# Eli's Rehab Report

## CPT Unveils New Nerve Block Codes for 2003

CPT 2003 introduced four new somatic nerve block codes and five new alternative communication codes, offering practices much-needed specificity for these PM&R services. CPT 2003 unveiled more than 150 new codes, but the following outlines those most valuable to rehab practices.

New Continuous Infusion Codes for Nerve Blocks

Because many PM&R practices specialize in pain management, the following nerve block codes will probably be the most useful new codes for physiatrists in the coming year:

1. 64416 Injection, anesthetic agent; brachial plexus, continuous infusion by catheter [including catheter placement] including daily management for anesthetic agent administration
2. 64446 ... sciatic nerve, continuous infusion by catheter [including catheter placement], including daily management for anesthetic agent administration
3. 64447 ... femoral nerve, single
4. 64448 ... femoral nerve, continuous infusion by catheter [including catheter placement] including daily management for anesthetic agent administration.

CPT did not include a specific femoral nerve block code prior to 2003, so coders used the "other peripheral nerve or branch" code, 64450. The new code, 64447, will allow practices more specificity.

The new continuous infusion codes (64416, 64446 and 64448) allow practices to report just one code, whereas these procedures used to be coded with **CPT 64450** and 01996 (Daily hospital management of epidural or subarachnoid continuous drug administration).

Note that 01996 now specifies "hospital management" in CPT 2002, it was simply defined as "Daily management of epidural or subarachnoid drug administration."

Physicians use continuous infusion during postoperative pain management or as pain management during rehabilitation therapy.

CPT Alters Bursa Injection Codes

CPT 2003 altered several injection code descriptors in the 20550-20605 range. Foremost, the descriptor for 20550* eliminates the reference to ganglion cyst, now reading "Injection(s); tendon sheath, ligament."

Similarly, descriptors for 20600* (Arthrocentesis, aspiration and/or injection; small joint or bursa [e.g., fingers toes]) and 2060* ( intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]) also drop all mention of ganglion cysts. To compensate for this, CPT has created a new code, 20612 (Aspiration and/or injection of ganglion cyst[s] any location), to describe ganglion cyst injection or aspiration.

TPI Codes Revised

CPT 2003 offers new descriptors for 20552 (Injection[s]; single or multiple trigger point[s], one or two muscle[s]) and 20553 (... single or multiple trigger point[s], three or more muscle[s]), which now specify "muscle(s)" rather than "muscle group(s)."

But PM&R practices hoping that the revision will allow them to bill additional units of 20552 and 20553 for each muscle injected will probably be disappointed, since the billing rules are not likely to change.

"The word 'group(s)' was removed from 20552 and 20553 because there was a great deal of confusion regarding what constituted a muscle group, and different payers were interpreting it differently," says **Allison Waxler,** practice management policy analyst at the American Academy of Physical Medicine and Rehabilitation in Chicago.

"The codes are written to allow each code to be billed only once per day," Waxler says. "One or more injections in one or two muscles should be coded with one unit of 20552. One or more injections in three or more muscles should be coded with one unit of 20553. Providers cannot bill multiple units of either code if multiple injections are given or if multiple muscles are injected."

New Communication Codes Help Therapists

The new code 92610 (Evaluation of oral and pharyngeal swallowing function) will aid therapists who evaluate patients with strokes (436) or other conditions that interfere with their ability to swallow, says **Judith Thomas, MGA,** director of the reimbursement and regulatory policy department at the American Occupational Therapy Association. The new code replaces 92525 (Evaluation of swallowing and oral function for feeding), which was deleted.

CPT also introduces codes 92605-92609 to describe services for patients with speech-generating devices and non-speech-generating communication devices, such as those who cannot speak due to amyotrophic lateral sclerosis (ALS, 335.20) and other conditions. These codes replace the temporary HCPCS codes G0197-G0199.

The new codes will aid therapists who program and modify alternative and augmentative communication devices, but they should not be used for activities of daily living (ADL) training for these patients. Report ADL training using 97535 (Self-care/home management training [e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment] direct one-on-one contact by provider, each 15 minutes).

On-Call Service Codes Introduced

CPT 2003 also introduces two "Miscellaneous Services" codes. Medicare probably won't reimburse for these codes, presumes **Douglas Jorgensen, DO, CPC,** a practicing physician in Manchester, Maine, and chairman of the Osteopathic Medical Economics Committee, but physiatrists don't need to despair:

5. 99026 Hospital mandated on-call service; in-hospital, each hour
6. 99027 Hospital mandated on-call service; out-of-hospital, each hour.

If Medicare denies these codes "on the same basis as the after-hours codes (99050-99054), there is a chance that some private insurers may reimburse for them," Jorgensen says.

**Editor's note:** At press time, CMS had delayed the 2003 Physician Fee Schedule, originally due for release Nov. 1. PM&R Coding Alert will report on the new RVUs as soon as CMS releases them.