

# Pain Management Procedure Coding

April 2011



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## OIG—Pain Management

- In 2007 Medicare paid over \$2 Billion for interventional pain management services
- Injections
- Nerve blocks
- Spinal cord stimulation
- “Blind” injections (i.e., without radiologic guidance)
- Office based vs. hospital or ASC



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## DOJ Press Release

Dr. Jorge A. Martinez was convicted by a jury of 56 counts of mail, wire and health care fraud. Martinez ran “pain management” clinics in Ohio. He treated all patients with weekly injections during visits that lasted no more than a few minutes, then claimed thousands of dollars in insurance reimbursements per visit. He saw upward of 100 patients per day. Martinez submitted \$60 million in fraudulent bills to the victim health care benefit programs, claiming he was performing multiple, complex epidural and nerve block injections when, in fact, he performed crude versions of lower cost trigger-point injections. He was paid over \$12 million by Medicaid, Medicare and the Ohio Bureau of Workers’ Compensation.

DOJ Press Release June 9, 2006



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## Maryland Newspaper

“Anesthesiologist in Maryland pleaded guilty in Feb. 2008 for health care fraud related to transforaminal epidural injections...claims were also sought for reimbursement for myelography...submitted claims for “moderate” office visits. Such office visits are typically defined as a doctor spending “25 minutes face to face with the patient and/or family,” according to court papers. However, moderate office visits were not held, according to the evidence submitted to the court.”

[http://www.somdnews.com/stories/022708/indycr103010\\_32135.shtml](http://www.somdnews.com/stories/022708/indycr103010_32135.shtml)



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## OIG—Pain Management

- Transforaminal Epidural Injections—August 2010 (OEI-05-09-00030)
- Physician payment increase (\$57 million in 2003 up to \$141 million in 2007)
- CPT codes 64479, 64480, 64483, 64484
- Random sample (433 services) from 2007
- 34% Error rate--\$45 million in improper payments



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# OIG—Pain Management

**Table 3: Improperly Paid Medicare Transforaminal Epidural Injection Services—Physician Claims, 2007**

Type of Error	Sample		Projected	
	Services	Allowed Amount	Services	Allowed Amount
Documentation	87	\$19,504	19%	\$29 million
Medical Necessity	56	\$12,109	13%	\$19 million
Coding	35	\$3,626	8%	\$6 million
(Overlapping Errors)	(30)	(\$6,161)	(7%)	(\$9 million)
<b>Total</b>	<b>148</b>	<b>\$29,078</b>	<b>34%*</b>	<b>\$45 million</b>

Source: OIG analysis of medical review results, 2009.

\*Numbers do not always sum to total because of rounding.

Source: OIG report OEI-05-09-00030



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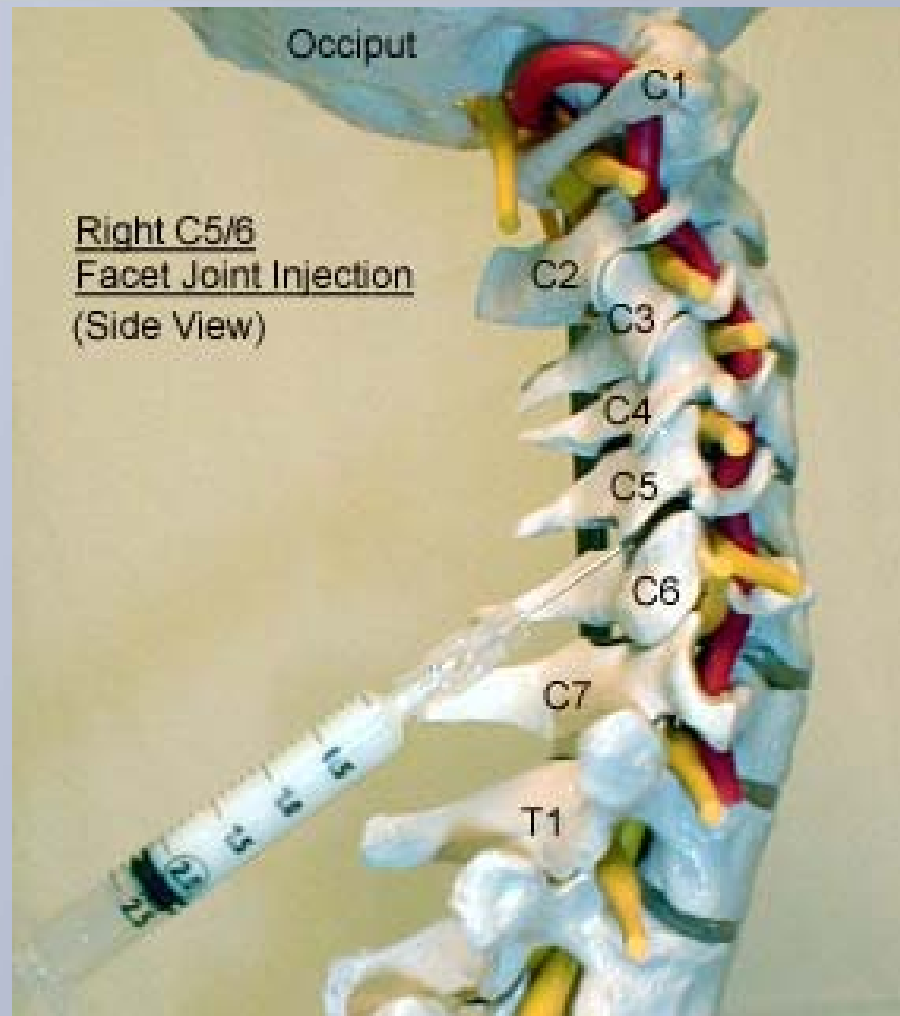
## OIG—Pain Management

- Medical necessity—lack of evidence of a condition requiring TEI or procedure repeated at close intervals without evidence injections were relieving pain.
- Coding—improper use of add on codes and bilateral modifier (150% of reimbursement is obtained when modifier -50 is used).
- Documentation errors were more likely in office setting vs. hospital/ASC.



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Source: The Pain Clinic. Available online at [www.painclinic.org](http://www.painclinic.org).





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## OIG—Pain Management

- Facet Joint Injections—Sept. 2008 (OEI-05-07-00200 )
- Physician payment increase (\$141 million in 2003 up to \$307 million in 2006)
- CPT codes 64470, 64472, 64475, 64476
- Random sample (646 services) from 2006
- 63% Error rate--\$96 million in improper payments



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# OIG—Pain Management

**Table 4: Improperly Paid Medicare Facet Joint Injection Services  
Physician Claims, 2006**

Type of Error	Sample		Projected	
	Services	Allowed Amount	Services	Allowed Amount
Documentation	196	\$35, 835	38%	\$81 million
Coding	173	\$11,670	31%	\$21 million
Medical Necessity	43	\$7,394	8%	\$17 million
(Overlapping Errors)	(71)	(\$12,247)	(14%)	(\$23 million)
<b>Total</b>	<b>341</b>	<b>\$42,651*</b>	<b>63%</b>	<b>\$96 million</b>

Source: OIG analysis of medical review results, 2008.

\* Numbers do not sum to total because of rounding.

Source: OIG report OEI-05-07-00200



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## OIG—Pain Management

- Medical necessity—lack of evidence of a condition requiring facet joint injections or no medical imaging documented.
- Coding—improper use of add on codes and bilateral modifier (overpayments and underpayments).
- Documentation errors were more likely in office setting vs. hospital/ASC.



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## OEI-05-07-00200

**Table 6: Physician Specialty Error Rate in an Office Setting for Sample**

Specialty**	Specialty Code	Any Error in Office*	Services in Office*	Percentage of Services With an Error in Office
General Practice	01	36	37	97%
Internal Medicine	11	13	15	87%
Family Practice	08	7	9	78%
Neurology	13	8	11	73%
Rheumatology	66	5	7	71%
Orthopedic Surgery	20	9	14	64%
Anesthesiology	05	30	48	63%
Pain Management	72	14	25	56%
Physical Medicine and Rehabilitation	25	8	15	53%

Source: OIG analysis of medical review results, 2008.

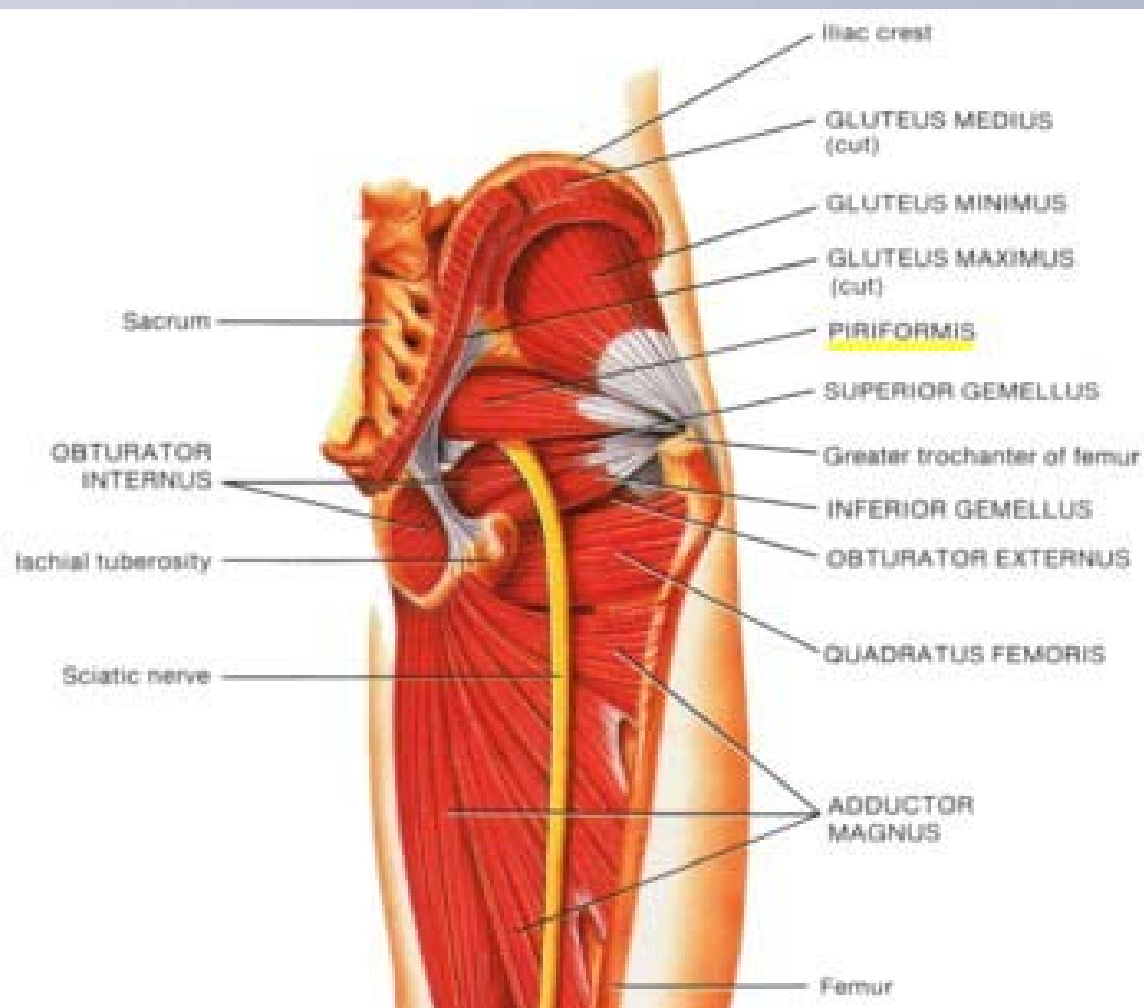
\* Figures are based only on the sample and are not projected to the population.

\*\* Only specialties with sample frequency equal to or greater than five are shown here.



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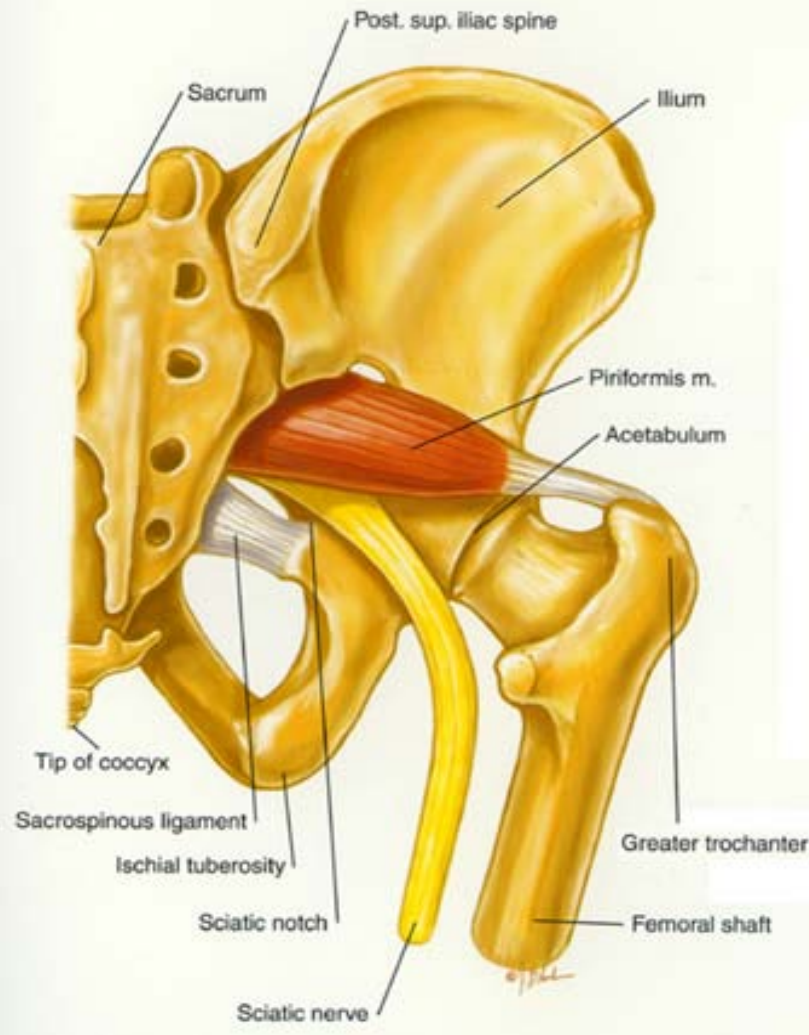
# OIG – Pain Management





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# OIG – Pain Management





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# OIG – Pain Management

- Per July 2008 CPT Assistant:

**Question:** What is the appropriate code to use for reporting implanted pump catheter dye studies? The patient is not getting pain relief, and an intrathecal catheter is evaluated for dislodgement, discontinuity, or kinking. Contrast is injected through the catheter with fluoroscopic guidance to identify a potential problem.

**Answer:** It is appropriate to report code 75809, Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation, for the radiologic supervision and interpretation (RSI) portion of such a procedure to evaluate for shunt catheter patency or leakage. This code can be used for evaluation of a variety of similar and related nonvascular shunt catheters and devices, and requires the injection of contrast. Occasionally, evaluation for discontinuity is performed using plain radiography or CT imaging, without catheter contrast injection. In such cases, the service should be reported using appropriate radiography or CT codes describing which anatomical areas were imaged (eg, brain, neck, chest, and/or abdomen). Implanted pump catheter dye studies typically require an injection component and an RSI component; therefore, it would also be appropriate for the physician performing the injection to report code 61070, Puncture of shunt tubing or reservoir for aspiration or injection procedure, to describe the injection service itself.





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# OIG- Pain Management

## Coding of Qutenza®

(6/22/2010)

Effective January 16, 2009, the Food and Drug Administration (FDA) granted approval for Qutenza® (capsaicin) 8%. Qutenza is indicated for the management of neuropathic pain associated with Postherpetic Neuralgia (PHN). PHN can complicate herpes zoster (shingles).

Qutenza is supplied as a 14 cm x 20 cm patch that must be handled carefully. Qutenza is applied for 60 minutes, during which periodic monitoring of pain and skin reaction is necessary. Local (topical) or systemic (enteral) analgesic may be required during administration. Cleansing the application site following removal of the patch is required. Qutenza must be applied by a physician or other appropriate health care professional under close physician supervision. A physician must mark or otherwise indicate the application site for any other health care professional applying the patch. Qutenza must not be applied to the face or scalp.

Qutenza is administered no more often than every three months. More than one patch (up to four) may be required as is reasonable and necessary, depending on the dermatomal size affected by PHN.

### Notes:

- This drug is only approved for treatment of:
  - Postherpetic neuralgia NEC (ICD-9-CM diagnosis code 053.19).
  - Claims are reviewed individually and approval is made on a case-by-case basis.
- It is not covered for:
  - Geniculate ganglion postherpetic neuralgia (053.11).
  - Trifacial or trigeminal postherpetic neuralgia (053.12).
- Medical records must specify that all of the above precautions and application procedures were followed.
- Payment for an Evaluation and Management (E/M) service on the same day as payment for Qutenza application is permitted, but not routinely reasonable and necessary.
  - Documentation of the E/M service must demonstrate necessity for the E/M visit. Documentation of the E/M service must meet all related coding and documentation requirements of the service and must meet the requirements for using modifiers 24 or 25.
- Reporting a separate service for application of Qutenza is permitted. Such a service must be reported with NOC code 64999. No other neurologic or drug administration service code is appropriate for reporting application of Qutenza.





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## Questions?

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(web site also includes recorded coding and compliance webinars)