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Pain Management Coding Alert

Office Procedures: Brush Up On When You Might Code E/M With Injections

Modifier indicators are your key to success.

It's not uncommon for pain management specialists to administer therapeutic injections during the same patient encounter as an E/M service. Experienced coders know that doesn't mean you can always code for both services, however. Read on for a refresher on which E/M services should not find separate status on your claim.

Keep a Close Eye on Edits

Hundreds of Correct Coding Initiative (CCI) edits apply to pain management services and E/M care. As long as you remember that the injection procedure probably overrides the E/M service, your coding will be simple.

For example, report these injections alone instead of in conjunction with E/M codes, according to CCI edits:

- 20550-20551 for tendon and ligament injections
- 20552-20553 for trigger point injections
- 20600-20610 for aspiration or injection of small, intermediate and major joints or bursa
- 27096 for sacroiliac joint injections
- 62310-62318 for continuous or single-shot epidural placement
- 64400-64681 for nerve injection and destruction procedures.

Several spine procedures are also part of the same edit structure, with these procedures listed as the ones you should report instead of E/M services on the same day:

- 22520-22521 for vertebroplasty
- 22523-22524 for kyphoplasty
- 22526 for IDET.

Learn the List of Affected E/M Codes

The edits all involve E/M services, so once you get familiar with the applicable E/M codes, most of your work is done. The following E/M services are bundled into the procedures listed above and should not be separately reported under normal circumstances:

- Patient office visits (99202-99205 for new patients or 99212-99215 for established patients)
- Initial hospital observation care (99218-99220)
- All hospital inpatient E/M services (99221-99239)
- All inpatient and outpatient consultation services (99241-99255)
- Critical care services (99291 and +99292)
- Nursing facility services (99304-99316)
- Most domiciliary and home services (99324-99350)
- Four codes for care plan oversight services (99374, 99375, 99377, and 99378).

Background: E/M services have always been considered part of a procedure by virtue of the rules defining global periods. Minor procedures (those with 0- and 10-day global periods) have included a minor E/M procedure that was not "significant and separately identifiable." Major procedures (with a 90-day global period) have always included any E/M services provided the day of and the day before the procedure.

Double Check for Modifier Possibilities

The vast majority of pain management edits are due to "CPT® manual or CMS manual coding instructions." Nearly all edit pairs carry a modifier indicator of "1," however, meaning that you might sometimes be able to report both services in an edit pair when they're completed during the same encounter. If you have clear documentation that justifies reporting both services, include that information with your claim and append a modifier (such as 25, Significant, separately identifiable E/M service or 57, Decision for surgery) to the E/M code.

"So, just like we have always used the 25 and 57 modifiers because of the global rules with minor and major procedures with E/M services, we will continue to use these modifiers when they have been appropriately documented and the circumstances support their use," **Barbara J. Cobuzzi, MBA, CENTC, CPC-H, CPC-P, CPC-I, CHCC**, president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. "This bundle really has not changed how minor and major procedures with E/M services are coded and handled. It just adds another level to the regulations via the CCI."