

# Pain Management

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In addition to the General Guidelines, this section applies to the unique guidelines for Pain Management services.

## I. Reimbursement for Pain Management Services

### A. Pain Management Base Units for Professional Services

Base units for Professional services in the Pain Management section are state-specific and have been authorized by the Mississippi Workers' Compensation Commission for the professional reimbursement of procedures in Pain Management. Reimbursement is for base units only. Time units will not be considered for reimbursement purposes.

*The conversion factor for Pain Management is \$40.00 per unit. The formula for calculating professional reimbursement is: Base Unit x Conversion factor = Professional reimbursement.*

### B. Modifiers

#### **-PM Pain Management**

*The '-PM' modifier is a Mississippi specific pain management code. '-PM' modifier is used to charge for the third injection of a specific injection/destruction series. (i.e. CPT 64470 is the primary procedure; and CPT 64472 is the additional level injection; and CPT 64472-PM is for the third level injection of a three-level injection series. Procedures billed with the '-PM' modifier are reimbursed at 25% of*

*the primary procedure allowable reimbursement; 50% of add-on.*

## Injection/Destruction Procedures

*1. The new CPT codes for Pain Management typically have separate codes for injections that may involve additional levels (i.e. 64470 is for injection cervical facet-level 1, and 64472 is used for additional levels. The '-PM' modifier would therefore only apply to the 64472 code. This rule also applies to lumbar facets and neurolytic (destruction) procedures such as 6426. As only 2 levels can be reimbursed for transforaminal epidural injections (CPT 64479, 64480, 64483, 64484) the '-PM' modifier would not apply because the additional level code could only be used once.)*

*2. Facet injections and nerve destruction procedures are reimbursed at a maximum of 3 anatomic joint levels. Therefore, the '-PM' modifier would only be used a maximum of one time (i.e. a 3 level lumbar facet injection would be billed as 64475 for 1<sup>st</sup> level, 64476 for 2<sup>nd</sup> level, and 64476-PM for 3<sup>rd</sup> level.) Additional injected levels would not be reimbursed. Procedures are considered inherently bilateral, and modifiers to allow bilateral injections do not alter reimbursement amounts.*

**3. Reimbursement for injection/destruction procedure codes is made on the basis of facet levels treated, not nerve branches (i.e. destruction by neurolytic agent of the L4-L5 and L5-S1 facets counts as two (2) levels and should be billed as 64622 and 64623.) There are two nerves supplying each joint level but reimbursement is based upon level treated not the number of nerves treated. This applies to CPT codes 64622, 64623, 64626, and 64627.)**

**4. A maximum of two (2) levels of transforaminal epidural steroid injections are reimbursable for a given date of service. This applies to codes 64479, 64480, 64483, and 64484.**

**5. A maximum of one (1) translaminar epidural steroid injection reimbursable for a given date of service. This applies to codes 62310 and 62311.**

**6. A maximum of three (3) facet level procedures are reimbursable for a given date of service. This maximum applies to facet joint injections, nerve blocks, or nerve destruction procedures.**

#### **E. Multiple Procedure Reimbursement**

**Reimbursement for multiple pain procedures shall be**  
**-100% for the primary procedure**  
**- 50% for the 2<sup>nd</sup> procedure**  
**- 25% for the 3<sup>rd</sup> procedure.**

**For purposes of reimbursement. Each injection is considered a separate procedure and will be reimbursed according to the multiple procedure rule.**

#### **Example:**

**A three level lumbar facet would be billed as 64475– reimbursement would be 100% for the first level; 64476 for the second level-- reimbursed at 50%; 64476-PM for the third level -- reimbursed at 25%.**

**There is no reimbursement for more than two (2) procedures on a given date of service, except as allowed by the -PM modifier.**

#### **F. Facility Fees**

Pain management facility fees are state-specific and are based upon the intensity of the procedure and the amount of resources required to complete the procedure. The facility fee is paid for the use of personnel, materials, drugs, equipment and space. The facility reimbursement is all-inclusive and will not be unbundled.

**Facility Reimbursement Levels**

Level I Procedures	\$ 75.00
Level II Procedures	\$ 120.00
Level III Procedures	\$ 260.00
Level IV Procedures	\$ 480.00
Level V Procedures	\$ 790.00
Level VI Procedures	\$ 990.00
Fluoroscopy	\$ 100.00

(In addition to the facility fee if fluoroscopy is performed and not included in the descriptor for the procedure)

***Only one (1) fluoroscopy fee per date of service will be reimbursed***  
 CPT 76005 is to be reimbursed as separate procedure and multiple procedure rule would not apply.

**Guidelines for Facility Reimbursement for Pain Management**

Recovery times

minimal:	1-15 minutes
moderate:	30-60 minutes
short:	15-30 minutes
extended:	> 60 minutes

**LEVEL 1**

Minimal equipment requirements  
 Generally minimal or no recovery time no necessity for IV or sedation  
 Minimal personnel requirements (number,time)  
 Minimal risk for cardiovascular changes or major neurological impairment post procedure

**LEVEL 2**

Minimal equipment requirements  
 May involve short recovery periods  
 IV sedation or fluid requirement unlikely  
 Minimal personnel requirements (number, time)  
 Minimal risk for cardiovascular changes or major neurological impairment

**LEVEL 3**

May require specialized equipment  
 Moderate recovery times likely  
 Minimal personnel requirements (number and time)  
 IV sedation or fluids likely  
 Moderate likelihood of slight cardiovascular or major neurological impairment

**LEVEL 4**

May require specialized equipment  
 Extended recovery times likely  
 Increased personnel requirements (number and time)  
 IV sedation or fluids likely  
 Moderate cardiovascular or major neurological impairment likely

**LEVEL 5**

Requires highly technical specialized equipment (eg radio frequency,cryoanagesia)  
 Extended recovery times expected  
 Increased personnel requirements  
 IV sedation or fluids likely  
 Substantial cardiovascular or major

neurological impairment likely

injection sites.

## II Guidelines

- A. Reimbursement for an approved epidural series is limited to two injections. Documentation of a positive patient response will be required prior to continued epidural treatment. If there is no documented pain relief after two injections, no further injections will be considered medically necessary.
- B. Reimbursement will be limited to three (3) epidural pain injections in a 9-month period at any one level unless the payer gives prior approval for more than three (3). Separate billing for the drug injected is not appropriate and will not be reimbursed.
- C. Epidural adhesiolysis also known as Racz procedure or lysis of epidural adhesions is considered investigational and will not be reimbursed unless the payer gives prior approval.
- D. Reimbursement for more than one (1) facet injection per calendar year will require prior approval from the payer.
- E. Contralateral facet injections performed within a month of each other are considered part of the same procedure and will not command a separate reimbursement.
- F. Trigger point injection is considered one (1) procedure and is reimbursed as such regardless of the number of

- G. Sacroiliac arthroscopy (CPT code 73542) assumes the use of a fluoroscope is considered an integral part of the procedure(s) and therefore does not command an additional fee for the fluoroscopy.
- H. Epidurography (CPT code 72275) aka “epidural myelogram” or “epidural without dural puncture” is the proper code to use for contrast material injected into the epidural space. The epidurography code involves the inherent use of a fluoroscope and therefore an additional fluoroscopy charge would not be allowed.
- I. CPT code 62318 includes needle placement, catheter infusion and subsequent injections. Code 62310 should be used for multiple solutions injected by way of the same catheter, or multiple bolus injections during the initial procedure. The epidural needle or catheter placement is inherent to the procedure.
- J. The procedure interdiskal electrical thermal therapy (IDET), is presently considered to be in the investigational stage. Therefore, per the General Guidelines section, this service is presently not reimbursed unless the payer has given prior approval.
- K. Intraventricular administration of Morphine is considered investigational and would not qualify for reimbursement under the

guidelines of the *Official Mississippi Workers' Compensation Medical Fee Schedule*, unless the payer has given prior approval.

- L. Pulse radiofrequency is considered an investigational procedure and is, therefore, not covered under this schedule.
- M. The following procedures must be performed fluoroscopically in order to qualify for reimbursement:
  - Facet injections (64470, 64472, 64475, 64476)
  - SI Injections (27096)
  - Transforaminal epidural steroid injections (64483)
- N. Any anesthesia/sedation used in the performance of the procedures in this section is considered integral to the procedure and will not be separately reimbursed.
- O. Interdisciplinary Chronic Pain Management Program is a highly structured, goal-oriented, individualized treatment program. These programs are interdisciplinary in nature with a capacity for addressing the functional, physical, and emotional/behavioral health needs of the person served. An interdisciplinary team must be incorporated to include a physical therapist, occupational therapist, psychologist, and dietary education. The program must have oversight supervision by a physician.

Reimbursement is based on an hourly charge and should be billed using code Q0105. For easier reference, code Q0105 is listed in both the Pain Management and Physical Medicine sections.

- P. Anatomical descriptions of the procedures performed must accompany the bill for service in order for reimbursement to be made.

- Q. **Discography**  
Discography is a diagnostic test to identify (or rule out) painful intervertebral discs. A Discography is appropriate only in patients for whom no other treatment options remain except for possible surgical stabilization (spinal fusion). A Discography is then used on these patients to determine which discs, if any are painful and abnormal, so that a surgical correction (fusion) can be performed. If a patient is not considered to be a candidate for surgery (fusion), then a discography should not be performed. Investigational intradiscal therapies such as percutaneous disc decompression (Dekompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies are not an indication for a discography.

Reimbursement of Discography  
62290, 62291            12 units  
72288, 72295            14 units

May be used only once, regardless of number of levels tested.

Facility Level 5