Eli's Rehab Report

Bill Fluoroscopy for SI Injections With No Arthrography

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Although many insurers argue that fluoroscopy should not be billed separately from injection procedures, there are circumstances when PM&R practices should appeal denials and fight for their rightful fluoroscopy reimbursement.

Fluoroscopic guidance (76000-76005) is a must for many pain management injections, but the Correct Coding Initiative (CCI) bundles fluoroscopy into most injection procedures. Because 27096 (Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid) includes arthrography in its descriptor, many coders believe that they should not report radiological supervision or fluoroscopic guidance separately. The arthrogram should be billed separately, however, and if the physiatrist does not perform arthrography with the injection, practices can bill fluoroscopy in addition to 27096.

CPT Assistant has clarified the various codes that can be submitted with 27096, advising coders to use 73542 (Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation) for the radiological supervision and interpretation associated with sacroiliac [SI] joint arthrography."" Because fluoroscopic guidance is included in 73542" you should not bill fluoroscopy separately when an arthrogram is performed. Therefore an SI injection with arthrography and fluoroscopy should be billed as follows:

27096
73542.

In some cases the physiatrist does not perform arthrography or issue a formal radiologic report with SI injections but still uses fluoroscopy to identify the appropriate injection site. In these instances you should not report 73542 but you can bill separately for the fluoroscopy using 76005 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural transforaminal epidural subarachnoid paravertebral facet joint paravertebral facet joint nerve or sacroiliac joint] including neurolytic agent destruction). Consequently an SI injection with fluoroscopy but without a formal arthrography should be billed as follows:

27096
76005.

If your carrier denies fluoroscopy claims billed with 27096 appeal the denials with a copy of the CPT reporting guidelines (listed under the 27096 code descriptor in the CPT manual) along with a copy of your chart notes demonstrating medical necessity for the fluoroscopy and as proof that you did not perform an arthrogram with the injection.

Hip Injections Include Fluoroscopy

Hip injections often require as much precision as SI injections and therefore physiatrists frequently use fluoroscopy to correctly identify the site. In fact a comment in CPT following 20610* (Arthrocentesis aspiration and/or injection; major joint or bursa [e.g. shoulder hip knee joint subacromial bursa]) advises "If imaging guidance is performed see 76003 76360 76393 76942." Coders report constant denials however when billing 76003 (Fluoroscopic guidance for needle placement [e.g. biopsy aspiration injection localization device]) with 20610.

This occurs because CCI edits bundle 76003 into most injection procedures including joint injections says **Trish Buskauskas CPC** the chief executive officer of TB Consulting a coding and reimbursement company in Aliquippa Pa. " CPT does refer coders to 76003 when reporting 20610 but CCI does not feel that there is enough medical necessity to support the use of guidance for a mere joint or muscle injection." Buskauskas reminds coders that the AMA publishes CPT

but Medicare establishes the CCI edits and the two do not always agree.

CCI may have instituted this edit because 20610 also applies to knee and shoulder injections which are performed more often than hip injections but do not require fluoroscopic guidance says **Ryan Price CPC CCS-P** manager of coding operations at Aviacode a coding outsourcing company in Salt Lake City. "The only joint injection normally performed under fluoroscopy is the hip injection " Price says and therefore CCI bundles fluoroscopy with 20610.

Price advises practices whose patients require fluoro-scopic guidance with hip injections to bill 76003 in addition to 20610 because it's correct coding to bill for the services you perform. "I'm a strong believer in coding properly and fighting for what you should be paid rather than coding to get the fastest reimbursement " Price says. He recommends appending modifier -59 (Distinct procedural service) to 76003 billed with hip injections and to fight denials if you believe the fluoroscopy is medically necessary.

Remember to append modifier -26 (Professional component) to your fluoroscopic guidance claims unless your practice owns the fluoroscopy equipment.

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