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Maxine Collins, MBA, CPA,
CMC, CMIS, CMOM

On the topic:
Coding & Billing for Pain Management Services in 2019
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Coding & Billing for Pain Management Services in 2019

Presented by
Maxine Collins, MBA, CPA, CMC, CMIS, CMOM
Faculty, Practice Management Institute
Director of Audits, Compliance, &
Education, CoreMD Partners, LLC

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CENTERS FOR MEDICARE 
AND MEDICAID SERVICES

2019 FINAL RULE FOR THE 
MEDICARE PHYSICIAN FEE 
SCHEDULE
• Some good, some bad for Interventional Pain Management & Anesthesia in 2019:
  – Conversion factor payment increase for Physicians up $.0431 - Wow!
  – Conversion factor payment increase for Anesthesia up $.0843
  – Evaluation and Management Documentation changes:
    • Physicians no longer required to re-record elements of history and physical exam when there is evidence that he/she reviewed and updated.
    • Physicians can now only document that they reviewed and verified information regarding chief complaint and history that has already been recorded by ancillary staff or the patient.
    • Warning – these changes apply only to Medicare patients. It remains to be seen how other carriers will follow.
  – CMS did not finalize rules proposed to reduce the payment when an office visit was performed on the same day as another service. This is still being considered for future proposals.

– CMS is not going forward in 2019 (postponing until 2021) the proposed single payment rate for office/outpatient visits Levels 2 thru 5. Instead proposing for 2021 to collapse Levels 2 thru 4 into a single payment and maintaining Level 5 for more complex patients.

– Interventional Pain Management payment changes reflect minor additional increases of 1%-3% for some procedures.

– The proposed rule showed a significant increase for CPT 63650 (Percutaneous lead placement in an office setting) from $1,353.72 to $1,613.43. The final rule actually increased payment to $1,657.08.

– CMS did not increase the reimbursement for peripheral nerve blocks and neurolytic blocks and there are also some reductions for interspinous prosthesis.
TO SUMMARIZE - STREAMLINING EVALUATION AND MANAGEMENT (E/M) AND REDUCING CLINICIAN BURDEN

- The 2019 Medicare Physician Fee Schedule Conversion Factor is:
  - $36.0391 – up from $35.996. - up $.0431!
- The 2019 Anesthesia Conversion Factor is:
  - $22.2730 – up from $22.1887 – up $.0843.
- For CYs 2019 and 2020:
  - CMS will continue the current coding and payment structure for E/M office/outpatient visits; and
  - Practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare.

Source: www.cms.gov

### SUMMARY CMS’ ESTIMATED IMPACT OF 2019 MPFS ON ALLOWED CHARGES

<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th>ALLOWED CHGS (IN MILLIONS)</th>
<th>IMPACT OF WORK RVU CHANGES</th>
<th>IMPACT OF PE RVU CHANGES</th>
<th>IMPACT OF MP RVU CHANGES</th>
<th>COMBINED IMPACT OF RVU CHANGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL</td>
<td>$92,733</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>ANESTHESIOLOGY</td>
<td>$1,982</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
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<td>INTERVENTIONAL PAIN</td>
<td>$868</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>NURSE ANES/ANES ASST</td>
<td>$1,242</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

CMS FINALIZED WORK RVUs FOR THE FOLLOWING NEW, REVISED AND POTENTIALLY MISVALUED CODES FOR 2019

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>DESCRIPTION</th>
<th>2018 WORK RVU</th>
<th>PROPOSED 2019 WORK RVU</th>
<th>FINAL 2019 WORK RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>64405</td>
<td>Injection, anesthetic agent; greater occipital nerve</td>
<td>0.94</td>
<td>0.94</td>
<td>0.94</td>
</tr>
<tr>
<td>76942</td>
<td>US guidance for needle placement (e.g. biopsy, fine needle aspiration biopsy)</td>
<td>0.67</td>
<td>0.67</td>
<td>0.67</td>
</tr>
<tr>
<td>95970</td>
<td>Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve neurostimulator pulse generator/transmitter, without programming</td>
<td>0.45</td>
<td>0.35</td>
<td>0.35</td>
</tr>
</tbody>
</table>


MODERNIZING MEDICARE PHYSICIAN PAYMENT

- CMS is finalizing its proposals to pay separately for two newly defined physicians’ services furnished using communication technology:
  - **Brief communication technology-based service:**
    - Example – *virtual check-in (HCPCS code G2012)*
  - **Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010).**
- CMS is also finalizing policies to pay separately for **new coding describing chronic care remote physiologic monitoring:**
  - **CPT codes 99453, 99454, and 99457; and**
  - Interprofessional internet consultation
    - **CPT codes 99451. 99452, 99446, 99447, 99448, and 99499.**
NEW MEDICARE HCPCS CODES FOR 2019

- **G2010** - Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment
  - RVU/Reimbursement – Non-Facility - 0.35; Medicare Allowable - $ 12.61 (National)
  - RVU – Facility - 0.25; Medicare Allowable - $ 9.14

- **G2012** - Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
  - RVU – Non-Facility - 0.401; Medicare Allowable - $ 14.78 (National)
  - RVU – Facility - 0.36; Medicare Allowable - $ 12.96

NEW MEDICARE HCPCS CODE(S) FOR 2019

- **G2011** - Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes
  - RVU – Non-Facility & Facility - 0.46; Medicare Allowable - $ 16.52 (National)
EXPANDING USE OF TELEHEALTH SERVICES FOR TREATMENT OF OPIOID USE DISORDER

• Through an interim final rule with comment period, CMS is implementing a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that
  – Removes the originating site geographic requirements; and
  – Adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished on or after July 1, 2019

TELEHEALTH SERVICES FOR 2019 MPFS

• New interpretation of Medicare’s telehealth services:
  – Formerly restricted to beneficiaries located in a rural geographic setting at a clinical facility (“originating site”).
  – Re-defined definition by stating that “Medicare telehealth services applies to a discrete set of services that are ordinarily defined, coded, and paid as if they were furnished in an in-person encounter”.
  – CMS – “communication technology-based services are inherently remote and rely on technology communication and are therefore outside the scope of the definition of Section 1834(m) of the Social Security Act”.
  – The Act defined “Medicare telehealth services as including professional consultations, office visits and office psychiatric visits that are furnished using two-way, real-time interactive communication between an eligible beneficiary and practitioner. To be eligible, the beneficiary had to be located in a rural site”.
  – The change now provides new opportunities to recognize practitioners for the work they perform outside of the traditional office setting and leads to updated payment policies.

INTER-PROFESSIONAL CONSULTATIONS

Two new codes and separate payment for:
- Inter-professional internet/telephone consultations between a treating physician and a consulting physician:
  - CPT code 99451 - Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time. RVU – Facility and Non-Facility - 1.01.; Reimbursement $ 36.47.
  - CPT code 99452 - Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes. RVU – Facility and Non-Facility - 1.01; Reimbursement $ 36.47..

REMOTE PATIENT MONITORING

Three new Chronic Care remote physiologic monitoring codes effective 01/01/2019:
- CPT 99453 - Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment. RVU Facility or Non-Facility - 0.51. AMA Guidelines: (Do not report 99453 more than once per episode of care)
  - (Do not report 99453 for monitoring of less than 16 days)
- CPT 99454 - Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. RVU – Facility or Non-Facility - 1.67. AMA Guidelines: (For physiologic monitoring treatment management services, use 99457)
  - (Do not report 99454 for monitoring of less than 16 days)
  - (Do not report 99453, 99454 in conjunction with codes for more specific physiologic parameters [e.g., 93296, 94760])
- CPT 99457 - Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month. RVU Facility - 0.88; Non-Facility - 1.37.00 AMA Guidelines:
  - (Report 99457 once each 30 days, regardless of the number of parameters monitored)
  - (Do not report 99457 in conjunction with 99991)
TWO NEW TELEHEALTH CPT CODES FOR PROLONGED PREVENTIVE SERVICES

• These qualify as “Medicare telehealth services” and must use the telehealth place of service (POS) code “02”.
  – G0513 - Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service). RVU – Facility - 1.68; Non-Facility - 1.78.
  – G0514 - Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service). RVU – Facility – 1.68; Non-Facility - 1.78.

PROVIDING PRACTICE FLEXIBILITY FOR RADIOLOGIST ASSISTANTS

• CMS is revising the physician supervision requirements so that:
  – Diagnostic tests performed by a Radiologist Assistant (RA) that meets certain requirements, that would otherwise require a personal level of physician supervision as specified in its regulations;
    • May now be furnished under a direct level of physician supervision to the extent permitted by state law and state scope of practice requirements.
CHANGES TO OUTPATIENT THERAPY

• CMS is finalizing its proposal to:
  – Discontinue the functional status reporting requirements for services furnished after January 1, 2019.
  – In addition, The Bipartisan Budget Act of 2018 requires payment for services furnished in whole or in part by a therapy assistant at 85% of the applicable Part B payment amount for service effective January 1, 2022.
    – In order to implement this payment reduction, the law requires CMS to establish a new modifier by January 1, 2019 and CMS to detail its plans to accomplish this in the final rule.
    – Two New modifiers have been finalized:
      • One for Physical Therapy Assistants (PTA); and
      • Another for Occupational Therapy Assistants (OTA)
    – When services are furnished in whole or in part by a PTA or OTA:
      • However, CMS is finalizing the new modifiers as “payment” rather than as “therapy” modifiers, based on comments by stakeholders.
      • These will be used alongside of the current PT and OT modifiers to report all PT, OT, and Speech Language Pathology (SLP) services, that have been used since 1998 to track outpatient therapy services that were subject to therapy caps.
    – CMS is also finalizing a de minimis standard under which a service is furnished by the PTA or OTA, instead of the proposed definition that applied when a PTA or OTA furnished any minute of a therapeutic service:
      • The new therapy modifiers for services furnished by PTAs and OTAs are not required on claims until January 1, 2020.

<table>
<thead>
<tr>
<th>Local Coverage Determination (LCD): Facet Joint Interventions for Pain Management (L34892)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LCD Information</strong></td>
</tr>
<tr>
<td><strong>Document Information</strong></td>
</tr>
<tr>
<td>LCD ID</td>
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<tr>
<td>L34892</td>
</tr>
<tr>
<td>Original ICD-9 LCD ID</td>
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<tr>
<td>L27512</td>
</tr>
<tr>
<td>LCD Title</td>
</tr>
<tr>
<td>Facet Joint Interventions for Pain Management</td>
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<tr>
<td>Proposed LCD in Comment Period</td>
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<tr>
<td>N/A</td>
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<tr>
<td>Source Proposed LCD</td>
</tr>
<tr>
<td>DL34892</td>
</tr>
<tr>
<td>AMA CPT / ADA CDT / AHA NUBC Copyright Statement</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
Covered Indications

1. Facet Joint Interventions:

Facet Joint Interventions are considered medically reasonable and necessary for the diagnosis and treatment of chronic pain in patients who meet ALL of the following criteria:

- Duration of pain of at least three (3) months
- Pain is intermittent or continuous with average pain levels of 6 or greater on a visual-numerical analogue pain scale (VNAS) of 0 to 10 (primary [index] pain), or functional disability
- Documented failure to respond to conservative care such as nonsteroidal anti-inflammatory drugs (NSAIDS), acetaminophen, physical therapy for a minimum of 6 weeks (as tolerated)
- History of pain that is predominantly axial and, with the possible exception of facet joint cysts, not associated with radiculopathy or neurogenic claudication
- Physical examination with documented signs that the facet joint is the primary suspected source of pain
- There is no non-facet pathology per clinical assessment or radiology studies that could explain the source of the patient’s pain, including but not limited to fracture, tumor, infection, or significant deformity

DIAGNOSTIC FACET INJECTIONS

The primary indication of diagnostic facet joint injection(s) is to confirm a clinical suspicion of facet syndrome. Dual MBBs (a series of two MBBs) are necessary to diagnose facet pain to establish consistency of results due to high false positive rate of a single MBB injection.

- For the first diagnostic MBB to be considered medically reasonable and necessary, the patient must meet the criteria outlined under indications for facet joint interventions.
- A second confirmatory MBB is considered medically reasonable and necessary when ALL of the following is met:
  - The patient meets the criteria for the first diagnostic block; AND
  - After the first diagnostic MBB, there must be a positive response of at least 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used) or at least 50% improvement in the ability to perform previously painful movements and activities of daily living (ADLs), or a change in technique can be considered.

Note: Intraarticular facet block(s) are considered reasonable and necessary as a diagnostic test only if medial branch blocks cannot be performed due to specific documented anatomic restrictions. These restrictions must be clearly documented in the medical record and made available upon request.
**CPT/HCPCS Codes**

**Group 1 Paragraph:**
Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.

**Group 1 Codes:**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>64490</td>
<td>Inj paravert f jnt c/t 1 lev</td>
</tr>
<tr>
<td>64491</td>
<td>Inj paravert f jnt c/t 2 lev</td>
</tr>
<tr>
<td>64492</td>
<td>Inj paravert f jnt c/t 3 lev</td>
</tr>
<tr>
<td>64493</td>
<td>Inj paravert f jnt l/s 1 lev</td>
</tr>
<tr>
<td>64494</td>
<td>Inj paravert f jnt l/s 2 lev</td>
</tr>
<tr>
<td>64495</td>
<td>Inj paravert f jnt l/s 3 lev</td>
</tr>
<tr>
<td>64633</td>
<td>Destroy cerv/thor facet jnt</td>
</tr>
<tr>
<td>64634</td>
<td>Destroy c/t facet jnt addl</td>
</tr>
<tr>
<td>64635</td>
<td>Destroy lumb/sac facet jnt</td>
</tr>
<tr>
<td>64636</td>
<td>Destroy l/s facet jnt addl</td>
</tr>
</tbody>
</table>

**Group 2 Paragraph:**
The following CPT/HCPCS codes are non-covered.

*Note: CPT code 64999 is non-covered when used to report non-thermal facet joint denervation including chemical, low grade thermal energy (less than 60 degrees Celsius), or any form of pulsed radiofrequency.*

**ICD-10-CM CODE**

<table>
<thead>
<tr>
<th>ICD-10-CM CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>M46.82</td>
<td>Other spec. inflammatory spondylopathies, cervical region</td>
</tr>
<tr>
<td>M46.83</td>
<td>Other spec. inflammatory spondylopathies, cervicothoracic region</td>
</tr>
<tr>
<td>M46.84</td>
<td>Other spec. inflammatory spondylopathies, thoracic region</td>
</tr>
<tr>
<td>M46.85</td>
<td>Other spec. inflammatory spondylopathies, thoracolumbar region</td>
</tr>
<tr>
<td>M46.86</td>
<td>Other spec. inflammatory spondylopathies, lumbar region</td>
</tr>
<tr>
<td>M46.87</td>
<td>Other spec. inflammatory spondylopathies, lumbosacral region</td>
</tr>
<tr>
<td>M47.12</td>
<td>Other spondylosis with myelopathy, cervical region</td>
</tr>
<tr>
<td>M47.13</td>
<td>Other spondylosis with myelopathy, cervicothoracic region</td>
</tr>
<tr>
<td>M47.14</td>
<td>Other spondylosis with myelopathy, thoracic region</td>
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<tr>
<td>M47.15</td>
<td>Other spondylosis with myelopathy, thoracolumbar region</td>
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<td>M47.16</td>
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<td>M47.17</td>
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<td>M47.892</td>
<td>Other spondylosis, cervical region</td>
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<td>M47.893</td>
<td>Other spondylosis, cervicothoracic region</td>
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<tr>
<td>M47.894</td>
<td>Other spondylosis, thoracic region</td>
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<td>M47.896</td>
<td>Other spondylosis, lumbar region</td>
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<tr>
<td>M47.897</td>
<td>Other spondylosis, lumbosacral region</td>
</tr>
<tr>
<td>*M70.30</td>
<td>Other bursal cyst, unspecified site</td>
</tr>
<tr>
<td>*M70.38</td>
<td>Other bursal cyst, other site</td>
</tr>
</tbody>
</table>

(Note: M71.30 and M71.38 are allowed for facet cyst rupture procedures only.)
Local Coverage Determination (LCD): Controlled Substance Monitoring and Drugs of Abuse Testing (L35006)

**LCD Information**

**Document Information**

- **LCD ID**: L35006
- **Original Effective Date**: For services performed on or after 10/01/2015
- **Original ICD-9 LCD ID**: L30050
- **Revision Effective Date**: For services performed on or after 10/01/2018
- **LCD Title**: Controlled Substance Monitoring and Drugs of Abuse Testing
- **Revision Ending Date**: N/A
- **Proposed LCD in Comment Period**: N/A
- **Retirement Date**: N/A
- **Source Proposed LCD**: DL35006
- **Notice Period Start Date**: 11/05/2015
- **AHA CPT / ADA CDT / AHA NUBC Copyright**:
- **Notice Period End Date**: 12/30/2015

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**CPT/HCPCS Codes**

**Group 1 Paragraph:**

*Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.*

**Presumptive UDT**

**Group 1 Codes:**

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>80305</td>
<td>Drug test prsmv dir opt obs</td>
</tr>
<tr>
<td>80306</td>
<td>Drug test prsmv instrmnt</td>
</tr>
<tr>
<td>80307</td>
<td>Drug test prsmv chem anlyzer</td>
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</table>

**Group 2 Paragraph:**

**Definitive UDT**

**Group 2 Codes:**

<table>
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<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
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</thead>
<tbody>
<tr>
<td>G0480</td>
<td>Drug test def 1-7 classes</td>
</tr>
<tr>
<td>G0481</td>
<td>Drug test def 8-14 classes</td>
</tr>
<tr>
<td>G0482</td>
<td>Drug test def 15-21 classes</td>
</tr>
<tr>
<td>G0483</td>
<td>Drug test def 22+ classes</td>
</tr>
</tbody>
</table>
• **Increases of 12.5%** for Percutaneous adhesiolysis procedure, transforaminal epidural injections, facet joint injections, sympathetic blocks, celiac plexus, intercostal nerve and pudendal nerve neurolysis.

• **Increase of 8.9%** for Cervical and lumbar interlaminar epidural injections and Sacroiliac joint injections.

• **Minor decreases of 1% to 2%** for some procedures.

**ORGANIZATIONS:** SIPMS NASPERABIPAAAIPMP
CMS - 2019 MIPS ELIGIBLE CLINICIAN TYPES ADDED

- **2019 the following eligible clinician types were added:**
  - Physical therapist
  - Occupational therapist
  - Qualified speech-language pathologist
  - Qualified audiologist
  - Clinical psychologist
  - Registered dietitian or nutrition professionals

- Already included in previous years programs were:
  - Physician
  - Physician assistant
  - Nurse practitioner
  - Clinical nurse specialist
  - Certified registered nurse anesthetist

CMS - KEY CHANGES 2019 MIPS APMs FINAL RULE

MIPS – Merit-based Incentive Payment System
APMs – Alternative Payment Models

- When reporting for Promoting Interoperability and participation in an Advance APM:
  - Individual eligible clinicians and groups will **have to use 2015-certified EHR technology**.

- The **Cost category will count toward 15% of the MIPS final score** – which is an increase from 10% in 2018. /This information is taken from Claims data filed by providers.

- **Group practices can now report quality data measures using multiple data submission avenues**, such as EHR and registry reporting.

- **If a clinician or group falls below the low-volume threshold, they may choose to voluntarily opt-in to the MIPS program. If they do so, they will be subject to the same rules and payment adjustments as other participants.**

- CMS has not announced any new Advanced APMs. Approximately 165,000 to 220,000 eligible clinicians are expected to become qualifying APM in 2019. This means that they” will be exempt from MIPS and eligible for a 5% Bonus”. It is estimated that APM bonuses will total from “$600-$800 million for the 2021 payment year”.

Eligible Clinicians (EPs) and group practices will continue to be scored from 0-100 points. Based on 4 Performance Categories:
- Quality 45 points
- Promoting Interoperability 25 points
- Cost 15 points
- Improvement Activities 15 points
- The bonus will still be available that can add up to 5 points to the final MIPS score for ECs and groups who treat complex patients.

ECs and group practices must earn at least 30 points in 2019 to avoid a Medicare payment penalty of up to 7% in 2021. (An increase of 15 points from 2018).

Additionally, just as it was in 2018, $500 million will be available for ECs and groups whose final score meets or exceeds the proposed exceptional threshold of 75 points in 2019. (An increase from 70 points in 2018.)

ECs and groups must report a minimum of 90 consecutive days of data for the Promoting Interoperability and Improvement Activity categories; and 12 months of Quality measure data in 2019.
2019 NEW CPT CODES THAT COULD IMPACT PAIN MGT CODES/SERVICES

• **99451** - Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time. (Novitas – Non-Facility Fee - $ 36.47.)

• **99452** Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes. (Novitas – Non-Facility Fee - $ 36.47.)

AMA© Guidelines:

• The consultant should use codes:
  – 99446, 99447, 99448, 99449, 99451
    • To report interprofessional telephone/Internet/electronic health record consultations.
    • An interprofessional telephone/Internet/electronic health record consultation is an assessment and management service in which a patient’s treating (eg, attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist the treating physician or other qualified health care professional in the diagnosis and/or management of the patient’s problem without patient face-to-face contact with the consultant.


AMA© Guidelines:

• The patient for whom the interprofessional telephone/Internet/electronic health record consultation is requested may be:
  – Either a new patient to the consultant;
  – Or an established patient with a new problem or an exacerbation of an existing problem.
  – However, the consultant should not have seen the patient in a face-to-face encounter within the last 14 days.
  – When the telephone/Internet/electronic health record consultation leads to a transfer of care or other face-to-face service (eg, a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes are not reported.

AMA© Guidelines:

- When reporting 99446 (RVU 0.497), 99447 (RVU 0.985), 99448 (RVU 1.482), 99449 (RVI 1.97), 99451 (RVU 1.012):
- Review of:
  - pertinent medical records,
  - laboratory studies,
  - imaging studies,
  - medication profile,
  - pathology specimens, etc

is included in the telephone/Internet/electronic health record consultation service and should not be reported separately.

The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal or Internet discussion.

If greater than 50% of the time for the service is devoted to data review and/or analysis, 99446, 99447, 99448, 99449 should not be reported.

However, the service time for 99451 is based on total review and interprofessional-communication time.

*Using Novitas RVUs.


AMA© Guidelines:

- If more than one telephone/Internet/electronic health record contact(s) is required to complete the consultation request (eg, discussion of test results), the entirety of the service and the cumulative discussion and information review time should be reported with a single code.
- Codes 99446, 99447, 99448, 99449, 99451 should not be reported more than once within a seven-day interval.
- The written or verbal request for telephone/Internet/electronic health record advice by the treating/requesting physician or other qualified health care professional should be documented in the patient's medical record, including the reason for the request.
- Codes 99446, 99447, 99448, 99449 conclude with a verbal opinion report and written report from the consultant to the treating/requesting physician or other qualified health care professional.
- Code 99451 concludes with only a written report.

AMA© Guidelines:

• Telephone/Internet/electronic health record consultations of less than five minutes should not be reported.

• Consultant communications with the patient and/or family may be reported:
  – Using 98966 (Telephone assessment and management codes), 99441 (Telephone E/M), 99442, 99443, 99444, and the time related to these services is not used in reporting (Interprofessional internet/electronic health record assessment and management service) 99446, 99447, 99448, 99449.
  – Do not report (Prolonged E/M) 99358, 99359 for any time within the service period, if reporting 99446, 99447, 99448, 99449.

When the sole purpose of the telephone/Internet/ electronic health record communication is to arrange a transfer of care or other face-to-face service, these codes are not reported.


AMA© Guidelines:

• The treating/requesting physician or other qualified health care professional may report 99452 (Interprofessional....) if spending 16-30 minutes in a service day preparing for the referral and/or communicating with the consultant.

• Do not report 99452 more than once in a 14-day period.

• The treating/requesting physician or other qualified health care professional may report the prolonged service codes 99354, (Prolonged E/M or Psychotherapy services) 99355, 99356, 99357 for the time spent on the interprofessional telephone/Internet/electronic health record discussion with the consultant (eg, specialist) if the time exceeds 30 minutes beyond the typical time of the appropriate E/M service performed and the patient is present (on-site) and accessible to the treating/requesting physician or other qualified health care professional.

• If the interprofessional telephone/Internet/electronic health record assessment and management service occurs when the patient is not present and the time spent in a day exceeds 30 minutes, then the non-face-to-face prolonged service codes 99358, 99359 may be reported by the treating/requesting physician or other qualified health care professional.

• (For telephone services provided by a physician to a patient, see 99441, 99442, 99443)
• (For telephone services provided by a qualified health care professional to a patient, see 98966, 98967, 98968)
• (For an on-line medical evaluation provided by a physician to a patient, use 99444)
• (For an on-line assessment and management service provided by a qualified health care professional to a patient, use 99449)
NEW 2019 CODES FOR ELECTRONIC ANALYSES OF CRANIAL NERVE NEUROSTIMULATOR TO TREAT CONDITIONS SUCH AS PAIN, EPILEPSY AND DEPRESSION – AMA CPT©

- **95976** Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional

- **95977** Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional

- **95983** Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional

- **95984** Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)

NEUROSTIMULATORS - AMA© GUIDELINES FROM CPT MANUAL

- “For coding purposes, a neurostimulator system is considered implanted when the electrode array(s) is inserted into the target area for either permanent or trial placement.”
- “There are several types of implantable neurostimulator pulse generator/transmitters and they are differentiated by the nervous system region that is stimulated:
  - A **brain** neurostimulator may stimulate either brain surface regions (cortical stimulation) or deep brain structures (deep brain stimulation).
    - A brain neurostimulation system consists of array(s) that targets one or more of these regions.”
  - A **cranial nerve** neurostimulator targets the fibers of the cranial nerves or their branches and divisions.
    - There are 12 pairs of cranial nerves (see nerve anatomy figure on page 706 of CPT© manual).
    - Each cranial nerve has its origin in the brain and passes through one or more foramina in the skull to innervate extracranial structures.
    - A cranial nerve neurostimulator stimulates the nerve fibers of either the extracranial or intracranial portion(s) of one or more cranial nerve(s) (eg, vagus nerve, trigeminal nerve).”
AMA® GUIDELINES

- A spinal cord or peripheral nerve neurostimulator targets:
  - Nerve(s) that originate in the spinal cord and exit the spine through neural foramina and gives rise to peripheral nerves.
  - The peripheral nervous system consists of the nerves and ganglia outside of the brain and spinal cord.
  - Peripheral nerves may give rise to independent branches or branches that combine with other peripheral nerves in neural plexuses (ie, brachial plexus, lumbosacral plexus).
  - Under the lumbosacral plexus, the sacral nerves (specifically S2, S3, S4) are located in the lower back just above the tailbone.
  - Neurostimulation of the sacral nerves affect pelvic floor muscles and urinary organs (eg, bladder, urinary sphincter).
AMA© GUIDELINES

• “Cranial nerve, spinal cord, peripheral nerve, and sacral nerve neurostimulator analysis with programming (95971 (RVU-Non-Fac.-1.39; Fac.-1.14), 95972, 95976, 95977) are reported based on the number of parameters adjusted during a programming session.

• Brain neurostimulator analysis with programming (95983 (RVU Non-Fac.-1.412; Fac.-1.39), 95984) is reported based on physician or other qualified health care professional face-to-face time.

• Code 95970 (RVU –N-Fac. – 0.524; Fac. 0.521) describes electronic analysis of the implanted brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve neurostimulator pulse generator/transmitter without programming.

• Electronic analysis is inherent to implantation codes 43647, 43648, 43881, 43882, 61850, 61860, 61863, 61864, 61867, 61868, 61870, 61880, 61885, 61886, 61888, 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688, 64553, 64555, 64561, 64566, 64568, 64569, 64570, 64575, 64580, 64581, 64585, 64590, 64595, and is not separately reportable at the same operative session.”

PROGRAMMING OF THE IMPLANTED NEUROSTIMULATOR PULSE GENERATOR/TRANSMITTER – AMA CPT©

• Codes 95971, 95972, 95976, 95977 describe:
  – Electronic analysis with simple or complex programming of the implanted neurostimulator pulse generator/transmitter.
  – Simple programming of a neurostimulator pulse generator/transmitter includes adjustment of one to three parameter(s).

• Complex programming includes adjustment of more than three parameters.
  – For purposes of counting the number of parameters being programmed, a single parameter that is adjusted two or more times during a programming session counts as one parameter.

• Code 95971 (RVU N-Fac.1.39; Fac. 1.14) describes electronic analysis with simple programming of an implanted spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter.

• Code 95972 (RVU N-FAC. 1.56; FAC.-1.15) describes electronic analysis with complex programming of an implanted spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter.

• Code 95976 (RVU N-FAC 1.12; FAC 1.1) describes electronic analysis with simple programming of an implanted cranial nerve neurostimulator pulse generator/transmitter.

• Code 95977 (RVU N-FAC 1.49; FAC.1.47) describes electronic analysis with complex programming of an implanted cranial nerve neurostimulator pulse generator/transmitter.

• *Using Novitas RVUs

PROGRAMMING OF THE IMPLANTED NEUROSTIMULATOR PULSE GENERATOR/TRANSMITTER- AMA CPT ©

- Codes 95983, 95984 describe electronic analysis with programming of an implanted brain neurostimulator pulse generator/transmitter.
- Code 95983 (RVU N-FAC 1.41; FAC. 1.39) is reported for the first 15 minutes of physician or other qualified health care professional face-to-face time for analysis and programming.
- Code 95984 (RVU N-FAC. 1.23; FAC. 1.22) is reported for each additional 15 minutes. A unit of service is attained when the mid-point is passed. Physician or other qualified health care professional face-to-face time of less than eight minutes is not separately reportable.
- Code 95980 (RVU N-FAC. 1.26; FAC. 1.26) describes intraoperative electronic analysis of an implanted gastric neurostimulator pulse generator system, with programming;
- Code 95981 (RVU N-FAC. 0.92; FAC. 0.49) describes subsequent analysis of the device;
- Code 95982 (RVU N-FAC. 1.48; FAC. 1.00) describes subsequent analysis and reprogramming.
- For electronic analysis and reprogramming of gastric neurostimulator, lesser curvature, see 95980-95982.


WHEN PROGRAMMING PERFORMED BY PHYSICIAN OR OQHCP – AMA CPT©

- Codes 95971, 95972, 95976, 95977, 95983, 95984 are reported when programming a neurostimulator is performed by a physician or other qualified health care professional.
- Programming may be performed:
  - In the operating room,
  - Postoperative care unit,
  - Inpatient, and/or outpatient setting.
  - Programming a neurostimulator in the operating room is not inherent in the service represented by the implantation code and may be reported by either the implanting surgeon or other qualified health care professional, when performed.

63650 - Percutaneous implantation of neurostimulator electrode array, epidural

- Short Descr: IMPLANT NEUROELECTRODES
- Medium Descr: PROC. IMPLANT NSTIM ELECTRODE ARRAY EPIDURAL
- Long Descr: Percutaneous implantation of neurostimulator electrode array, epidural

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- Medicare Physician Fee Schedule (MPFS) Indicators
- APC Status Indicator: Hospital Part B services paid through a comprehensive APC
- ASC Payment Indicator: Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate.
- Status Code: A - Active Code
- Global Days: 010 - Minor Procedure
- Preoperative: 10%  Intraoperative: 80%  Postoperative: 10%
- PC/TC Indicator (26): 0 - Physician Service Code
- Multiple Procedures (61): 2 - Standard payment adjustment rules for multiple procedures apply.
- Bilateral Surgery (50): 0 - 100% payment adjustment for bilateral procedures does NOT apply.
- Physician Supervision: 09 - Concept does not apply.
- Assistant Surgeon (80, 82): 1 - Statutory payment restriction for assistants at surgery applies to this procedure...
- Co-Surgeons (62): 0 - Co-surgeons not permitted for this procedure.
- Team Surgery (66): 0 - Team surgeons not permitted for this procedure.
- Type of Service (TOS): 2 - Surgery
- Berenson-Eggers TOS (BETOS): P1G - Major procedure – Other
- Diagnostic Imaging Family: 09 - Concept Does Not Apply
- Non-Facility MUEs: 2
- CCS Clinical Classification: 6 - Insertion of catheter or spinal stimulator and injection into spinal canal
- SNOMED CT Relationships:
  - Anatomic Site: Structure of epidural space (body structure)
  - Device: Neurostimulator, device (physical object)
  - Method: Insertion - action (qualifier value)

* SNOMED CT® information is copyright ©2009 National Library of Medicine, Department of Health and Human Services, United States Government, SNOMED CT™, UMLS® Metathesaurus® - All Rights Reserved. Find-A-Code, LLC is a licencsee of the SNOMED CT® data set.
• “See below for common codes and resources used for Spinal cord stimulation (SCS), also known as dorsal column stimulator (DCS) is used for electrical stimulation for the treatment of chronic pain and muscle rehabilitation.”

• “TIP: Generally, electronic analysis services (CPT codes 95970–95973) are not considered medically necessary when provided at a frequency more often than once every 30 days.”

• “More frequent analysis may be necessary in the first month after implantation.”

**CMS NCD – NATIONAL COVERAGE DETERMINATION**

**A. Implanted Peripheral Nerve Stimulators**

**Indications/Limitations**

Two general classifications of electrical nerve stimulators are employed to treat **chronic intractable pain; peripheral nerve stimulators and central nervous system stimulators**

- **A. Implanted Peripheral Nerve Stimulators**
  - **Payment may be made under the prosthetic device benefit for implanted peripheral nerve stimulators.** Use of this stimulator involves implantation of electrodes around a selected peripheral nerve. The stimulating electrode is connected by an insulated lead to a receiver unit which is implanted under the skin at a depth not greater than 1/2 inch.
  - **Stimulation is induced by a generator connected to an antenna unit which is attached to the skin surface over the receiver unit.** Implantation of electrodes requires surgery and usually necessitates an operating room.
  - **NOTE:** Peripheral nerve stimulators may also be employed to assess a patient’s suitability for continued treatment with an electric nerve stimulator. As explained in §160.7.1, such use of the stimulator is covered as part of the total diagnostic service furnished to the beneficiary rather than as a prosthesis.
B. Central Nervous System Stimulators (Dorsal Column and Depth Brain Stimulators)

- The implantation of central nervous system stimulators may be covered as therapies for the relief of chronic intractable pain, subject to the following conditions:

  1. Types of Implantations
     - There are two types of implantations covered by this instruction:
       - **Dorsal Column (Spinal Cord) Neurostimulation** - The surgical implantation of neurostimulator electrodes within the dura mater (endodural) or the percutaneous insertion of electrodes in the epidural space is covered.
       - **Depth Brain Neurostimulation** - The stereotactic implantation of electrodes in the deep brain (e.g., thalamus and periaqueductal gray matter) is covered.

DURA MATER OF SPINAL CORD
2. Conditions for Coverage

- No payment may be made for the implantation of dorsal column or depth brain stimulators or services and supplies related to such implantation, unless all of the conditions listed below have been met:
  - The implantation of the stimulator is used only as a late resort (if not a last resort) for patients with chronic intractable pain;
  - With respect to item a., other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been tried and did not prove satisfactory, or are judged to be unsuitable or contraindicated for the given patient;
  - Patients have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation. (Such screening must include psychological, as well as physical evaluation);
  - All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment training, and follow up of the patient (including that required to satisfy item c) must be available; and
  - Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation.

Medicare Administrative Contractors may find it helpful to work with Quality Improvement Organizations to obtain the information needed to apply these conditions to claims.

Cross References

- See the Medicare Benefit Policy Manual, Chapter 15, “Covered Medical and Other Health Services,” §120, and the following sections in this manual, §§160.2 and 30.1.
IMPLANTED ELECTRICAL STIMULATOR FOR SPINAL CORD

Policy Number: 20300359
Effective Date: December 1, 2013

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Coverage Rationale

Implanted electrical stimulators for spinal cord, including high-frequency dorsal column stimulators (also known as dorsal DRG spinal cord stimulators), are proven and medically necessary. For medical necessity clinical coverage criteria, see MOG Case Guidelines, 23rd edition, 2018, Implanted Electrical Stimulator, Spinal Cord ACOG A-0543 (AC).

Notes:
- Coverage of a replacement battery/implant for a previously implanted electrical stimulator is appropriate when the individual's existing battery/implant is malfunctioning, cannot be repaired, and is no longer under warranty.
- For Dorsal Root Ganglion (DRG) stimulators, please refer to the Medical Policy titled Electrical Stimulation for the Treatment of Pain and Musculo-Skeletal Conditions.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Coverage Determination Guidelines may apply.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tr>
<td>63650</td>
<td>Percutaneous implantation of neurostimulator electrode array, epidural</td>
</tr>
<tr>
<td>63655</td>
<td>Laminectomy for implantation of neurostimulator electrodes, plate/pad, epidural</td>
</tr>
<tr>
<td>63656</td>
<td>Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling</td>
</tr>
<tr>
<td>63688</td>
<td>Revision or removal of implanted spinal neurostimulator pulse generator or receiver</td>
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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1767</td>
<td>Generator, neurostimulator (implantable), nonrechargeable</td>
</tr>
<tr>
<td>C1778</td>
<td>Lead, neurostimulator (implantable)</td>
</tr>
<tr>
<td>C1816</td>
<td>Receiver and/or transmitter, neurostimulator (implantable)</td>
</tr>
</tbody>
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UHC

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1820</td>
<td>Generator, neurostimulator (implantable), with rechargeable battery and charging system</td>
</tr>
<tr>
<td>C1822</td>
<td>Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system</td>
</tr>
<tr>
<td>C1833</td>
<td>Adapter/extension, pacing lead or neurostimulator lead (implantable)</td>
</tr>
<tr>
<td>C1857</td>
<td>Lead, neurostimulator test kit (implantable)</td>
</tr>
<tr>
<td>L6679</td>
<td>Implantable neurostimulator, pulse generator, any type</td>
</tr>
<tr>
<td>L6680</td>
<td>Implantable neurostimulator electrode, each</td>
</tr>
<tr>
<td>L6682</td>
<td>Implantable neurostimulator radiofrequency receiver</td>
</tr>
<tr>
<td>L6683</td>
<td>Implantable neurostimulator pulse generator, single array, rechargeable, includes extension</td>
</tr>
<tr>
<td>L6686</td>
<td>Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension</td>
</tr>
<tr>
<td>L6687</td>
<td>Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension</td>
</tr>
<tr>
<td>L6688</td>
<td>Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension</td>
</tr>
<tr>
<td>L6690</td>
<td>External recharging system for battery (external) for use with implantable neurostimulator, replacement only</td>
</tr>
</tbody>
</table>

U.S. Food and Drug Administration (FDA)

Totally implantable spinal cord stimulation systems for pain relief are regulated by the FDA as Class III devices and are approved through the Premarket Approval (PMA) process. See the following website for more information (use product code LDC): [https://www.accessdata.fda.gov/ scripts/cdrh/cfdocs/cfpmn/pmn.cfm](https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfpmn/pmn.cfm) (Accessed August 21, 2018)

Centers for Medicare and Medicaid Services (CMS)

Medicare covers implantable electrical stimulators for the spinal cord when coverage criteria are met. Refer to the National Coverage Determination (NCD) for Electrical Nerve Stimulation (160.7). Local Coverage Determinations (LCDs) exist for Spinal Cord Stimulation (0510135), and Spinal Cord Stimulators for Chronic Pain.

Medicare does not have an NCD specifically for high-frequency dorsal column stimulators with BurstDR stimulation technology. LCDs that specifically address BurstDR stimulation technology do not exist at this time.

(Accessed August 24, 2018)

Policy History/Revision Information

<table>
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<tr>
<td>12/01/2018</td>
<td>• Reorganized policy template&lt;br&gt; • Replaced language indicating &quot;implanted electrical stimulator for spinal cord is proven and/or medically necessary in certain circumstances&quot; with &quot;implanted electrical stimulators for spinal cord, including high-frequency dorsal column stimulators (also known as BurstDR spinal cord stimulators), are proven and medically necessary&quot;&lt;br&gt; • Modified language to clarify the listed Hc0™ Care guidelines should be referenced for medical necessity decisions&lt;br&gt; • Added notation to indicate coverage of a replacement battery/generator for a previously implanted electrical stimulator is appropriate when the individual's existing battery/generator is malfunctioning, cannot be recharged, and is no longer under warranty&lt;br&gt; • Updated list of applicable CPT codes: added 63685&lt;br&gt; • Updated supporting information to reflect the most current CMS information&lt;br&gt; • Archived previous policy version 2016T09567</td>
</tr>
</tbody>
</table>
Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCS™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Example of LCD

Local Coverage Determination – Novitas JH
SPINAL CORD STIMULATION CMS - LOCAL COVERAGE DETERMINATION (LCD) NOVITAS JH

- Document Information
- LCD ID: L35450
  LCD Title: Spinal Cord Stimulation (Dorsal Column Stimulation)
  LCD Determination ID:
- Original Effective Date: For services performed on or after 10/01/2015
  Revision Effective Date: For services performed on or after 11/09/2017
- Revision Ending Date: N/A
  Retirement Date:
- Notice Period Start Date: N/A
  Notice Period End Date: N/A

- Jurisdiction: Not Specified.

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

History/Background and/or General Information

Spinal cord stimulation blocks pain conduction pathways to the brain and may stimulate endorphins.

- The neurostimulator electrodes used for this purpose are implanted percutaneously in the epidural space through a special needle.
- Some patients may need an open procedure requiring laminectomy to place the electrodes.

After placement of the electrodes, the patient is provided with an external neurostimulator, initially on a trial basis.

- The trial period may be extended up to four weeks.
- If during the trial period it is determined that the modality is not effective, or it is not acceptable to the patient, the electrodes may be removed.

If the trial has been successful, a spinal neurostimulator and pulse generator are inserted subcutaneously and connected to the implanted electrodes.

- In some cases, the trial may be conducted using temporary electrodes.
Dorsal column stimulators may be covered as therapies for the relief of chronic intractable pain under the following circumstances:

- To treat chronic pain caused by lumbosacral arachnoiditis that has not responded to medical management including physical therapy. (Presence of arachnoiditis is usually documented by presence of high levels of proteins in the Cerebrospinal Fluid (CSF) and/or by myelography or Magnetic Resonance Imaging (MRI)).
- To treat intractable pain caused by nerve root injuries, post-surgical or post-traumatic including that of post-laminectomy syndrome (failed back syndrome).
- To treat intractable pain caused by complex regional pain syndrome I & II.
- To treat intractable pain caused by phantom limb syndrome that has not responded to medical management.
- To treat intractable pain caused by end-stage peripheral vascular disease, when the patient cannot undergo revascularization or when revascularization has failed to relieve painful symptoms and the pain has not responded to medical management.
- To treat intractable pain caused by post-herpetic neuralgia.
- To treat intractable pain caused byplexopathy.
- To treat intractable pain caused by intercostal neuralgia that did not respond to medical management and nerve blocks.
- To treat intractable pain caused by cauda equina injury.
- To treat intractable pain caused by incomplete spinal cord injury.

WHAT IS?

Arachnoiditis - “a pain disorder caused by the inflammation of the arachnoid, one of the membranes that surrounds and protects the nerves of the spinal cord. “It is characterized by severe stinging, burning pain, and neurological problems”. Feb 9, 2017

Source: https://www.webmd.com/pain-management/guide/pain-management-arachnoiditis
WHAT IS?

• An abnormal protein level in the CSF?
  – This suggests a problem in the central nervous system.
  – Increased protein level may be a sign of a tumor, bleeding, nerve inflammation, or injury.
  – A blockage in the flow of spinal fluid can cause the rapid buildup of protein in the lower spinal area. May 15, 2017

Sources:
CSF total protein MedlinePlus Medical Encyclopedia
https://medlineplus.gov/ency/article/003628.htm

WHAT IS?

• What is a syndrome? Webster's Dictionary defines a syndrome “as a group of signs and symptoms that occur together and characterize a particular abnormality or condition.”
• Another definition is “a set of concurrent things, such as emotions or actions, that form an identifiable pattern.”
• It comes from the Greek words meaning “running together”.
• “Symptoms running together”.

Source: https://healthcare.utah.edu/the-scope/shows.php?shows=0_3982mr
WHAT IS?

• Chronic complex regional pain syndrome?
  – Complex regional pain syndrome (CRPS) is a **chronic (lasting greater than six months) pain condition** that most often affects one limb (arm, leg, hand, or foot) usually after an injury.
  – CRPS is **believed to be caused by damage to, or malfunction of, the peripheral and central nervous systems**.
  – The central nervous system (CNS) is composed of the brain and spinal cord;
  – The peripheral nervous system involves nerve signaling from the brain and spinal cord to the rest of the body.
  – CRPS is characterized by prolonged or excessive pain and changes in skin color, temperature, and/or swelling in the affected area.


COMPLEX REGIONAL PAIN SYNDROME

CRPS is divided into two types:
• CRPS-I and CRPS-II.
  – Individuals without a confirmed nerve injury are classified as having CRPS-I (previously known as reflex sympathetic dystrophy syndrome).
  – CRPS-II (previously known as causalgia) is when there is an associated, confirmed nerve injury.
  – As some research has identified evidence of nerve injury in CRPS-I, it is unclear if this disorders will always be divided into two types. Nonetheless, the treatment is similar.
• CRPS symptoms vary in severity and duration, although some cases are mild and eventually go away.
• In more severe cases, individuals may not recover and may have long-term disability.
WHAT IS?

Plexopathy?

• The networks of interwoven nerve fibers from different spinal nerves (plexuses) may be damaged by injury, tumors, pockets of blood (hematomas), or autoimmune reactions.

• Pain, weakness, and loss of sensation occur in all or part of an arm or a leg.

Sources:
Plexus Disorders - Brain, Spinal Cord, and Nerve Disorders - Merck ...
https://www.merckmanuals.com/home/brain,-spinal-cord,-and.../plexus-disorders

LUMBAR PLEXUS

Electrodiagnosis of brachial plexopathies and proximal upper extremity neuropathies.

Zachary Simmons
Published 2013 in Physical medicine and rehabilitation clinics of...
DOI: 10.1016/j.pmr.2012.08.021

Table 2
Median and radial sensory studies of importance in assessment of brachial plexopathy

<table>
<thead>
<tr>
<th>Clinical Finding</th>
<th>Clinical Considerations</th>
<th>Sensory Nerve to Study</th>
<th>Localization When Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensory loss lateral forearm and hand</td>
<td>• Upper trunk plexopathy</td>
<td>Median sensory to the thumb</td>
<td>Upper trunk or lateral cord plexopathy or median neuropathy</td>
</tr>
<tr>
<td></td>
<td>• Lateral cord plexopathy</td>
<td></td>
<td>Upper trunk or posterior cord plexopathy or radial neuropathy</td>
</tr>
<tr>
<td></td>
<td>• C6 radiculopathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• C7 radiculopathy</td>
<td>Lateral antebrachial cutaneous nerve</td>
<td>Upper trunk or lateral cord plexopathy</td>
</tr>
<tr>
<td>Sensory loss medial forearm and hand</td>
<td>• Lower trunk plexopathy</td>
<td>Ulnar sensory to the little finger</td>
<td>Lower trunk or medial cord plexopathy or ulnar neuropathy</td>
</tr>
<tr>
<td></td>
<td>• Medial cord plexopathy</td>
<td></td>
<td>Lower trunk or medial cord plexopathy or ulnar neuropathy</td>
</tr>
<tr>
<td></td>
<td>• C8-T1 radiculopathy</td>
<td>Dorsal cutaneous ulnar sensory nerve</td>
<td>Upper trunk or medial cord plexopathy or ulnar neuropathy proximal to the wrist</td>
</tr>
<tr>
<td></td>
<td>• Medial antebrachial cutaneous nerve</td>
<td>Media antebrachial cutaneous nerve</td>
<td>Lower trunk or medial cord plexopathy</td>
</tr>
</tbody>
</table>

Source: https://www.semanticscholar.org/paper/Electrodiagnosis-brachial-plexopathies-and-upper-Simmons/f70b5c27f5302bec4df94f64c94c7a7ca2d55c556

CMS LCD - Limitations

• No payment may be made for the implantation of dorsal column stimulators or services and supplies related to such implantation, unless all of the following conditions have been met:
  - The implantation of the stimulator is used only as a late resort (if not a last resort) for patients with chronic intractable pain.
  - Other treatment modalities (pharmacological, surgical, physical or psychological therapies) have been tried and did not prove satisfactory or are judged unsuitable or contraindicated for the given patient.
  - Patients have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation (such screening must include psychological as well as physical evaluation).
  - All facilities, equipment and personnel required for the proper diagnosis, treatment, training and follow-up of the patient must be available.
  - Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation.
  - For frequency limitations please refer to the Utilization Guidelines section below.
Notice: This LCD imposes frequency limitations as well as diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

• As published in CMS IOM 100-08, Chapter 13, Section 13.5.1, to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under Section 1862(a)(1)(A).
• Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:
  • Safe and effective.
  • Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the clinical trials NCD are considered reasonable and necessary).
• Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  – Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient’s condition or to improve the function of a malformed body member.
  – Furnished in a setting appropriate to the patient’s medical needs and condition.
  – Ordered and furnished by qualified personnel.
  – One that meets, but does not exceed, the patient’s medical needs.
  – At least as beneficial as an existing and available medically appropriate alternative.
• The redetermination process may be utilized for consideration of services performed outside of the reasonable and necessary requirements in this LCD.

CMS – LCD - CPT/HCPCS CODES

• Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.
  
  Note: The following CPT/HCPCS codes associated with the services outlined in this policy will not have diagnosis limitations applied at this time: 63661, 63662, 63663, 63664, 95970, 95971, 95972, L8681, L8682, L8683, L8685, L8686, L8687, L8688, L8689, L8695 and L8699.

• 63650 - Percutaneous implantation of neurostimulator electrode array, epidural (RVU – N-FAC 43.48; FAC 11.43; REIMBURSEMENT NON-F -$1,566.84 (NOVITAS); FACILITY - $412.07; (MPPR DOES APPLY TO BOTH)
• 63655 - Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural (RVU N-FAC. 22.76; FAC. 22.76; REIMBURSEMENT BOTH - $820.41 (MPPR DOES APPLY TO BOTH).
• 63685 - Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling (RVU-N-FAC 9.93; FAC. 9.93; REIMBURSEMENT BOTH $357.74 (MPPR DOES APPLY TO BOTH)
CMS – LCD - ICD-10-CM Codes that support Medical Necessity

- **Note:** It is the provider’s responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

**Dual diagnosis requirement:** Claims submitted for spinal cord stimulation must include both:
1. A primary ICD-10-CM diagnosis code indicating the reason for the procedure AND
2. A secondary ICD-10-CM diagnosis code indicating the etiology of the chronic pain.

Medicare is establishing the following limited coverage for CPT/HCPCS codes 63650, 63655 and 63685:

**Primary Diagnosis Codes**
- G89.21 - Chronic pain due to trauma
- G89.28 - Other chronic postprocedural pain
- G89.3 - Neoplasm related pain (acute) (chronic)
- G89.4 - Chronic pain syndrome

**Secondary Diagnosis Codes:**
- B02.0 - Zoster encephalitis
- B02.22 - Postherpetic trigeminal neuralgia
- B02.29 - Other post herpetic nervous system involvement
- G03.9 - Meningitis, unspecified
- G54.0 - Brachial plexus disorders
- G54.1 - Lumbosacral plexus disorders
- G54.6 - Phantom limb syndrome with pain
- G54.7 - Phantom limb syndrome without pain
- G54.8 - Other nerve root and plexus disorders
- G55 - Nerve root and plexus compressions in diseases classified elsewhere
- G56.40 - Causalgia of unspecified upper limb
- G56.41 - Causalgia of right upper limb
- G56.42 - Causalgia of left upper limb
- G56.43 - Causalgia of bilateral upper limbs
- G56.80 - Other specified mononeuropathies of unspecified upper limb
- G56.81 - Other specified mononeuropathies of right upper limb
- G56.82 - Other specified mononeuropathies of left upper limb
- G56.83 - Other specified mononeuropathies of bilateral upper limbs
- G56.90 - Unspecified mononeuropathy of unspecified upper limb

You have to have two - The following are required Secondary Diagnosis Codes for CPT/HCPCS codes 63650, 63655 and 63685:

*(NOTE THIS IS AN EXCERPT FROM THE LIST. IT IS NOT INCLUSIVE OF ALL SECONDARY REQUIRED CODES. PLEASE SEE LCD FOR COMPLETE LIST.)*

- B02 0 - Zoster encephalitis
- B02 22 - Postherpetic trigeminal neuralgia
- B02 29 - Other post herpetic nervous system involvement
- G03 9 - Meningitis, unspecified
- G54 0 - Brachial plexus disorders
- G54 1 - Lumbosacral plexus disorders
- G54 6 - Phantom limb syndrome with pain
- G54 7 - Phantom limb syndrome without pain
- G54 8 - Other nerve root and plexus disorders
- G55 - Nerve root and plexus compressions in diseases classified elsewhere
- G56 40 - Causalgia of unspecified upper limb
- G56 41 - Causalgia of right upper limb
- G56 42 - Causalgia of left upper limb
- G56 43 - Causalgia of bilateral upper limbs
- G56 80 - Other specified mononeuropathies of unspecified upper limb
- G56 81 - Other specified mononeuropathies of right upper limb
- G56 82 - Other specified mononeuropathies of left upper limb
- G56 83 - Other specified mononeuropathies of bilateral upper limbs
- G56 90 - Unspecified mononeuropathy of unspecified upper limb
63685 - Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling

- ACTIVE CODE.
- RUV N-FAC. – 9.93; FAC. 9.93. (USING NOVITAS)
- 10-DAY GLOBAL – MINOR PROCEDURE.
- STANDARD PAYMENT ADJUSTMENT RULES FOR MULTIPLE PROCEDURES APPLY.
- 150% PAYMENT ADJUSTMENT FOR BILATERAL PROCEDURES DOES NOT APPLY.
- PAYMENT RESTRICTIONS FOR ASSISTANT AT SURGERY DOES NOT APPLY.
- CO-SURGEONS COULD BE PAID ALTHOUGH SUPPORTING DOCUMENTATION WOULD HAVE TO JUSTIFY.

63661 - Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

- RVU - N-FAC. 16.67; FAC. 8.94
- ACTIVE CODE.
- 10-DAY GLOBAL – MINOR PROCEDURE
- STANDARD RATES FOR MULTIPLE PROCEDURE APPLY.
- 150% FOR BILATERAL PROCEDURES DOES NOT APPLY.
- PAYMENT RESTRICTIONS FOR ASSISTANTS AT SURGERY DO NOT APPLY.
- CO-SURGEONS COULD BE PAID, ALTHOUGH SUPPORTING DOCUMENTATION WOULD HAVE TO SHOW MEDICAL NECESSITY.
### 63663 - Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed

- **ACTIVE CODE.**
- **RVU – N-FAC. 22.33; FAC. 12.49.**
- **10 DAY GLOBAL – MINOR PROCEDURE.**
- **STANDARD PAYMENT ADJUSTMENT RULES APPLY FOR MULTIPLE PROCEDURES.**
- **150% PAYMENT ADJUSTMENT FOR BILATERAL PROCEDURES DOES NOT APPLY.**
- **PAYMENT RESTRICTIONS FOR ASSISTANT AT SURGERY DOES NOT APPLY.**
- **CO-SURGEONS COULD BE PAID ALTHOUGH DOCUMENTATION MUST JUSTIFY.**

### REVISED CODES FOR 2019

- **95970** - Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming

- **95971** - Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional

- **95972** - Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional

PSYCH TESTING

OTHER PERTINENT CPT© CHANGES 2019

PSYCH TESTING

CHANGES IN NEUROPSYCHOLOGICAL TESTING FOR 2019

• CPT Code 96103 - Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report has been deleted for 2019.
  - AMA Guidelines: (96101, 96102, 96103 have been deleted.)
  - (To report psychological testing evaluation and administration and scoring services, see 96130, 96131, 96136, 96137, 96138, 96139, 96146)
  - (To report psychological test administration using a single automated instrument, use 96146)

• CPT 96146 - Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only

• AMA Guidelines: (If test is administered by physician, other qualified health care professional, or technician, do not report 96146. RVU – Non-Fac – 0.05; Fac. – 0.05 – Reimbursement (Novitas $ 1.98.
  - To report, see 96127, 96136, 96137, 96138, 96139)

Source: American Psychological Association & AMA CPT® Manual
OTHER OPTIONS

- **96127 - Brief emotional/behavioral assessment** (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument (RVU – N-Fac. 0.14; Fac. 0.14; Reimbursement - $ 5.02.

AMA Guidelines: (For developmental screening, use 96110)

- **96136 - Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes** (RVU – N-Fac. – 1.28; Fac. 0.69; Reimbursement Non-Fac - $ 46.04.

AMA Guidelines: (For developmental screening, use 96110)

- **96137 - Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes** (List separately in addition to code for primary procedure) RVU – N-Fac. – 1.18; Fac. 0.54; Reimbursement Non-Fac. $42.51.

AMA Guidelines: (96136, 96137 may be reported in conjunction with 96130, 96131, 96132, 96133 on the same or different days)

- **96138 - Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes** (RVU-N-Fac. 1.01; Fac. 1.01. Reimbursement $ 36.46.)

AMA Guidelines: (96138, 96139 may be reported in conjunction with 96130, 96131, 96132, 96133 on the same or different days)

- **96139 - Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes** (List separately in addition to code for primary procedure)

AMA Guidelines: (96138, 96139 may be reported in conjunction with 96130 (Per hour code), 96131, 96132, 96133 on the same or different days)

– (For 96136, 96137, 96138, 96139, 96130 do not include time for evaluation services [e.g., integration of patient data or interpretation of test results]. This time is included in 96130, 96131, 96132, 96133)

---

WHAT ELSE DO WE HAVE TO DEAL WITH?

THIRD PARTY PREAUTHORIZATIONS, ELIGIBILITY
Who loves eviCore?

Provider Promise: Connecting The Dots

• eviCore offers our providers real-time access to patient authorization and eligibility information via the Web. In addition, you can submit requests at any time that best suits your schedule.

• Stay informed. We offer convenient access to valuable resources such as current clinical guidelines and worksheets, comprehensive tutorials that overview specific registration and submission processes, and program tools and criteria.

• We also furnish our providers access to important contact information so that they can reach the appropriate department for immediate assistance.

• Have questions? We have provider engagement representatives, who are dedicated to providing support for inquiries and specialized training.

• Email us at portal.support@evicore.com and we will get back to you shortly.

Source: https://www.evicore.com/

Ask eviCore: Denied Requests

• Jan 17, 2019 Blog Post:
  – To begin the new year, our January Ask eviCore feature is focused on adverse determinations and navigating the path forward with your patient after a request has been denied.
  – We receive a lot of questions about this topic, so we’ve answered some of the most frequently ask...
Faces of eviCore: Dr. Tod Nakatsuka

Meet Dr. Tod Nakatsuka, DC.

Having gone through the authorization process himself, he is able to relate to the pain points that a provider is facing.

That understanding allows him to do everything he can to lessen that pain and make a provider’s experience the best that i...

READ MORE


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eviCore 2018 Interventional Pain Management Guidelines

- The documents on this page reflect the 2018 amendments to eviCore’s Interventional Pain Management Guidelines.

- Included in the documentation posted below are the 2018 Executive Summary of Changes, Redlined/Change Documents, and the Complete Final Interventional Pain Guideline document.

- The 2018 Guidelines will become effective October 22, 2018.
CLINICAL GUIDELINES
Interventional Pain Management
Version 20.0.2018
Effective October 22, 2018

CMM-200: Epidural Steroid Injections (ESI)
CMM-200.1: Definitions 4
CMM-200.2: General Guidelines 5
CMM-200.3: Indications: Selective Nerve Root Block (SNRB) 6
CMM-200.4: Indications: Epidural Steroid Injections (Transforaminal, Interlaminar, or Caudal) 6
CMM-200.5: Non-Indications: SNRB 7
CMM-200.6: Non-Indications: ESI 7
CMM-200.7: Procedure (CPT®) Codes 8
CMM-200.8: References 9
**EPIDURAL STEROID INJECTIONS**

- 3 common methods for delivering steroid into the epidural space:
  1. **Interlaminar ESI** – places the needle into the back of the epidural space to deliver the steroid over a wider area.
     - Usually involves anesthetic, sterile saline and steroid

  2. **Caudal approach** – Uses the sacral hiatus (a small boney opening just above the tailbone) caudal /ˈkɔːdəl/ adjective of or like a tail. - at or near the tail or the posterior part of the body. “the caudal vertebrae”
     - Allows needle placement into bottom of the epidural space.
     - Will often spread medication over several spinal segments and cover both sides of spinal canal.
EPIDURAL STEROID INJECTIONS

3. Transforaminal ESI approach – “nerve block”.

- Needle is placed alongside the nerve as it exits the spine. “Medication is placed into the “nerve sleeve” and travels up the sleeve and into the epidural space from the side.”
- This approach allows for a more direct delivery of the medication into “one affected area (usually one segment and one side.”
- “Transforaminal ESIs can also be modified to allow for more specific coverage of a single nerve and can provide diagnostic benefit, in addition to improved pain and function.”


(for-a-men /fәˈrәmәn/noun ANATOMY: an opening, hole, or passage, especially in a bone)
EPIDURAL STEROID INJECTIONS

• All 3 of the approaches generally involve:
  – Placing a thin needle into the area using fluoroscopic guidance.
  – Contrast dye is used to determine that the medication is getting to the desired target area.
  – Often, a local anesthetic is added to provide pain relief to the area prior to injection.

Source: Treatments – Epidural Steroid Injection, by Ray Baker, M.D., 2009,
https://www.spine.org/KnowYourBack/Treatments/InjectionTreatmentsforSpinalPain/EpiduralSteroidInjections

THE EPIDURAL SPACE

• The Epidural Space – “a flat filled “sleeve” that surrounds the spinal sac and provides cushioning for the nerves and spinal cord.”

• Narrowing (stenosis) of the spinal canal can be caused by several conditions:
  – Disc herniation
  – Bone spurs
  – Thickening of the ligaments
  – Cyst
  – Abnormal alignment of vertebrae (spondylolisthesis or “slipped vertebrae”)

Source: Treatments – Epidural Steroid Injection, by Ray Baker, M.D., 2009,
https://www.spine.org/KnowYourBack/Treatments/InjectionTreatmentsforSpinalPain/EpiduralSteroidInjections
CMM-200.1: Definitions

Transforaminal epidural steroid injection (ESI) is a therapeutic injection of contrast (absent allergy to contrast) performed at a single or multiple spinal levels, followed by the introduction of a corticosteroid and possibly a local anesthetic by inserting a needle into the neuroforamen under fluoroscopic or computed tomography (CT) guidance.

Selective Nerve Root Block (SNRB) is a diagnostic injection of contrast (absent allergy to contrast) of a single nerve root to assist with surgical planning, followed by the introduction of a local anesthetic by inserting a needle into the neuroforamen under fluoroscopic or computed tomography (CT) guidance. SNRB’s are erroneously referred to as Transforaminal Epidural Steroid Injection (TFESI), although technically SNRB’s involve the introduction of anesthetic only and are used for diagnostic purposes.

Interlaminar epidural steroid injection (ESI) is an injection of contrast (absent allergy to contrast), followed by the introduction of a corticosteroid and possibly a local anesthetic into the epidural space of the spine either through a paramedian or midline interlaminar approach under fluoroscopic guidance.

Caudal epidural steroid injection (ESI) is an injection of contrast (absent allergy to contrast), followed by the introduction of corticosteroids and possibly a local anesthetic into the epidural space of the spine by inserting a needle through the sacral hiatus under fluoroscopic guidance into the epidural space at the sacral canal.
eviCore DEFINITIONS (The “magic words” for Documentation)

Radiculopathy, for the purpose of this policy, is defined as the presence of pain, dysesthesia(s), or paraesthesia(s) reported by the individual in a specified dermatomal distribution of an involved named spinal root(s) causing significant functional limitations (i.e., diminished quality of life and impaired, age-appropriate activities of daily living), and either of the following:

- Documentation of ONE or MORE of the following, concordant with nerve root compression of the involved named spinal root(s) demonstrated on a detailed neurologic examination within the prior three (3) months:
  - Loss of strength of specific named muscle(s) or myotomal distribution(s)
  - Altered sensation to light touch, pressure, pin prick or temperature in the sensory distribution
  - Diminished, absent or asymmetric reflex(es)
- Documentation of EITHER of the following performed within the prior 12 months:
  - A concordant radiologist’s interpretation of an advanced diagnostic imaging study (MRI or CT) of the spine demonstrating compression of the involved named spinal nerve root(s)
  - Electrodiagnostic studies (EMG/NCV’s) diagnostic of nerve root compression of the involved named spinal nerve root(s).

eviCore DEFINITIONS

Radicul pain is pain which radiates to the lower extremity along the course of a spinal nerve root, typically resulting from compression, inflammation and/or injury to the nerve root.

Radiculitis is defined, for the purpose of this policy, as radicular pain without objective neurological findings on physical examination.
Comprehensive Musculoskeletal Management Guidelines

Spinal stenosis refers to the narrowing of the spinal canal usually due to spinal degeneration that occurs with aging. It may also be the result of spinal disc herniation, osteoarthritis, or a tumor. Lumbar spinal stenosis results in low back pain as well as pain or abnormal sensations in the legs, thighs, feet or buttocks, or loss of bladder and bowel control. Neurogenic claudication is often a clinical condition that results from spinal stenosis.

CMM-200.2: General Guidelines

The determination of medical necessity for the performance of a selective nerve root block (SNRB) or a therapeutic epidural steroid injection is always made on a case-by-case basis.

Please note: this guideline does not apply to epidural injections administered for obstetrical or surgical epidural anesthesia.

An epidural steroid injection should be performed with the use of fluoroscopic or CT guidance and the injection of a contrast, with the exception of an emergent situation or when fluoroscopic/CT guidance or the injection of contrast is contraindicated (e.g., pregnancy).

The use of an indwelling catheter to administer a continuous infusion/intermittent bolus should be limited to use in a hospital setting only. It is inappropriate to represent the use of a catheter for single episode injection(s) that is/are commonly performed in an outpatient setting as an indwelling catheter for continuous infusion/intermittent bolus.
There is insufficient scientific evidence to support the scheduling of a “series-of-three” injection in either a diagnostic or therapeutic approach. The medical necessity of subsequent injections should be evaluated individually and be based on the response of the individual to the previous injection with regard to clinically relevant sustained reductions in pain, decreased need for medication and improvement in the individual’s functional abilities.

Selective nerve root blocks performed for the purpose of treating pain may be termed therapeutic selective nerve root blocks. There is insufficient evidence to support the clinical utility of therapeutic selective nerve root blocks.

When performing transforaminal blocks (SNRB), no more than two (2) nerve root levels should be injected during the same session/procedure.

When medical necessity criteria is met, a total of three (3) epidural steroid injection per episode of pain may be performed during a 12 month period of time, and no more than four (4) epidural steroid injections per region, per year may be performed.

Additionally, when medical necessity criteria are met for a cervical/thoracic interlaminar and/or cervical/thoracic transforaminal epidural steroid injection (ESI), advanced diagnostic imaging should be performed within 12 months prior to the injection.

CMM-200.3: Indications: Selective Nerve Root Block (SNRB)

- A diagnostic selective nerve root block (SNRB), performed at a single nerve root, involving the introduction of anesthetic only, is considered medically necessary when attempting to establish the diagnosis of radicular pain (including radiculitis) or radiculopathy when the diagnosis remains uncertain after standard evaluation (neurologic examination, radiological studies and electrodiagnostic studies) in the following clinical situations:
  - When the physical signs and symptoms differ from that found on imaging studies
  - When there is clinical evidence of multi-level nerve root pathology
  - When the clinical presentation is suggestive, but not typical for both nerve root and peripheral nerve or joint disease involvement.
  - When the clinical findings are consistent with radiculopathy in a dermatomal distribution, but the imaging studies do not corroborate the findings (positive straight leg raise test)
  - When the individual has had previous spinal surgery
  - For the purposes of surgical planning.

- A second selective nerve root block is considered medically necessary when the following criteria are met:
  - Evidence of multi-level pathology
  - It has been at least two weeks since the prior injection
CMM-200.4: Indications: Epidural Steroid Injections (Transforaminal, Interlaminar, or Caudal)

- An epidural steroid injection is considered medically necessary for ANY of the following indications when the associated medical necessity criteria are met:
  - For treatment of presumed radiculopathy when there has been failure of at least six (6) weeks of conservative treatment (e.g., exercise, physical methods including physical therapy and/or chiropractic care, nonsteroidal anti-inflammatory drugs [NSAIDs] and/or muscle relaxants).
  - For treatment of presumed radiculitis or radicular pain when ALL of the following criteria are met:
    - Radicular pain, with or without motor weakness, which follows a specified dermatomal distribution of an involved named spinal root(s)
    - A positive straight leg raise, crossed leg raise, and/or Spurling’s
    - Failure of at least six (6) weeks of conservative treatment (e.g., exercise, physical methods including physical therapy and/or chiropractic care, NSAID’s and/or muscle relaxants).

- When a transforaminal epidural steroid injection is performed in addition to an intra-articular facet joint injection with synovial cyst aspiration, when the following criteria are met:
  - Advanced diagnostic imaging studies (e.g., MRI, CT, CT myelogram) confirm compression or displacement of the corresponding nerve root by a facet joint synovial cyst.

Comprehensive Musculoskeletal Management Guidelines

- Clinical correlation with the individual’s signs and symptoms of radicular pain or radiculopathy, based on history and physical examination.
- As an initial trial when there is evidence of symptomatic spinal stenosis and ALL of the following criteria are met:
  - Diagnostic evaluation has ruled out other potential causes of pain
  - MRI or CT with or without Myelography within the past twelve (12) months demonstrates severe spinal stenosis at the level to be treated
  - Significant functional limitations resulting in diminished quality of life and impaired, age-appropriate activities of daily living.
  - Failure of at least four (4) weeks of conservative treatment (e.g., exercise physical methods including physical therapy and/or chiropractic care, NSAIDS, and/or muscle relaxants)
- A repeat epidural steroid injection when at least TWO of the following criteria are met for two or more week’s duration:
  - 50% or greater pain relief
  - Increase in the level of function/physical activity (e.g., return to work)
  - Reduction in the use of pain medication and/or additional medical services such as physical therapy/chiropractic care.
NOW LET'S LOOK AT 2019 PAYMENT FOR SOME ESIs

<table>
<thead>
<tr>
<th></th>
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<td>62320</td>
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<td>$170.47</td>
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1. Medial Branch Blocks
2. Radiofrequency Ablation/Neurotomy (of the medial branches) – RFA

Being able to correctly and effectively perform these two procedures requires an excellent understanding of the course of the medial branch of the dorsal primary ramus, along with the knowledge that each facet joint has dual innervation.

Medial Branch Nerve Blocks

- Important to Understand the course of the medial branch of the dorsal ramus:
  - **Dorsal** - Posterior division of a spinal nerve.
  - The **Dorsal Ramus** - *(Latin for branch, plural rami)* is the dorsal branch of a spinal nerve that forms from the dorsal root of the nerve after it emerges from the spinal cord.
  - The spinal nerve is formed from the dorsal and ventral rami (the ventral root or anterior root is the efferent motor root of a spinal nerve)
  - The **dorsal ramus carries information that supplies muscles and sensation to the human back.**
MEDIAL BRANCH BLOCKS

- **What are the Medial branch nerves?**
  - *Small nerves* that feed out from the facet joints in the spine and carry pain signals from the facet joints to the brain.

- **What is a medial branch nerve block?**
  - A procedure in which an anesthetic is injected near small *medial nerves* connected to a *specific facet joint*.

Source:
Medial Branch Nerve Blocks - Spine-Health
IS A MEDIAL BRANCH BLOCK THE SAME AS AN EPIDURAL?

• It is similar to a transforaminal epidural steroid injection.
  – However, in a selective nerve root block there is no attempt to have the medication enter the epidural space.
  – The aim is strictly to cover the offending nerve root.

  
Epidural Steroid Injections and Selective Nerve Root Blocks - APM...
apmspineandsports.com/diagnosis/epidurals/

FACET JOINTS

• The articular processes or zygapophyses of a vertebra:
  – Greek combination of words for – “yoke” (links 2 vertebra) + “away” = process.
  – The projections of the vertebra
  – Serve purpose of fitting with an adjacent vertebra.
  – The region of contact is called the facet.
• “The facet joints are the joints in your spine that make your back flexible and enable you to bend and twist.”
• “Nerves exit your spinal cord through these joints on their way to other parts of your body.”
• “Healthy facet joints have cartilage, which allows your vertebrae to move smoothly against each other without grinding.”

Source:
Facet Joint Syndrome - Patients | DePuy Synthes Companies
https://www.depuy.synthes.com/patients/.../facetjointsyndrome
Medial branch blocks

- Is sometimes over-coded due to misunderstanding of the spinal anatomy.
  - Example - A procedural note stating, "medial branch blocks of L3, L4 and L5 nerves" if not followed with sufficient procedure documentation can be misleading.

- "According to the AMA, the code series for medial branch blocks and the facet joint injections are the same (i.e., CPT series 64490-64495), with reporting based on the number of facet joints injected, not the number of nerves injected. Sep 21, 2010”.

- “Because each lumbar facet joint is innervated by two medial branches of the primary dorsal ramus, both must be anesthetized to completely block a single joint.”
  - “For example, to block the L4-L5 facet joint, both L3 and L4 medial branch nerves are anesthetized at the transverse processes of L4 and L5 respectively. CPT codes 64490-64495, according to the AMA CPT Assistant, "refer to the injection of a facet joint either by injection into the joint with one needle puncture or by anesthetizing the two medial branch nerves that supply each joint (two needle punctures)."

SOURCE:
Incorrect Medial Branch Block Reporting: Top Procedural Mistake...
https://www.beckersasc.com/.../incorrect-medial-branch-block-reporting-top-procedural...

EACH FACET JOINT HAS DUAL INNERVATION
LOOKING BACK AT THE ORIGINAL DOCUMENTATION

Example - A procedural note stating, "medial branch blocks of L3, L4 and L5 nerves" if not followed with sufficient procedure documentation can be misleading.

- "The L3, L4 and L5 medial branch nerves innervate the L4-L5 and L5-S1 facet joint."
- Correct way to report? If documentation indicates the injections were performed with image guidance (fluoroscopy or CT):
  - 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 (Novitas Fee – Facility - $ 85.45; MPPR - $ 42.72; Non-Facility - $ 168.71; MPPR - $ 84.36.)
  - 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) (Novitas Fee – Facility - $ 52.14; Non-Facility - $ 85.95.)

AMA Guidelines:(Use 64494 in conjunction with 64493)
- Two CPT codes (64493 and 64494 provided the injections were performed with fluoroscopic guidance or CT guidance) for two facet joint injections despite having injected three nerves. Remember, the code description is for a facet joint injection. (Aug. 2010 AMA CPT Assistant)"

IMPORTANT TO HAVE REFERENCE SHEETS FOR PAIN MANAGEMENT CODING

- For the Codes
- For the NCDs, if any
- For the LCDs
- AMA Guidelines for your top codes
- ICD-10-CM Codes allowable for each of your services
- For each Carrier’s Guidelines and
- Be familiar with not only the Plan, but the Member’s individual coverage.
EXAMPLE - 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 (intraarticular 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 (intraarticular 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. Symptoms of facet joint syndrome include - absence of radiculopathy, pain that is aggravated by extension, rotation or lateral bending of the spine and is normally not associated with any neurological deficits.

d. Diagnostic facets are considered experimental and investigational for neck and back pain for untreated radiculopathy

e. 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.

f. Aetna considers ultrasound guidance of facet injections experimental and investigational.

Place this information in a Table that is easy to read to grasp the main documentation requirements for your Physicians.

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. Symptoms have existed for more than three months and trigger points have been identified by palpation, and trigger point injections are not administered in isolation but as part of a comprehensive pain program.

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

F. 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.

G. 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.

H. 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. Pain is radicular in nature.
B. Intraspinal tumor or other space-occupying lesion, or non-spinal origin for pain, had been ruled out as the cause of pain; and
C. Member has failed to improve after (4) or more weeks of conservative measures (e.g. rest, systemic analgesics and/or physical therapy); and
D. Interlaminar epidural injections are provided as part of a comprehensive pain management program, which includes physical therapy, patient education, psychosocial support, and oral medications, where appropriate.

Interlaminar epidural injections of corticosteroid preparations, with or without added anesthetic agents, are considered experimental and investigational 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.

Initially, the individual may receive the first three injections at intervals of no sooner than two weeks. If the initial interlaminar epidural injections are unsuccessful, additional interlaminar epidural injections are considered not medically necessary.

Note: A successful interlaminar injection is one in which there is a 50% reduction in pain and/or symptoms.

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 – ESIs - CONTINUED

- Interlaminar epidural injections beyond the first three are considered medically necessary, if the initial injections resulted in at least a 50% relief in pain and/or symptoms, and the interlaminar epidural injections are provided as part of a comprehensive pain management program, which includes physical therapy, patient education, psychosocial support, and oral medications, where appropriate.

- If the member experiences less than 50% relief of pain after three interlaminar epidural injections, additional epidural injections are not considered medically necessary.

- After the initial three injections, repeat epidural injections more frequently than every two months are not considered medically necessary.

- A total of four interlaminar epidural steroid injections per region (ie, cervical, thoracic, lumbar) per rolling 12-month period are considered medically necessary, only upon return of pain and/or deterioration in function and only when responsiveness to prior injections has occurred (ie, the individual should have at least a 50% reduction in pain and/or symptoms for two months).

- Additional interlaminar epidural injections per region per rolling 12-month period are considered experimental and investigational because they have no proven value.

REFERENCE SHEETS FOR INJECTIONS and OTHER SERVICES YOUR PRACTICE PERFORMS

- Create one for each of the following with the information that is relevant to your coding and billing with notations of pertinent information for successful billing/collections.
  - Tendons, Ligaments and Muscle Injections
  - Nerve Blocks
  - Epidural Steroid Injections (ESIs)
  - Facet Joint Procedures
  - Radiofrequency Ablation
  - SI Joint Injections
  - Vertebroplasty/Kyphoplasty
  - Neurostimulation (Spinal Cord Stimulator/Dorsal Column Stimulator)
  - Botox Injections
  - Regenerative Medicine
  - Acupuncture
  - PT/OT Modalities
  - Injectables (J Codes)
  - EMG & Nerve Conduction Studies
  - Autonomic Testing
  - Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion
  - Any other services – such as E/M, lab, testing, etc.
EXAMPLE: JOINT AND BURSA – INJECTIONS OR ASPIRATIONS (ADD ANOTHER COLUMN FOR SPECIFIC MAJOR CARRIER COVERSAGES)

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<tr>
<th>CPT CODE</th>
<th>DESCRIPTION</th>
<th>RVU- NON-FAC</th>
<th>RVU- FAC</th>
<th>NOTES</th>
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<tbody>
<tr>
<td>20610</td>
<td>Major joint/bursa (knee, hip, shldr, etc.)</td>
<td>1.64</td>
<td>1.27</td>
<td>If imaging use 76942, 77002, 77012, 77021</td>
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<td>20605</td>
<td>Intermediate joint/bursa (wrist, elbow, ankle, acromioclavicular, etc.)</td>
<td>1.38</td>
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<td>w/o US guid.</td>
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<td>20600</td>
<td>Minor joint/bursa (fingers, toes, etc)</td>
<td>1.32</td>
<td>1.00</td>
<td>w/o US guid.</td>
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<td>27096</td>
<td>Sacroiliac joint with fluoroscopy</td>
<td>4.35</td>
<td>2.31</td>
<td>Only with imaging with CT/Fluro which is included; if imaging not used, use 20552; For Bilateral use 50.</td>
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<td>20552</td>
<td>Sacroiliac joint without fluoroscopy</td>
<td>1.50</td>
<td>1.05</td>
<td>See above</td>
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<tr>
<td>77002</td>
<td>Fluoroscopic needle guidance</td>
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<td>Add-on code; Use only with other codes listed in CPT/ Use 26, TC as appropriate.</td>
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<td>Genicular Nerve Blocks; Injection Other Peripheral Nerve</td>
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<td>Nerve or branch; Watch eviCore Guidelines</td>
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<td>64440</td>
<td>Genicular nerve RFA; Destruct by neurolytic agent other peripheral nerve or branch</td>
<td>3.68</td>
<td>2.59</td>
<td>Use 59 after 1st.</td>
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REFERENCE SHEET FOR ID CARDS

QUESTIONS??

• THANK YOU!!

• Contact information: mcollins@pmimd.com
  Cell 940-631-4279