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Pain Management Coding Alert

Coding Tips: Ask 'Tunneled or Non-tunneled?' to Start Your Spinal Cath Coding

Following these 5 steps will ensure you cover all the bases.

Coding for spinal catheters may pose a challenge if you don't know the specifics (such as the approach and catheter handling) to search for in the clinical note. The next time your pain management specialist implants a spinal catheter for a patient who needs long-term intrathecal or epidural infusions, follow these steps to coding success.

Step 1: Confirm the Approach

The physician can place either a "tunneled" or "non-tunneled" catheter, depending on the situation. For example, he might tunnel an epidural catheter subcutaneously and attach the catheter directly to an external pump or an implanted programmable infusion pump. Your surgeon's notes should be clear regarding whether he used a tunneled or non-tunneled approach.

Step 2: Verify Anatomical Site for Non-Tunneled Trial Catheter Placement

If your surgeon placed a non-tunneled catheter, you code the trial with either 62318 (Injection[s], including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance[s] [including anesthetic, antispasmodic, opioid, steroid, other solution], not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic) or 62319 (... lumbar or sacral [caudal]).

Check original location: You choose the correct code based on the anatomical location where your surgeon placed the catheter in the spine. This may or may not be the same spinal region your physician finally "threads" the catheter to. For example, the physician might insert the catheter at L2-L3 and advance it until the catheter tip is at the T6-T7 level. You would still report 62319 for the lumbar/sacral level, not 62318 for the thoracic level.

"The cervicothoracic placement is coded distinctly from lumbosacral placement because the cervicothoracic region contains the spinal cord, and placement of catheters in this region carries greater risk than in the lumbosacral spine," explains **Gregory Przybylski, MD**, director of neurosurgery at JFK Medical Center's New Jersey Neuroscience Institute in Edison.

Step 3: Check for Laminectomy in Tunneled Approach for Permanent Catheter Placement

Knowing whether the physician performed a laminectomy is your first step in coding a tunneled spinal catheter. Your choices are 62350 (Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy) and 62351 (... with laminectomy).

Note: Both codes 62350 and 62351 apply to the implantation, revision, or repositioning of the spinal catheters. Both also apply to intrathecal and epidural catheters. Therefore, you'll report one of these two codes regardless of whether your physician placed the catheter in the epidural or intrathecal space.

Step 4: Look For a Follow-Up Visit

After the implantation, revision, or repositioning of a tunneled spinal catheter, the patient may return for a follow-up exam. Code 62350 has a 10-day global period, and 62351 has a 90-day global period. If the patient returns for follow-up during the global period, submit code 99024 (Postoperative follow-up visit, normally included in the surgical package, to

indicate that an evaluation and management service was performed during a postoperative period for a reason[s] related to the original procedure).

To report follow-up after a non-tunneled trial catheter placement, check the documentation to confirm the complexity of the problem and how long the evaluation and patient counseling lasted. Then report the appropriate E/M code from 99212-99215 (Office or other outpatient visit for the evaluation and management of an established patient ...).

Remember: Removing a trial, non-tunneled catheter is not separately billable. You can submit an E/M code, however, if the provider performs additional work during the same encounter beyond the trial catheter removal.

Step 5: Report Other Services as Needed

If the patient has a permanently implanted catheter, he or she will return at some point for your physician to remove the catheter. When this happens, you report 62355 (Removal of previously implanted intrathecal or epidural catheter).

Note: Like 62350 and 62351, code 62355 also applies to both epidural and intrathecal catheters.

Tip: If an internal pump was also implanted, don't forget to report its removal in addition to the catheter's removal. For pump removal you report code 62365 (Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion).

"Don't forget to consider use of the 58 (Staged or related procedure or service by the same physician during the postoperative period) modifier if the removal procedure occurs within the global period of the placement procedure," advises Przybylski. If the implanted catheter and infusion pump need to be removed during the global period because of complications (such as an infection or mechanical failure), modifier 78 (Unplanned return to the OR/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period) might be more appropriate than modifier 58.