

# Medicare Reimbursement for Fluoroscopic Guidance And Localization During Pain Management Procedures<sup>1</sup>

This advisory discusses Medicare coding, coverage and payment for mobile fluoroscopy guidance during pain management procedures when performed in the hospital inpatient, hospital outpatient department, independent diagnostic testing facility (IDTF), physician office and ambulatory surgical center settings.<sup>2,3</sup> While it focuses on Medicare program policies, these policies also may be applicable to selected private payers throughout the country.

## Coding

Medicare's reimbursement system relies mostly on Current Procedural Terminology (CPT) codes to consistently identify diagnostic imaging procedures provided to Medicare patients.<sup>4</sup> The CPT coding system was developed and is maintained by the American Medical Association (AMA) and the codes are updated annually.

### ***Coding for Fluoroscopic Guidance and Localization***

Table 1 lists the appropriate CPT codes used to report fluoroscopic guidance and localization during pain management injection procedures. CPT code 77002 is used to report fluoroscopic guidance of all anatomical areas except the spine. CPT code 77003 is used to report fluoroscopic guidance and localization of the spinal anatomy.

It is important to note that there are general limitations on the use of fluoroscopy codes. With respect to coding of fluoroscopy procedures, the American College of Radiology (ACR) points out "*a general rule of thumb is if fluoroscopy is always performed as a part of the radiological imaging study, fluoroscopy is included in the radiological procedure code.*" In these cases, fluoroscopy should not be coded or reported separately.<sup>5</sup> Additionally, injection of contrast during fluoroscopic guidance and localization is an inclusive component of pain management codes and is not separately reported.<sup>6</sup>

There are more specific limitations with respect to the use of the fluoroscopy guidance and localization codes, as well as limitations on reporting each of these codes separately with pain management injection procedures. Table 2 summarizes guidance from the AMA and the ACR on when it is appropriate to report fluoroscopy separately during pain management procedures.



However, providers should confirm their local Medicare contractor has not published coding instructions different than or inconsistent with this guidance before billing Medicare for fluoroscopy in conjunction with pain management procedures.

## Other Requirements Associated with Reporting Fluoroscopy Procedure Codes

According to Medicare regulations, fluoroscopy procedures performed in physician offices, IDTFs and, with certain exceptions, facilities designated by CMS as provider-based facilities require personal supervision (ie, a physician in attendance in the room during the performance of the procedure).<sup>7</sup>

This requirement should typically be met because the fluoroscopy procedure is performed in conjunction with a pain management procedure by a physician. Further, fluoroscopy procedures provided in **hospital inpatient and outpatient settings** should follow the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation standards and internal hospital policies. Fluoroscopy services should not be coded or billed unless these requirements are met.

Many of the pain management codes are subject to National Correct Coding Initiative (NCCI) edits. NCCI edits are pairs of CPT or Healthcare Common Procedure Coding System (HCPCS) codes that are not separately coded and payable except under certain circumstances. The edits are applied to services billed by the same provider for the same beneficiary on the same date of service and are updated on a quarterly basis. The NCCI edits may be obtained through the CMS website at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>.

When submitting claims to Medicare, procedural CPT codes are reported with diagnosis codes describing the patient's documented medical condition. These diagnoses are reported using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM).

### Coding for Pain Management Procedures

There are a wide variety of pain management procedures. A listing of pain management procedures and their related CPT codes is included in Table 2. This listing was developed based on the following information sources: (1) procedures and codes identified by the American Society of Interventional Pain Physicians, (2) additional codes listed in AMA coding documentation as being included in the pain management coding series and (3) Healthcare Common Procedure Coding System (HCPCS) codes developed by the Centers for Medicare and Medicaid Services (CMS) to report selected pain management procedures to the Medicare program. It is important to note that inclusion of a procedure on this list does not denote coverage or payment of the procedure.

## Reimbursement

Medicare reimbursement for fluoroscopic guidance is comprised of a **professional component**, the amount paid for the physician's service, and a **technical component**, the amount paid for all other services (including staffing and equipment costs). When these components are combined and paid to the same individual or entity, this is often referred to as the **total** or **global reimbursement**.

Currently, Medicare reimburses fluoroscopic guidance differently depending on the site of care. The technical (facility) component of a procedure performed in a **hospital inpatient** site of care is subsumed within the payment to the hospital that is determined based on the Medicare Severity Diagnosis Related Group (MS-DRG) to which the patient is assigned. In a **hospital outpatient department**, the technical component payment is packaged into the technical payment for the primary procedure which is reimbursed under an Ambulatory Payment Classification (APC) under Medicare's hospital outpatient prospective payment system (HOPPS). The technical component of the procedure performed in a **physician's office or IDTF** is reimbursed under the Medicare physician fee schedule. In an **ambulatory surgical center**, the technical component is packaged into the technical payment for the primary procedure. The primary procedure is

reimbursed under an APC-based payment rate under the ambulatory surgical center prospective payment system. The professional component is reimbursed under the Medicare physician fee schedule regardless of setting.

Table 1 provides information concerning Medicare national payment rates for fluoroscopy imaging guidance performed in the hospital inpatient, hospital outpatient, IDTF, physician office, and ambulatory surgical center sites of service. It is important to note that, in the hospital outpatient and ambulatory surgical center sites of care, the fluoroscopy procedures are not reimbursed separately, but rather are “packaged” or included in the APC or ASC APC payment, respectively. For more information about reimbursement of these procedures in your area, consult your local Medicare contractor.

**Table 1: 2009 Medicare Reimbursement for Selected Fluoroscopic Imaging Procedures**

(Reflects National Rates, Unadjusted For Locality)

CPT/HCPCS Code	Medicare Reimbursement Component	Hospital Inpatient Department <sup>8</sup>	Hospital Outpatient Department <sup>9</sup>	IDTF or Physician Office <sup>10,11</sup>	Ambulatory Surgical Center <sup>12</sup>
CPT 77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)	Technical	MS-DRG	Packaged in APC	\$44.00	Packaged in APC
	Professional	\$26.69	\$26.69	\$26.69	\$26.69
	Total	MS-DRG + \$26.69	APC + \$26.69	\$70.69	APC + \$26.69
CPT 77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction	Technical	MS-DRG	Packaged in APC	\$31.02	Packaged in APC
	Professional	\$28.13	\$28.13	\$28.13	\$28.13
	Total	MS-DRG + \$28.13	APC + \$28.13	\$59.15	APC + \$28.13

\* Technical is the facility payment

\*\*Professional is the physician payment

## Coverage

Currently, Medicare does not have a national coverage policy that addresses fluoroscopy for pain management procedures. Coverage of these procedures is at the discretion of local Medicare contractors who process claims on behalf of the Medicare program. Providers should ascertain coverage for the pain management procedure in addition to coverage for fluoroscopy itself.

To confirm coverage, consult with your local Medicare contractor or the contractor's Local Coverage Determination (LCD). A directory of local Medicare contractors can be found at: [http://www.cms.hhs.gov/ContractingGeneralInformation/Downloads/02\\_ICdirectory.pdf](http://www.cms.hhs.gov/ContractingGeneralInformation/Downloads/02_ICdirectory.pdf). To access the LCDs, refer to: <http://www.cms.hhs.gov/mcd/search.asp> or the individual contractor's website.

With respect to private payers, some may rely on Medicare reimbursement policies, while others consider alternative information. Therefore, it is important to consult with individual private payers regarding coverage for these procedures as well.

**Table 2: Coding for Fluoroscopic Guidance in Pain Management Procedures**<sup>13</sup>

CPT Code and Description	When Not to Report the Code Separately	When to Report the Code Separately <sup>14</sup>	Other
<p><b>All anatomical areas except the spine</b></p> <p><b>CPT 77002</b> Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)</p>	<p>CPT code 77002 should not be reported separately with any radiographic arthrography (CPT 70332, 73040, 73085, 73115, 73525, 73580, 73615) with the exception of supervision and interpretation for CT and MR arthrography.</p>	<p>Report this code when fluoroscopic guidance is required in the performance of needle placement in areas other than spine, for pain management injection procedures. CPT code 77002 should be reported in conjunction with the primary pain management procedure.</p>	<p>Injection of contrast during fluoroscopic guidance is an inclusive component and is not separately reported.</p>
<p><b>Spine</b></p> <p><b>CPT 77003</b> Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction</p>	<p>Injection of contrast during fluoroscopic guidance and localization (77003) is included 22526, 22527, 62263, 62264, 62267, 62270-62282, 62310-62319.</p> <p>For percutaneous or endoscopic lysis of epidural adhesions, 62263, 62264 include fluoroscopic guidance and localization</p>	<p>Report this code when fluoroscopic guidance is required in the performance of spinal or paraspinal injection procedures, as long as these procedures are not myelography, epidurography, arthrography or discography.</p> <p>CPT code 76003 should be reported in conjunction with injection codes (CPT 62270-62273, 62280- 62282, 62310-62319, 64470-64476, 64479-64484 and 64600-64680; 73542 and in certain circumstances with CPT 27096).</p>	<p>Injection of contrast during fluoroscopic guidance and localization is an inclusive component and is not separately reported.</p> <p>Reported per spinal region (eg, cervical, lumbar), and not per level.</p>

**Table 3: Pain Management Procedures<sup>15</sup>**

CPT/HCPCS Code	Description
20526	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")
20551	Injection(s); single tendon origin/insertion
20552	Injection(s); single or multiple trigger point(s), one or two muscle(s)
20553	Injection(s); single or multiple trigger point(s), three or more muscle(s)
20600	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)
27093	Injection procedure for hip arthrography; without anesthesia
27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
62267	Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purpose
62268	Percutaneous aspiration, spinal cord cyst or syrinx
62269	Biopsy of spinal cord, percutaneous needle
62270	Spinal puncture, lumbar, diagnostic
62272	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)
62273	Injection, epidural, of blood or clot patch
62280	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid
62281	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic
62282	Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)
62284	Injection procedure for myelography and/or computed tomography, spinal (other than C1C2 and posterior fossa)
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar (eg, manual or automated percutaneous discectomy, percutaneous laser discectomy)
62290	Injection procedure for discography, each level; lumbar
62291	Injection procedure for discography, each level; cervical or thoracic

CPT/HCPCS Code	Description
62292	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar
62294	Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal
62310	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
62311	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
62319	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)
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
62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy
62355	Removal of previously implanted intrathecal or epidural catheter
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
62361	Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming
62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion
62367	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming
62368	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

CPT/HCPCS Code	Description
63660	Revision or removal of spinal neurostimulator electrode percutaneous array(s) or plate/paddle(s)
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
64400	Injection, anesthetic agent; trigeminal nerve, any division or branch
64402	Injection, anesthetic agent; facial nerve
64405	Injection, anesthetic agent; greater occipital nerve
64408	Injection, anesthetic agent; vagus nerve
64410	Injection, anesthetic agent; phrenic nerve
64412	Injection, anesthetic agent; spinal accessory nerve
64413	Injection, anesthetic agent; cervical plexus
64415	Injection, anesthetic agent; brachial plexus, single
64416 <sup>16</sup>	Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration
64417	Injection, anesthetic agent; axillary nerve
64418	Injection, anesthetic agent; suprascapular nerve
64420	Injection, anesthetic agent; intercostal nerve, single
64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block
64425	Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves
64430 <sup>17</sup>	Injection, anesthetic agent; pudendal nerve
64435 <sup>18</sup>	Injection, anesthetic agent; paracervical (uterine) nerve
64445	Injection, anesthetic agent; sciatic nerve, single
64446 <sup>19</sup>	Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement), including daily management for anesthetic agent administration
64447 <sup>20</sup>	Injection, anesthetic agent; femoral nerve, single
64448 <sup>21</sup>	Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration
64449	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration
64450	Injection, anesthetic agent; other peripheral nerve or branch
64455	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)
64470	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level
64472	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64475	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level

CPT/HCPCS Code	Description
64476	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64479	Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level
64480	Injection, anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483	Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level
64484	Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64505	Injection, anesthetic agent; sphenopalatine ganglion
64508	Injection, anesthetic agent; carotid sinus (separate procedure)
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)
64517	Injection, anesthetic agent; superior hypogastric plexus
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
64530	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring
64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale
64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring
64612	Chemodestruction of muscle(s); muscle(s) innervated by facial nerve (eg, for blepharospasm, hemifacial spasm)
64613	Chemodestruction of muscle(s); neck muscle(s) (eg, for spasmodic torticollis, spasmodic dysphonia)
64614	Chemodestruction of muscle(s); extremity(s) and/or trunk muscle(s) (eg, for dystonia, cerebral palsy, multiple sclerosis)
64620	Destruction by neurolytic agent, intercostal nerve
64622	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level
64623	Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64626	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level
64627	Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64630	Destruction by neurolytic agent; pudendal nerve
64632	Destruction by neurolytic agent; plantar common digital nerve
64640	Destruction by neurolytic agent; other peripheral nerve or branch
64680	Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus

CPT/HCPCS Code	Description
64681	Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus
73542	Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction
G0259 <sup>22</sup>	Injection procedure for sacroiliac joint; arthrography
G0260 <sup>23</sup>	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

1 Information presented in this document is current as of January 1, 2009. Any subsequent changes which may occur in coding, coverage and payment are not reflected herein.

2 The Food and Drug Administration (FDA) approved labeling for a particular item of GEHC equipment may not specifically cover all of the procedures discussed in this customer advisory. Some payers may in some instances treat a procedure which is not specifically covered by the equipment's FDA-approved labeling as a non-covered service.

3 The federal statute known as the Stark Law (42 U.S.C. §1395nn) imposes certain requirements which must be met in order for physicians to bill Medicare patients for in-office radiology services. In some states, similar laws cover billing for all patients. In addition, licensure, certificate of need, and other restrictions may be applicable.

4 CPT codes and descriptions only are copyright © 2008 American Medical Association. All rights reserved. No fee schedules are included in CPT. The American Medical Association assumes no liability for data contained or not contained herein.

5 American College of Radiology (ACR) Bulletin, March 2002.

6 American Medical Association. CPT® 2009 Professional Edition.

7 Title 42- Public Health and Welfare. CFR §410.32(b)(3) and §410.28(e), and ACR Bulletin, March 2002, *Update on Fluoroscopy Coding*.

8 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component for fluoroscopy imaging performed in the hospital inpatient setting is paid pursuant to the hospital inpatient prospective payment system. The professional component is paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 73, No. 224, November 19, 2008. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

9 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical component is a payment amount assigned to an Ambulatory Payment Classification unless the procedure is packaged under another procedure under the hospital outpatient prospective payment system, as published in Federal Register, Vol. 73, No. 223 November 18, 2008. The professional component is paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 73, No. 224, November 19, 2008. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, please consult with your local Medicare contractor.

10 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. The technical and professional components are paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on the relative value units published in Federal Register, Vol. 73, No. 224, November 19, 2008. The total reimbursement amount for the IDTF and physician office settings reflects the DRA cap adjustment when applicable. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, please consult with your local Medicare contractor.

11 Per the Deficit Reduction Act (DRA) of 2005, designated imaging services with a 2009 Medicare physician fee schedule technical payment (prior to geographic adjustment) that exceeds the comparable 2009 hospital outpatient prospective payment system (HOPPS) technical payment (prior to geographic adjustment), as published in Federal Register, Vol. 73, No. 224, November 19, 2008.

12 Third party reimbursement amounts and coverage policies for specific procedures will vary by payer and by locality. If the procedure is not listed on the ASC covered procedure listing, no technical or professional payment is listed. The technical payment is a payment amount assigned to an APC based payment rate under the ambulatory surgical center prospective payment system as published in Federal Register, Vol. 73, No. 224, November 19, 2008. The professional component is paid under the Medicare physician fee schedule (MPFS). The MPFS payment is based on relative value units published in Federal Register, Vol. 73, No. 224, November 19, 2008. Amounts do not necessarily reflect any subsequent changes in payment since publication. To confirm reimbursement rates for specific codes, consult with your local Medicare contractor.

13 American Medical Association, CPT® 2009 Professional Edition. American Medical Association, CPT® Assistant, Nov. 1999, Vol. 9, Issue 11 and Dec 2005, Vol. 15, Issue 12. AMA CPT® Changes 2000- An Insider's View. American College of Radiology Coding Source, March/April 2006. Memorandum dated March 19, 2007 from American Society of Anesthesiologists Committee on Economics regarding Fluoroscopic Guidance for Spinal Injections.

14 Many of the pain management codes are subject to National Correct Coding Initiative (NCCI) edits. The edits are applied to services billed by the same provider for the same beneficiary on the same date of service and are updated on a quarterly basis. 15 Except where noted otherwise herein, these codes were identified by the American Society of Interventional Pain Physicians as comprising pain management codes, [www.asipp.org](http://www.asipp.org).

16 CPT Assistant February 2004, Volume 14, Issue 2. 17 CPT Assistant October 2001, Volume 11, Issue 10. 18 Ibid. 19 Ibid. 20 Ibid. 21 Ibid. 22 HCPCS codes G0259 and G0260 were created to replace CPT code 27096 in order to facilitate appropriate reporting and payment under HOPPS

for the procedures described by CPT code 27096. Information was obtained from the following sources: Federal Register, November 01, 2002, CMS Transmittal A-02-129, and CPT Assistant April 2003, Vol. 13, Issue 4. 23 Ibid.

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