patient education, psychosocial support, and oral medications, were appropriate.

Note: Epidural injections of corticosteroid preparations, with or without added anesthetic agents, are considered experimental and investigations for all other indications (e.g. non-specific low back pain (LBP) and failed back syndrome) because their effectiveness for indications other than the ones listed above has not been established.

AETNA – BACK PAIN INVASIVE PROCEDURES – ESIs continued-

- “D. Repeat epidural injections beyond the (first set of 3) injections are considered medically necessary when provided as part of a comprehensive pain management program, which includes physical therapy, patient education, psychosocial support, and oral medications, where appropriate.
- E. Repeat ESIs more frequently than (every 7 days) are not considered medically necessary.
- F. (UP to 3 ESIs) are considered medically necessary to diagnose a member’s pain and achieve a therapeutic effect. Additional injections are not considered medically necessary. If the member experiences no pain relief after (3) ESIs, additional ESIs are not considered medically necessary.
- G. Once a therapeutic effect is achieved, it is rarely medically necessary to repeat ESIs more frequently than 1 time every (2) months.
- H. In selected cases where more definitive therapies (e.g. surgery) cannot be tolerated or provided, additional ESIs may be considered medically necessary.
- I. Repeated injections extending beyond 12 months may be reviewed for continued medical necessity.
- J. Aetna considers ultrasound guidance of ESIs experimental and investigational”
AETNA – BACK PAIN INVASIVE PROCEDURES – CHYMOPAPAIN CHEMONUCLEOLYSIS

• “V. Chymopapain chemonucleolysis – Aetna considers medically necessary for the treatment of sciatica due to a herniated disc when all of the following are met:
  – A. Member has leg pain worse than low back pain; and
  – B. Member has radicular symptoms reproduced by sciatic stretch tests; and
  – C. Member has only a single level herniated disc with nerve root impingement at clinically suspected level demonstrated by MRI, CT, or myelography; and
  – D. Member has objective neurologic deficit (e.g. diminished deep tendon reflex, motor weakness, or hypealgesia in dermatomal distribution); and
  – E. Pain is not relieved by at least (6 weeks) of conservative therapy.”

CHYMOPAPAIN CHEMONUCLEOLYSIS

Chymopapain chemonucleolysis:
A medical procedure that involves the dissolving of the gelatinous cushioning material in an intervertebral disk.

Chymopapain: An enzyme derived from (the milky white fluid of) papyrus, to dissolve the disk material that has been displaced because of injury. Herniated disks are the cause of only a small proportion of cases of lower back pain, and chemonucleolysis is appropriate for only some cases of HNP.

Source: http://medical-dictionary.thefreedictionary.com/chemonucleolysis
**AETNA – BACK PAIN INVASIVE PROCEDURES – CHYMOPAPAIN CHEMONUCLEOLYSIS**

- “Note: chymopapain chemonucleolysis is considered experimental and investigational for all other indications, including the following because its effectiveness for these indications has not been established:
  - 1. Acute LBP alone
  - 2. Cauda equina syndrome
  - 3. For hemiated thoracic or cervical discs
  - 4. Multiple back operations (failed back surgery syndrome)
  - 5. Neurologic diseases (e.g. multiple sclerosis)
  - 6. Pregnancy
  - 7. Profound or rapidly progressive neurologic deficit
  - 8. Sequestered disc fragment
  - 9. Severe spinal stenosis
  - 10. Severe spondylothesis
  - 11. Spinal cord tumor
  - 12. Spinal instability
  - 13. When performed with chondroitinase ABC or agents other than chymopapain”

---

**AETNA – INVASIVE PROCEDURES FOR BACK PAIN - CONTINUED**

- “VII. Non-pulsed radiofrequency facet denervation – (also known as facet neurotomy, fact rhizotomy, or articular rhizolysis) is considered medically necessary for treatment of members with intractable cervical or back pain with or without sciatica in the outpatient setting when all of the following are met:
  - A. Member has experienced severe pain limiting activities of daily living for at least (6) months; and
  - B. Member has had no prior spinal fusion surgery; and
  - C. Neuroradiologic studies are negative or fail to confirm disc herniation; and
  - D. Member has no significant narrowing of the vertebral canal or spinal instability requiring surgery; and
  - E. Member has tried and failed conservative treatments such as bed rest, back supports, physiotherapy, correct of postural abnormality, as well as pharmacotherapies (e.g. anti-inflammatory agents, analgesics and muscle relaxants); and
  - F. Trial of facet joint injections has been successful in relieving the pain.
Non-pulsed radiofrequency facet denervation policy

- Note: Non-pulsed radiofrequency facet denervation is considered experimental and investigational for all other indications because its effectiveness for indications other than the ones listed above has not been established.

- “Only (1) treatment procedure per level per side is considered medically necessary in a (6) month period.”

- “See also CPB 07385- Pulsed Radiofrequency”

Aetna considers any of the following experimental and investigational (not a complete listing):
- Chemical ablation (including but not limited to alcohol, phenol or sodium morrhuate) of facet joints
- Coccygeal ganglion (ganglion Impar) block for coccydynia, pelvic pain, and all other indications
- Epidural injections of lytic agents (e.g. hyaluronidase, hypertonic saline) or mechanical lysis in the treatment of adhesive arachnoiditis, epidural fibrosis, failed back syndrome, or other indications
- Epidural steroid injections for the treatment of non-radicular low back pain
- Epiduroscopy (also known as epidural myeloscopy, epidural spinal endoscopy, myeloscopy, and spinal endoscopy) for the diagnosis and treatment of intractable LBP or other indications
- Facet chemodenervation/chemical facet neurolysis
- Intercostal nerve blocks for intercostal neuritis
- Intradiscal, paravertebral, or epidural oxygen or ozone injections
- Intradiscal steroid injections
- Intravenous administration of corticosteroids, lidocaine, magnesium, Toradol or vitamin B12 (cyanocobalamin) as treatment for back pain
- Khan kinetic treatment (KKT)
- Laser facet denervation
- Racz procedure (epidural adhesiolysis with the Racz catheter) for treatment of adhesive arachnoiditis, epidural adhesions, failed back syndrome from multiple previous surgeries for herniated lumbar disk, or other indications
- Radiofrequency denervation for sacroiliac joint pain
- Radiofrequency lesioning of terminal (peripheral) nerve endings for back pain
- Radiofrequency/pulsed radiofrequency ablation of trigger point pain
Number 2.04.513, Effective 04/24/15

Qualitative Urine Drug Testing:

- In outpatient pain management setting “qualitative urine drug testing is used to verify treatment compliance, identify drug use or abuse that has not been reported, or to evaluate aberrant behavior such as lost prescriptions, repeated requests for early refills, prescriptions from multiple providers, unauthorized dose escalation, and intoxication, or other unusual findings”.

- It is considered medically necessary as part of a routine monitoring for individuals who are:
  - Being treated for chronic pain with prescription opioid or other potentially abused substances; OR
  - Being treated or in a monitoring program for opioid addiction or substance abuse

- Usual screening is 24 times per year

- Also considered medically necessary in the following situations:
  - To evaluate an individual where the history or symptoms suggest use of non-prescribed medications or illegal substances; OR
  - Upon initial evaluation and admission to a pain management program or substance abuse recovery program.

Source: https://www.premera.com/medicalpolicies

Quantitative Urine Drug Testing:

- Considered medically necessary when ALL of the following criteria are met:
  - Qualitative urine drug testing was previously done for a medically necessary reason;
  - The qualitative test was concerning in any of the following ways:
    - Negative for prescribed medications
    - Positive for a prescription drug with abuse potential which was not prescribed; or
    - Positive for an illegal drug (such as methamphetamine or cocaine or other);
  - The specific quantitative test(s) ordered are documented to be appropriate based on clinical chart notes that describe the rationale for each quantitative test ordered; AND
  - Chart notes describe how test results will guide clinical management AND
  - Testing is for no more than 6 different drugs

Source: https://www.premera.com/medicalpolicies Note: See website for CPT codes.
Pain management:

- The risk level for a patient should include a global assessment of risk factors, and monitoring for the presence of aberrant behavior. Standardized risk assessment tools are available, such as the 5-item Opioid Risk Tool (ORT). Another screening instrument is the SOAPP-R, a 24-item tool. (Available at [http://paineduc.cor/soapp.asp?gclid=CPvL/OeF170CFY1F1MqooK4AAA](http://paineduc.cor/soapp.asp?gclid=CPvL/OeF170CFY1F1MqooK4AAA))

- Opinions vary on the optimal frequency of urine drug screening for monitoring a patient on opioid therapy for chronic pain. Frequency of screening using a risk based approach, as recommended by the Washington State Inter-Agency Guideline (1) is as follows:
  - Low risk by Opioid Risk Tool (ORT) (Note that the ORT is a copyrighted instrument): Up to 1 per year
  - Moderate risk by ORT: Up to 2 per year
  - High risk or opioid dose ≥120 MED/d: Up to 3 to 4 per year

- Most patients are expected to be on a stable dose of opioid medication within 4 weeks of initiating treatment. In some complicated patients, the stabilization phase may last longer than 4 weeks.

- For most patients, targeted qualitative screening once every 1 to 3 months is sufficient during the maintenance phase of treatment. More frequent testing may be appropriate for some complicated patients.

Natural Opioids (e.g. codeine, morphine):

- Immunoassays for “opiates” are responsible for morphine and codeine but do not distinguish which is present. Confirmatory testing is required to reliably identify drug(s) present. Since codeine is metabolized to morphine and small quantities to hydrocodone, these drugs may be found in the urine. Also morphine may metabolize to produce a small amount (~10%) of hydromorphone.

PREMERA BLUE CROSS MEDICAL POLICY – URINE DRUG TESTING

2009 – “American Pain Society (APS) and American Academy of Pain Medicine (AAPM) jointly published clinical guidelines on use of opioid therapy in chronic, noncancer pain. The guidelines do not address urine drug testing or other forms of monitoring adherence.”


2011 – American College of Occupational and Environmental Medicine (ACOEM) issued guidelines recommending the following:

- “Routine use of urine drug screening for patients on chronic opioids is recommended as there is evidence that urine drug screens can identify aberrant opioid use and other substance use that otherwise is not apparent to the treating physician.”
- “The intervention is recommend for appropriate patients. There is limited evidence that the intervention may improve important health and functional benefits.”
- “Screening is recommend for all patients at baseline and then randomly at least twice and up to 4 times a year and at termination. Screening should also be performed if the provider suspects abuse of prescribed medication.”
### BCBSMS – URINE DRUG TESTING IN CHRONIC PAIN – COVERED CODES

<table>
<thead>
<tr>
<th>CPT / HCPCS</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>80100</td>
<td>Drug screen, qualitative; multiple drug classes chromatographic method, each procedure (Deleted 12/31/2014)</td>
</tr>
<tr>
<td>80101</td>
<td>Drug screen, qualitative; single drug class method (e.g. immunoassay, enzyme assay), each drug class (Deleted 12/31/2014)</td>
</tr>
<tr>
<td>80102</td>
<td>Drug confirmation, each procedure (Deleted 12/31/2014)</td>
</tr>
<tr>
<td>80104</td>
<td>Drug screen, qualitative; multiple drug classes other than chromatographic method, each procedure (Deleted 12/31/2014)</td>
</tr>
<tr>
<td>80174</td>
<td>Stereoisomer (enantioner) analysis, single drug class (New 01/01/2015)</td>
</tr>
<tr>
<td>G0431</td>
<td>Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter</td>
</tr>
<tr>
<td>G0434</td>
<td>Drug screen, other than chromatographic, any number of drug classes by CLIA waived test or moderate complexity test, per patient encounter</td>
</tr>
</tbody>
</table>

### BCBSMS – URINE DRUG TESTING IN CHRONIC PAIN – COVERED DX CODES

- **ICD-9-CM:** V58.69 – Long-term (current) use of other medications

- **ICD-10-CM:** The following ICD-10 codes are generally equivalent* to The following ICD-10 code(s) are generally equivalent to this code (V58.69):

  - **Code**
  - **Description**
    - Z79.891
      - Long term (current) use of opiate analgesic
    - Z79.899
      - Other long term (current) drug therapy
### HARVARD PILGRIM HEALTH CARE – 2015 PAIN MANAGEMENT UTILIZATION REVIEW MATRIX

<table>
<thead>
<tr>
<th>Authorized CPT Code</th>
<th>Description</th>
<th>Allowable Billed Groupings</th>
</tr>
</thead>
<tbody>
<tr>
<td>62310</td>
<td>Cervical/Thoracic Interlaminar Epidural</td>
<td>62310, +77003, 64479, +64480, 0228T, +0229T</td>
</tr>
<tr>
<td>64479</td>
<td>Cervical/Thoracic Transforaminal Epidural</td>
<td>62310, +77003, 64479, +64480, 0228T, 0229T</td>
</tr>
<tr>
<td>62311</td>
<td>Lumbar/Sacral Interlaminar Epidural</td>
<td>62311, +77003, 64483, +64484, 0230T, +0231T</td>
</tr>
<tr>
<td>64483</td>
<td>Lumbar/Sacral Transforaminal Epidural</td>
<td>62311, +77003, 64483, +64484, 0230T, 0231T</td>
</tr>
<tr>
<td>64490</td>
<td>Cervical/Thoracic Facet Joint Block</td>
<td>64490, +64491, +64492, 0213T, +0214T, +0215T</td>
</tr>
<tr>
<td>64493</td>
<td>Lumbar/Sacral Facet Joint Block</td>
<td>64493, +64494, +64495, 0216T, +0217T, +0218T</td>
</tr>
<tr>
<td>64633</td>
<td>Cervical/Thoracic Facet Joint Radiofrequency Neurolysis</td>
<td>64633, +64634</td>
</tr>
<tr>
<td>64635</td>
<td>Lumbar/Sacral Facet Joint Radiofrequency Neurolysis</td>
<td>64635, +64636</td>
</tr>
</tbody>
</table>


**Note:**
- *CPT codes for procedures performed with ultrasound guidance are not a covered service and are not reimbursable: 0213T, 0214T, 0215T, 0216T, +0217T, +0218T, 0228T, +0229T, 0230T, +0231T, 0095T.
- **77003 (guidance):** In the 2015 final physician fee schedule Medicare bundled fluoroscopy (+77003) with epidural codes 62310 and 62311. NCCI has 77003 with 62310/62311 bundled as of April 1, 2015. So, 77003 should no longer be allowed with 62310 and 62311.
- ***+ codes (add on codes) do not require separate authorization and are to be used in conjunction with approved primary code for the service rendered.**
The following codes require Prior Authorization/Medical Necessity Determination:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>* investigational</th>
</tr>
</thead>
<tbody>
<tr>
<td>0213T</td>
<td>0214T</td>
</tr>
<tr>
<td>0218T</td>
<td>0219T</td>
</tr>
<tr>
<td>00640 *</td>
<td>01935</td>
</tr>
<tr>
<td>20552</td>
<td>20553</td>
</tr>
<tr>
<td>22512</td>
<td>22513</td>
</tr>
<tr>
<td>61790</td>
<td>61791</td>
</tr>
<tr>
<td>62290</td>
<td>62291</td>
</tr>
<tr>
<td>62318</td>
<td>62319</td>
</tr>
<tr>
<td>62361</td>
<td>62362</td>
</tr>
<tr>
<td>63664</td>
<td>63685</td>
</tr>
<tr>
<td>64483</td>
<td>64484</td>
</tr>
<tr>
<td>64493</td>
<td>64494</td>
</tr>
<tr>
<td>64633</td>
<td>64634</td>
</tr>
<tr>
<td>72285</td>
<td>72295</td>
</tr>
<tr>
<td>M0076 *</td>
<td>52348 *</td>
</tr>
</tbody>
</table>
### Medical Policy Updates

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Effective Date</th>
<th>Summary of Changes</th>
<th>Coverage Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Epidual Steroid Injections for Spinal Pain</strong></td>
<td>June 1, 2015</td>
<td>- Updated list of applicable ICD-10 diagnosis codes for facet injections (previously draft effective 10/01/15); added M47.021, M47.022, M47.019, S22.000A, S22.001A, S22.002A, S22.008A, S22.009A, S22.010A, S22.011A, S22.012A, S22.013A, S22.028A, S22.029A, S22.030A, S22.031A, S22.032A, S22.038A, S22.039A, S22.040A, S22.041A, S22.042A, S22.043A, S22.044A, S22.045A, S22.046A, S22.047A, S22.048A, S22.049A</td>
<td>Epidual steroid injections in this policy apply to the lumbar spine only. This section does not address cervical injections. The facet joint injections section of this policy addresses multiple sites, and is not limited to the lumbar spine. The use of ultrasound guidance for epidural steroid injection(s) or facet joint injection(s) is unwarranted and not medically necessary. There is insufficient clinical evidence regarding the safety and/or efficacy published peer-reviewed medical literature. The available published evidence for ultrasound guidance for epidural and facet injections is limited to a small feasibility study and a cadaver study.</td>
</tr>
<tr>
<td><strong>Epidual Steroid Injections</strong></td>
<td></td>
<td></td>
<td>Epidual steroid injection is proven and medically necessary for treatment of acute and sub-acute sciatica or radicular pain of the back caused by spinal stenosis, disc herniation or degenerative changes in the vertebral column. Epidual steroid injections have a clinically established role in the short-term management of low back pain when the following two criteria are met: The pain is associated with symptoms of nerve root irritation and/or back pain due to disc extrusions and/or contained herniations; and The pain is unresponsive to conservative treatment, including but not limited to pharmacotherapy, exercise or physical therapy.</td>
</tr>
<tr>
<td><strong>Epidual Steroid Injections</strong></td>
<td></td>
<td></td>
<td>Epidual steroid injection is proven and medically necessary for treatment of acute and sub-acute sciatica or radicular pain of the back caused by spinal stenosis, disc herniation or degenerative changes in the vertebral column. Epidual steroid injections have a clinically established role in the short-term management of low back pain when the following two criteria are met: The pain is associated with symptoms of nerve root irritation and/or back pain due to disc extrusions and/or contained herniations; and The pain is unresponsive to conservative treatment, including but not limited to pharmacotherapy, exercise or physical therapy.</td>
</tr>
</tbody>
</table>

#### Additional Information
- **Face Joint Injections**
  - Diagnostic facet joint injection and/or facet nerve block (e.g., not medically necessary).
• Importance of Documentation
  – “If it is not documented, it was not done”. (CMS)
  – More clinical in terminology and descriptions
  – Much more detail in specific codes
  – Right, left, bilateral
  – Encounter information
  – “dominant” vs. “non-dominate
  – Structure
  – Combination codes
  – ICD-9 “V” and “E” code information now embedded in the coding system for ICD-10-CM
    in many instances – will have to have specific information to code accurately

• Government - added some flexibility for 1 year as we transition into new coding system
  – Warning – if physician practices don’t start off coding correctly in ICD-10-CM, the
    chances of ever getting the required information could become problematic and affect
    reimbursement in the future.

COMPARISON BETWEEN ICD-9-CM & ICD-10-CM

<table>
<thead>
<tr>
<th></th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consists of three to five characters</td>
<td>Consists of three to seven characters</td>
<td></td>
</tr>
<tr>
<td>Approximately 13,000 codes</td>
<td>Approximately 68,000 codes</td>
<td></td>
</tr>
<tr>
<td>First character is numeric or alpha (E or V) or numeric, characters 2-5 are numeric</td>
<td>First character is alpha; Characters 2 is numeric; Characters 3 - 7 are alpha or numeric (alpha digits are not case sensitive)</td>
<td></td>
</tr>
<tr>
<td>Always at least three characters</td>
<td>Flexible for adding new codes; Very specific</td>
<td></td>
</tr>
<tr>
<td>Decimal placed after the first three characters</td>
<td>Decimal placed after the first three characters</td>
<td></td>
</tr>
<tr>
<td>No Laterality</td>
<td>Has laterality</td>
<td></td>
</tr>
</tbody>
</table>

ICD-9-CM Code Format

ICD-10-CM Code Format
Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88)

- Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals (S30-S39)
  - Injuries to the head
  - Injuries to the neck
  - Injuries to the thorax
  - Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals
  - Injuries to the shoulder and upper arm
  - Injuries to the elbow and forearm
  - Injuries to the wrist, hand, and fingers
  - Injuries to knee and lower leg
  - Injuries to ankle and foot

- 4th S24 Injury of nerves and spinal cord at thorax level

  - Note: Code to highest level of thoracic spinal cord injury. Injuries to the spinal cord (S24.0 and S24.1) refer to the cord level and not bone level injury, and can affect nerve roots at and below the level given.
  - Code also any associated:
    - Fracture of thoracic vertebra (S22.0-)
    - Open wound of thorax (S21.-)
    - Transient paralysis (R29.5)
  - Excludes 2: Injury of brachial plexus (S14.3)

  - The appropriate 7th character is to be added to each code from category S24:
    - A initial encounter
    - D subsequent encounter
    - S sequela

ICD-10 EXAMPLE – ANTERIOR CORD SYNDROME OF T1 LEVEL OF THORACIC SPINAL CORD – INITIAL ENCOUNTER

- 4th S24 Injury of nerves and spinal cord at thorax level

  - Note: Code to highest level of thoracic spinal cord injury. Injuries to the spinal cord (S24.0 and S24.1) refer to the cord level and not bone level injury, and can affect nerve roots at and below the level given.
  - Code also any associated:
    - Fracture of thoracic vertebra (S22.0-)
    - Open wound of thorax (S21.-)
    - Transient paralysis (R29.5)
  - Excludes 2: Injury of brachial plexus (S14.3)

  - The appropriate 7th character is to be added to each code from category S24:
    - A initial encounter
    - D subsequent encounter
    - S sequela
ICD-10 EXAMPLE – CONCUSSION AND EDEMA OF LUMBAR SPINAL CORD – SUBSEQUENT ENCOUNTER

- **5TH**: Concussion and edema of lumbar and sacral spinal cord
  - x7th  S34.01 Concussion and edema of lumbar spinal cord
- The appropriate 7th character is to be added to each code from category S24:
  - A initial encounter
  - D subsequent encounter
  - S sequela
- "Dummy" Placeholder "X" required to fill in any missing characters when a 6th or 7th character is required for the code.

7TH CHARACTER DESCRIBING ENCOUNTER

- **Initial encounter**: As long as patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter and evaluation and treatment by a new physician.
- **Subsequent encounter**: After patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
  - Examples of subsequent treatment are: cast change or removal, removal of external or internal fixations device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.
- **Sequela**: Complications or conditions that arise as a direct result of a condition (e.g., scar, formation after a burn).
- **Note**: For aftercare of injury, assign acute injury code with 7th character for subsequent encounter.
### DISC DISORDER – ALPHABETIC INDEX

- Disorder
  - disc (intervertebral) M51.9
  - with
    - myelopathy
      - cervical region M50.00
      - cervicothoracic region M50.03
      - high cervical region M50.01
      - lumbar region M51.06
      - mid-cervical region M50.02
      - sacroccocygeal region M53.3
        - thoracic region M51.04
        - thoracolumbar region M51.05
  - radiculopathy
    - cervical region M50.10
      - cervicothoracic region M50.13
      - high cervical region M50.11
      - lumbar region M51.16
      - lumbosacral region M51.17
      - mid-cervical region M50.12
      - sacroccocygeal region M53.3
      - thoracic region M51.14
      - thoracolumbar region M51.15

### RADICULOPATHY – ALPHABETIC INDEX

- Radiculopathy M54.10
  - cervical region M54.12
  - cervicothoracic region M54.13
  - due to:
    - disc disorder
    - C3 M50.11
    - C4 M50.11
    - C5 M50.12
    - C6 M50.12
    - C7 M50.12
    - C8 M50.13
  - displacement of intervertebral disc – see Disorder, disc, with, radiculopathy
    - leg M54.1-
    - lumbar region M54.16
CONVERTING SPINAL STENOSIS FROM “9” TO “10”

- ICD-9-CM 724.02 converts approximately to:
  - 2015 ICD-10-CM M48.06 Spinal stenosis, lumbar region
- 4th M48 Other spondylopathies
- 5th M48.0 Spinal stenosis (Caudal stenosis)
  - M48.00 Spinal stenosis, unspecified site
  - M48.01 Spinal stenosis, occipito-atlanto-axial region
  - M48.02 Spinal stenosis, cervical region
  - M48.03 Spinal stenosis, cervicothoracic region
  - M48.04 Spinal stenosis, thoracic region
  - M48.05 Spinal stenosis, thoracolumbar region
  - M48.06 Spinal stenosis, lumbar region
  - M48.07 Spinal stenosis, lumbosacral region
  - M48.08 Spinal stenosis, sacral and sacrococcygeal region

CONVERT THE FOLLOWING ICD-9-CM CODES TO ICD-10-CM

- ICD-9-CM 722.10 converts approximately to:
  1. 2015 ICD-10-CM M51.26 Other intervertebral disc displacement, lumbar region or:
     2015 ICD-10-CM M51.27 Other intervertebral disc displacement, lumbosacral region
  2. ICD-9-CM 722.0 - Displacement of cervical intervertebral disc without myelopathy
     - ICD-9-CM 722.0 converts approximately to:
     - 2015 ICD-10-CM M50.20 Other cervical disc displacement, unspecified cervical region
  3. ICD-9-CM 723.4 - Brachial neuritis or radiculitis NOS
     - ICD-9-CM 723.4 converts approximately to:
     - 2015 ICD-10-CM M54.12 Radiculopathy, cervical region or:
     - 2015 ICD-10-CM M54.13 Radiculopathy, cervicothoracic region
CONVERT FROM “9” TO “10”

4. ICD-9-CM 756.11 converts approximately to:
   • 2015 ICD-10-CM Q76.2 Congenital spondylolisthesis

5. ICD-9-CM – 723.0 Spinal stenosis in cervical region
   • ICD-9-CM 723.0 converts approximately to:
   • 2015 ICD-10-CM M48.02 Spinal stenosis, cervical region

6. ICD-9-CM – 722.6 Degeneration of intervertebral disc, site unspecified
   • ICD-9-CM 722.6 converts approximately to:
   • 2015 ICD-10-CM M51.34 Other intervertebral disc degeneration, thoracic region:
   • 2015 ICD-10-CM M51.35 Other intervertebral disc degeneration, thoracolumbar region:
   • 2015 ICD-10-CM M51.36 Other intervertebral disc degeneration, lumbar region:
   • 2015 ICD-10-CM M51.37 Other intervertebral disc degeneration, lumbosacral region

ADDITIONAL INFORMATION THAT MAY BE REQUIRED TO ACCURATELY CODE INJURIES & POISONINGS

• External Cause Code(s):
  – Provide information to “paint the picture” of information available to further describe the injury and/or poisoning:
    • What happened? (External cause code(s))
    • Where did the Incident happen? (Place of occurrence)
    • How did the incident happen? (An Activity code if it further describes the injury/poisoning)
    • What was the Status of the patient at the time of the injury? (External Cause Status)
CHAPTER 6: DISEASES OF NERVOUS SYSTEM (G00-G99)

• Pain: Category. G89

• General Coding Information:

• Codes in Category G89, Pain, not elsewhere classified
  May be used with codes from other categories and
  chapters to provide more detail about an acute or
  chronic pain and neoplasm-related pain unless otherwise
  indicated below.

QUESTIONS?

• Q & A

• TIPS

• CONTACT INFORMATION:
  mcollins@pmimd.com

• THANK YOU!!!!