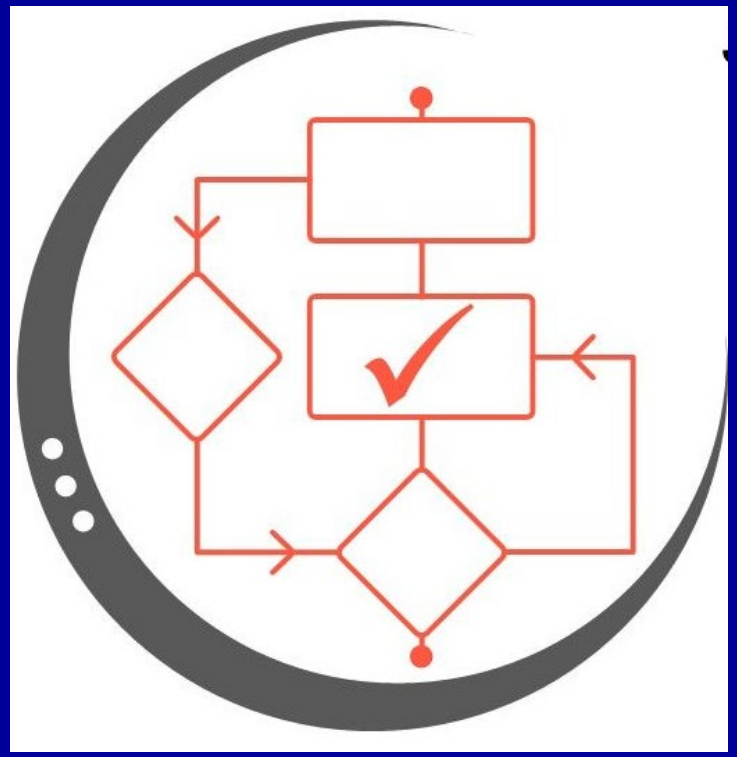
# Documentation of Medical Necessity: An Algorithmic Approach to Epidural, Facet Joint Intervention and Evaluation and Management Services



Laxmaiah Manchikanti, MD

**Laxmaiah Manchikanti, MD**

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# Slides Credited to:

- CGS
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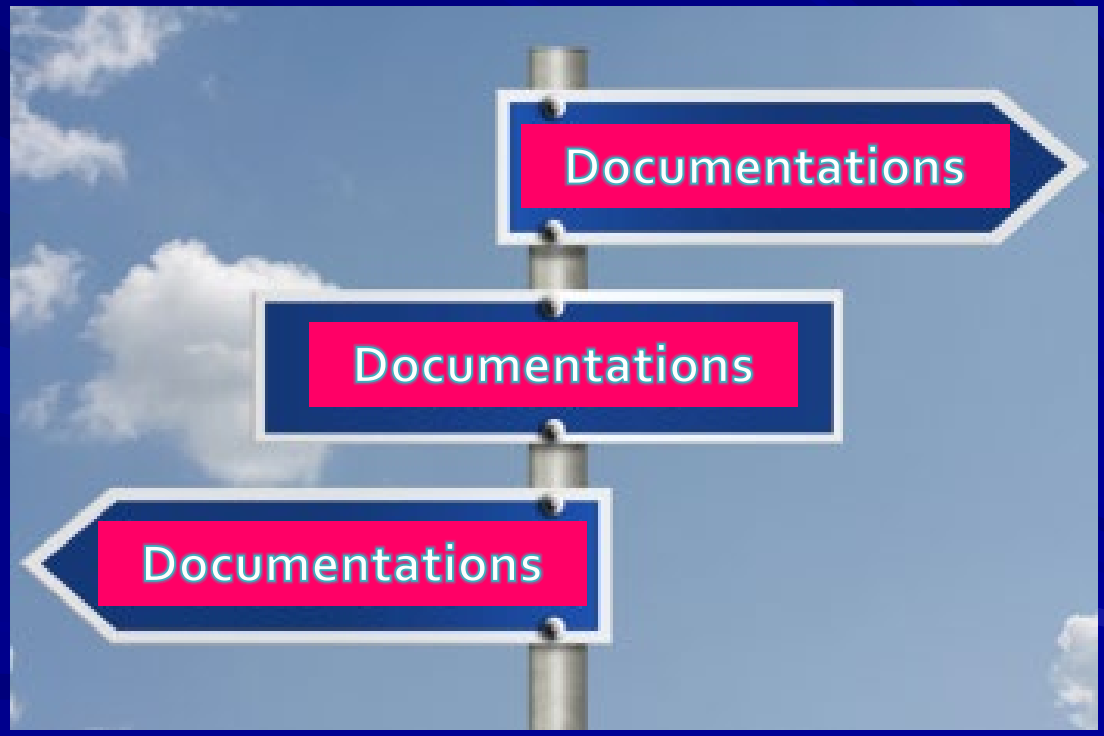
Remember!

For Good Restaurant Business


Remember!

For Good Medical Practice



## Purposes of Documentation

- It's required by LAW!!!
- Keep track of activities.
- Create legal documents.
- Provide a historical record.

*Keep in mind, after the product is distributed to the customer, what remains with us is documents.*


***"Excellence in medical documentation reflects and creates excellence in medical care."***

*Documentation reflects character and competency of a Physician*
*P. Prthivi raj*

# Auto-populate or Copy & Paste

- Lengthy, complex, irregularity notes
- Prevalence
  - 90% of physicians using EMR in 2009
  - 66% of physicians using EMR in 2016
- JCHAO 2015 Report
  - Several **sentinel** events leading potential harm
- Fraud & Abuse implications
- Medical Liability
- Compromised
  - Patient privacy & safety
  - Accuracy, security, note swift or guidelines for safer copy & paste guidelines from ECRI institute

Sometimes interval updates are called Auto-population/Copy & paste or Fraud

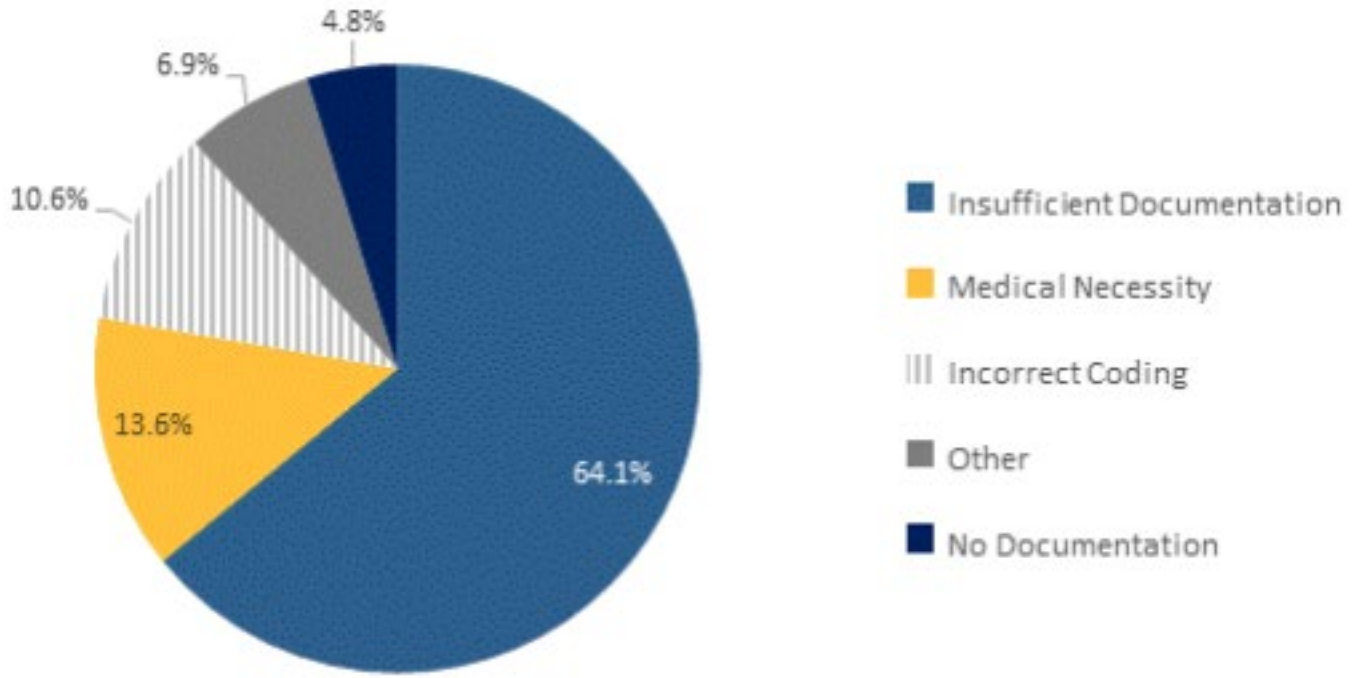
Now changing concepts: Similarity/templates are becoming Auto population/Copy/Paste

# FY 2021 CERT Improper Payment Rate

2021 Improper Payment Rates and Projected Improper Payments by Claim Type (Dollars in Billions) (Unadjusted for Impact of A/B Rebilling)

| Claim Type | Overall Improper Payments | | | Overpayments | | Underpayments | |
|---|---|---|---|---|---|---|---|
| | Total Amount Paid | Projected Improper Payments | Improper Payment Rate | Projected Improper Payments | Improper Payment Rate | Projected Improper Payments | Improper Payment Rate |
| **Part A (Total)** | $291.4 | $14.9 | 5.1% | $14.6 | 5.0% | $0.3 | 0.1% |
| Part A (Excluding Hospital IPPS) | $183.5 | $11.6 | 6.3% | $11.5 | 6.3% | $0.1 | 0.1% |
| Part A (Hospital IPPS) | $107.9 | $3.3 | 3.0% | $3.1 | 2.9% | $0.2 | 0.2% |
| **Part B** | $100.1 | $8.5 | 8.5% | $8.3 | 8.3% | $0.2 | 0.2% |
| **DMEPOS** | $8.3 | $2.4 | 28.6% | $2.4 | 28.6% | $0.0 | 0.0% |
| **Total** | **$399.8** | **$25.7** | **6.4%** | **$25.3** | **6.3%** | **$0.4** | **0.1%** |

# 2021 Improper Payment Rate Error




Categories by Percentage of 2021 National Improper Payments

# Epidural and Facet Joint Intervention

## 13.1.1 - Local Coverage Determinations (LCD) Definition & Statutory Authority for LCDs

(Rev. 863; Issued: 02-12-19; Effective: 10-03-18; Implementation: 01-08-19)

- An LCD, as defined in §1869(f)(2)(B) of the Social Security Act (SSA), is a determination by a Medicare Administrative Contractor (MAC) respecting whether or not a particular item or service is covered on a contractor–wide basis in accordance with section 1862(a)(1)(A) of the Act.

**Evidence-Based Implications**

- Considered Current Evidence Base
  - Basis for policies of other payers
- Standard of Care

# The illusion of evidence based medicine

**Evidence based medicine has been corrupted by corporate interests, failed regulation, and commercialisation of academia, argue these authors**

Jon Jureidini, [1] Leemon B. McHenry[2]

The advent of evidence based medicine was a paradigm shift intended to provide a solid scientific foundation for medicine. The validity of this new paradigm, however, depends on reliable data from clinical trials, most of which are conducted by the pharmaceutical industry and reported in the names of senior academics. The release into the public domain of previously confidential pharmaceutical industry documents has given the medical community valuable insight into the degree to which industry sponsored clinical trials are misrepresented.[1-4] Until this problem is corrected, evidence based medicine will remain an illusion.

The philosophy of critical rationalism, advanced by the philosopher Karl Popper, famously advocated for the integrity of science and its role in an open, democratic society. A science of real integrity would be one in which practitioners are careful not to cling to cherished hypotheses and take seriously the outcome of the most stringent experiments.[5] This ideal is, however, threatened by corporations, in which financial interests trump the common good. Medicine is largely dominated by a small number of very large pharmaceutical companies that compete for market share, but are effectively united in their efforts to expanding that market. The short term stimulus to biomedical research because of privatisation has been celebrated by free market champions, but the unintended, long term consequences for medicine have been severe.

partnership are exposed in the mainstream media, trust in academic institutions is weakened and the vision of an open society is betrayed.

The corporate university also compromises the concept of academic leadership. Deans who reached their leadership positions by virtue of distinguished contributions to their disciplines have in places been replaced with fundraisers and academic managers, who are forced to demonstrate their profitability or show how they can attract corporate sponsors. In medicine, those who succeed in academia are likely to be key opinion leaders (KOLs in marketing parlance), whose careers can be advanced through the opportunities provided by industry. Potential KOLs are selected based on a complex array of profiling activities carried out by companies, for example, physicians are selected based on their influence on prescribing habits of other physicians.[7] KOLs are sought out by industry for this influence and for the prestige that their university affiliation brings to the branding of the company's products. As well paid members of pharmaceutical advisory boards and speakers' bureaus, KOLs present results of industry trials at medical conferences and in continuing medical education. Instead of acting as independent, disinterested scientists and critically evaluating a drug's performance, they become what marketing executives refer to as "product champions."

Ironically, industry sponsored KOLs appear to enjoy

Our proposals for reforms include: liberation of regulators from drug company funding; taxation imposed on pharmaceutical companies to allow public funding of independent trials; and, perhaps most importantly, anonymised individual patient level trial data posted, along with study protocols, on suitably accessible websites so that third parties, self-nominated or commissioned by health technology agencies, could rigorously evaluate the methodology and trial results. With the necessary changes to trial consent forms, participants could require trialists to make the data freely available. The open and transparent publication of data are in keeping with our moral obligation to trial participants—real people who have been involved in risky treatment and have a right to expect that the results of their participation will be used in keeping with principles of scientific rigour. Industry concerns about privacy and intellectual property rights should not hold sway.

# 13.5.4 – Reasonable and Necessary Provisions in LCDs

(Rev. 863; Issued: 02-12-19; Effective: 10-03-18; Implementation: 01-08-19)

**An item or service may be covered by a contractor LCD if:**

- It is reasonable and necessary.
- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;
  - Furnished in a setting appropriate to the patient's medical needs and condition;
  - Ordered and furnished by qualified personnel;
  - One that meets, but does not exceed, the patient's medical need; and o At least as beneficial as an existing and available medically appropriate alternative.

# Legal Implications of LCDs

- Local coverage determination (LCD) means a decision by a fiscal intermediary or a carrier under Medicare Part A or Part B, as applicable, whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with section 1862(a)(1)(A) of the Act.
- An LCD may provide that a service is not reasonable and necessary for certain diagnoses and/or for certain diagnosis codes.

# Coverage Guidance

**Coverage Indications, Limitations, and/or Medical Necessity**

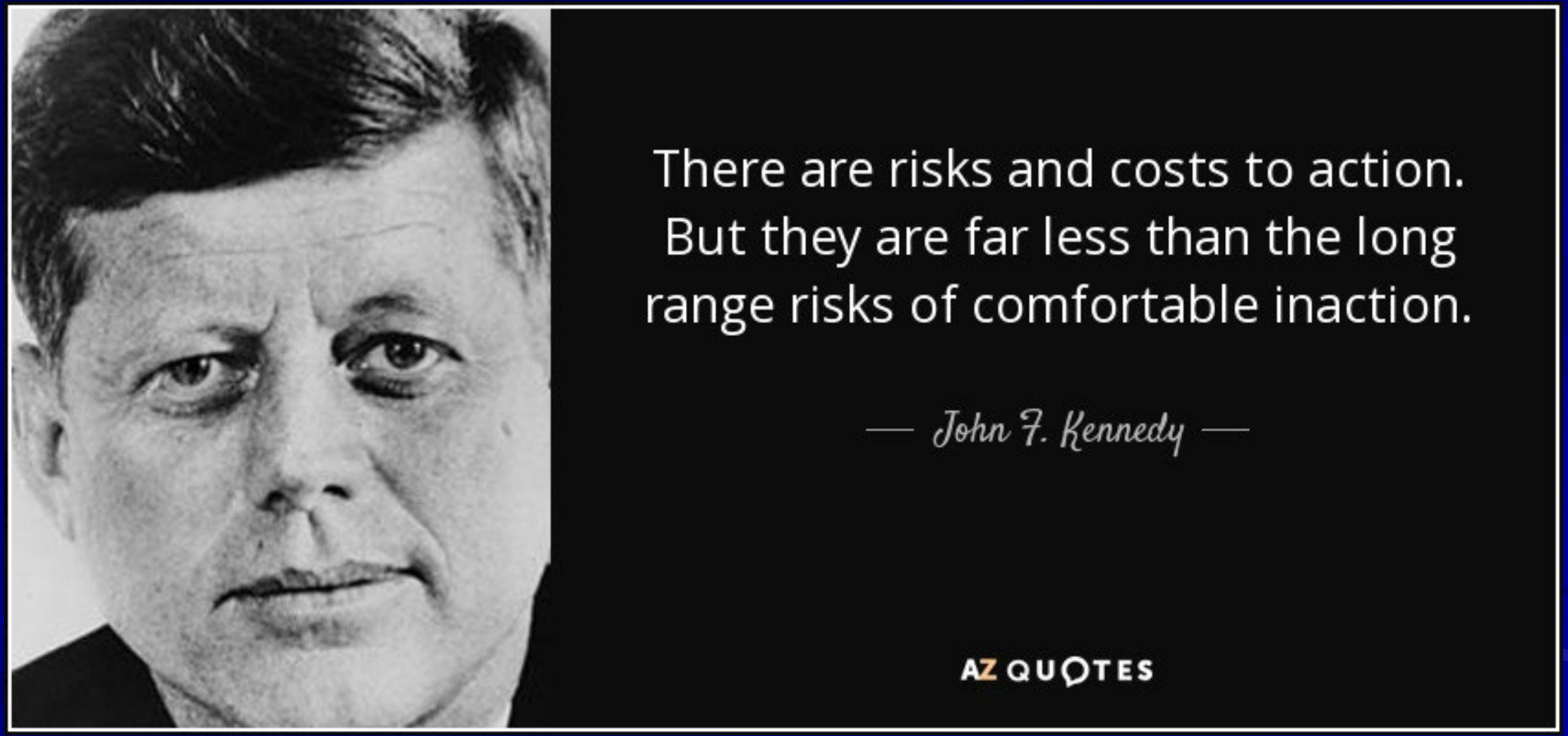
Compliance with the provisions in this LCD may be monitored and addressed through post payment data analysis and subsequent medical review audits.

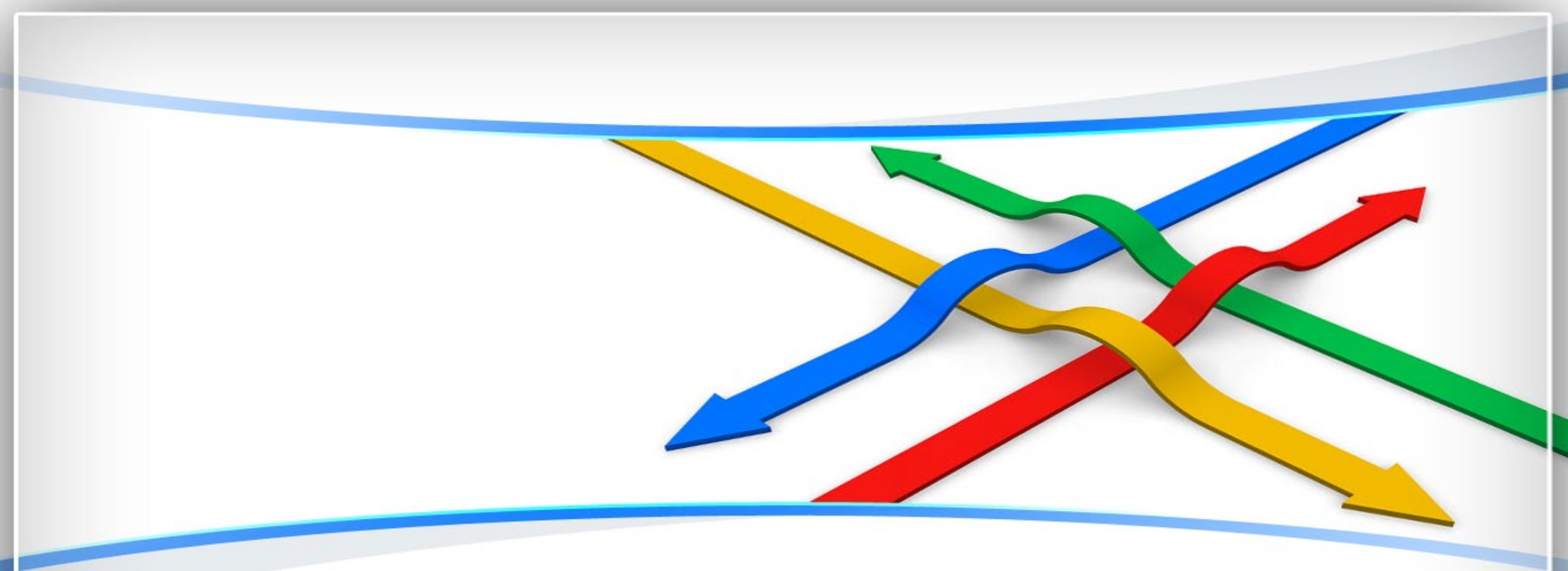
# Document what you do!

# Bill what you document!

**Earl Berman, MD**

CGS Medical Director


There are risks and costs to action.
But they are far less than the long
range risks of comfortable inaction.
— John F. Kennedy —
AZ QUOTES

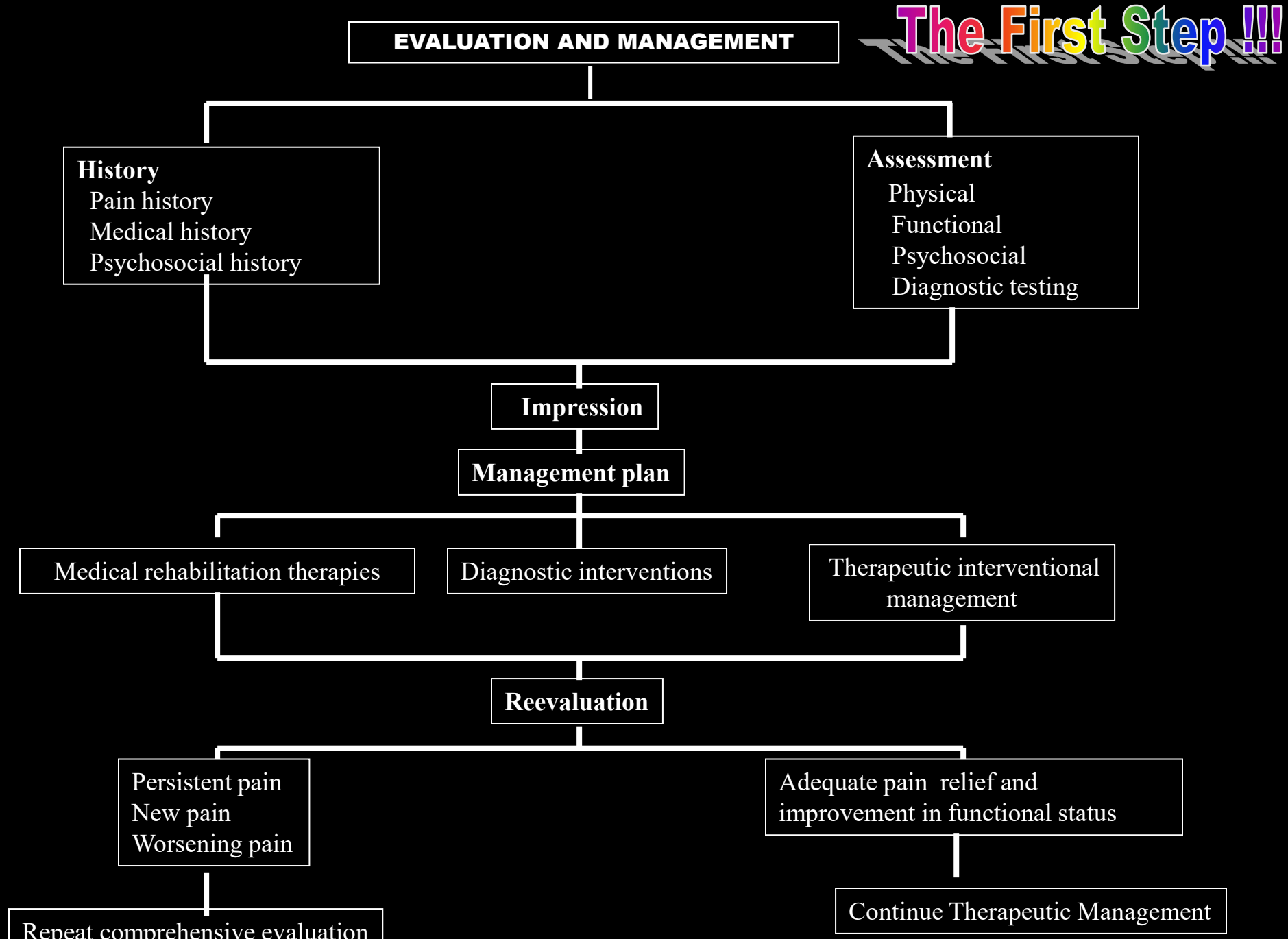


# An Algorithmic Approach To Keeping It Simple, Safe, and Successful


Success consists of going from failure to failure without loss of enthusiasm.
Winston Churchill
BrainyQuote

# What is an Algorithmic Approach?

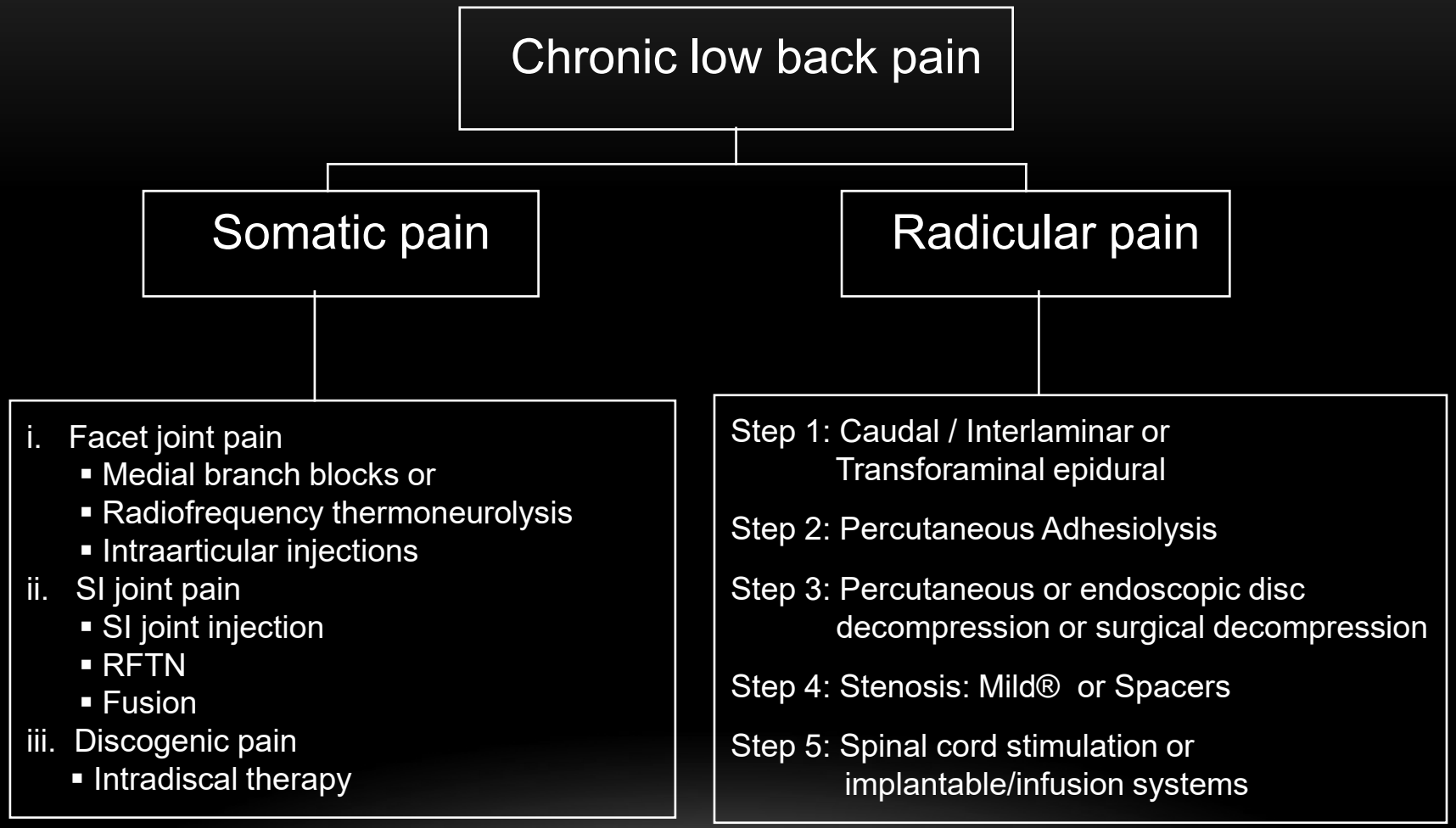
- A step-by-step approach
  - Methodic implementation of LCDs, Guidelines, and Evidence -Based Practices
- Is designed to promote the efficient use of evaluation and management services, and interventional pain management techniques based on the LCDs, Guidelines, and Evidence -Based Practices
  - This may not be applicable for each and every patient.
- Benefits:
  - Avoid unnecessary care.
  - Avoid poor documentation practices.
  - Increase compliance & avoid Fraud & Abuse.
- Ultimately designed to assist to follow and comply with Standard of Care




**Algorithmic Approach: Comprehensive Algorithm**

# An Algorithmic Approach:

## Low Back Pain Therapeutic Interventional Techniques






Manchikanti et al , Pain Physician 2021

# LCD - Epidural Steroid Injections for Pain Management

| State name | Effective Date (For services performed on or after) |
|---|---|
| **CGS Administrators, LLC**<br>Kentucky, Ohio | 12/05/2021 |
| First Coast Service Options, Inc<br>Florida | 12/12/2021 |
| National Government Services, Inc.<br>Connecticut, Illinois, Maine, Massachusetts, Minnesota, New Hampshire, New York, Rhode Island, Vermont, Wisconsin | 12/05/2021 |
| Noridian Healthcare Solutions, LLC<br>Alaska, Arizona, California, Idaho, Montana, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming | **Comment Period End Date**<br>03/26/2022 |
| Palmetto GBA<br>Alabama, Georgia, North Carolina, South Carolina, Tennessee, Virginia, West Virginia | 12/05/2021 |
| Novitas Solutions, Inc.<br>Arkansas, Colorado, Delaware, District of Columbia, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania, Texas | 12/12/2021 |
| **Wisconsin Physicians Service Insurance Corporation**<br>Indiana, Iowa, Kansas, Michigan. Missouri, Nebraska | 12/05/2021 |

# An Algorithmic Approach to Epidural Steroid Injections

## Indications

1. Radiculopathy or Radicular pain and/or neurogenic claudication (Except WPS?)
2. Pain duration of 4 weeks and failed 4 weeks of conservative management
3. Effectiveness: Three months of pain relief >= 50% relief, in conjunction with conservative management
4. Pain scale **OR** functional assessment

## Limitations

1. Steroids Dosage limits (Triamcinolone 80 mg – Betamethasone 12 mg , dexamethasone 15 mg) – No Methyl Prednisone. Steroids almost mandatory unless allergy or contraindication.
2. CT or Fluoro – except contrast allergy or pregnancy where ultrasound guidance without contrast may be considered
3. Imaging – Minimum of 2 views (Final needle position and contrast flow should be retained)
4. Only mild sedation

## Utilization

1. No multiple procedures
2. Two unilateral or bilateral for transforaminal. Maximum 4 per year per region.
3. Document medical necessity
4. Limited ICD-10 codes

# Covered Indications - I

1. **EPIDURAL** steroid injection (ESI) will be considered medically reasonable and necessary when the following three (3) requirements are met:

- History, physical examination, and concordant radiological image-based diagnostic testing supporting one of the following[5]:
  - Lumbar, cervical or thoracic radiculopathy, radicular pain and/or neurogenic claudication due to disc herniation, osteophyte or osteophyte complexes, severe degenerative disc disease, producing foraminal or central spinal stenosis[5]; **OR**
  - Post-laminectomy syndrome[6-8]; **OR**
  - Acute herpes zoster associated pain[6]

**AND**

- Radiculopathy, radicular pain and/or neurogenic claudication is severe enough to greatly impact quality of life or function. An objective pain scale or functional assessment must be performed at baseline (prior to interventions). The same scale* must be repeated at each follow-up for assessment of response.

**AND**

- Pain duration of at least four (4) weeks, and the inability to tolerate noninvasive conservative care or medical documentation of failure to respond to four (4) weeks of noninvasive conservative care **or** acute herpes zoster refractory to conservative management where a four (4) week wait is not required.[9]

Covered Indications – Continued …

# Covered Indications - II

2. The ESIs must be performed under CT or fluoroscopy image guidance with contrast.[10] unless the patient has a documented contrast allergy or pregnancy where ultrasound guidance without contrast may be considered.

3. Transforaminal **EPIDURAL** steroid injections (TFESIs) involving a maximum of two (2) levels in one spinal region are considered medically reasonable and necessary. It is important to recognize that most conditions would not ordinarily require ESI at two (2) levels in one spinal region. [11]

Covered Indications – Continued …

# Covered Indications - III

6. Repeat ESI when the first injection directly and significantly provided improvement of the condition being treated may be considered medically reasonable and necessary when the medical record documents at least 50% of sustained improvement in pain relief and/or improvement in function measured from baseline using SAME scale* for at least three months,[7,8]

<u>If a patient fails to respond well to the initial ESI, a repeat ESI after 14 days can be performed, using a different approach, level and/or medication if appropriate, with the rationale and medical necessity for the second ESI documented in the medical record.</u>

*Note: **The scales used to measure of pain and/or disability must be documented in the medical record.** Acceptable scales include but are not limited to: verbal rating scales, Numerical Rating Scale (NRS) and Visual Analog Scale (VAS) for pain assessment, and Pain Disability Assessment Scale (PDAS), Oswestry Disability Index (ODI), Oswestry Low Back Pain Disability Questionnaire (OSW), Quebec Back Pain Disability Scale (QUE), Roland Morris Pain Scale, Back Pain Functional Scale (BPFS), and the PROMIS profile domains to assess function.

# Covered Indications - IV

7. An initial injection of contrast is required to confirm **EPIDURAL** placement, unless the patient has a contraindication to contrast. The subsequent **EPIDURAL** steroid injections should include corticosteroids and may be combined with anesthetics or saline.

8. The ESIs should be performed in conjunction with conservative treatments.[9]

9. Patient's should be part of an active rehabilitation program, home exercise program or functional restoration program.[10,12]

# Limitations - I

3. It is not considered medically reasonable and necessary to perform multiple blocks (ESI, sympathetic blocks, facet blocks, trigger point injections etc.) during the same session as ESIs, with the exception of a facet synovial cyst and ESI performed in the same session.

4. Use of Moderate or Deep Sedation, General Anesthesia, and Monitored Anesthesia Care (MAC) is usually unnecessary or rarely indicated for these procedures and therefore not considered medically reasonable and necessary.[16] Even in patients with a needle phobia and anxiety, typically oral anxiolytics suffice. In exceptional and unique cases, documentation must clearly establish the need for such sedation in the specific patient.

5. ESIs to treat non-specific low back pain (LBP), axial spine pain, complex regional pain syndrome, widespread diffuse pain, pain from neuropathy from other causes, cervicogenic headaches are considered investigational and therefore are not considered medically reasonable and necessary.[6,17,18]

Limitations– Continued …

RE: Two other questions on facet joint interventions

ML MEREDITH LOVELESS <MEREDITH.LOVELESS@cgsadmin.com>
To DRM
You forwarded this message on 3/14/2022 10:08 AM.

I answered the questions below in red and happy to address questions.
Meredith

1. Under limitations, #2 reads as follows:

**It means that general anesthesia, MAC and moderate-deep sedation are not allowed. Light sedation to relieve anxiety is allowed but should not be so deep as the alter patients awareness.**

2. Next questions is #4. This question relates to providing multiple blocks, e.g., epidural injections, sympathetic blocks, trigger point injections, etc.

Multiple blocks in the same session (day of service) are not allowed. This is based on session not regions. Exceptional circumstances must be documented in the medical record as they may require review on appeal. The exception is synovial cyst rupture where facet cyst rupture and epidural injection may be indicated in the same session.

# Limitations - II

6. ESIs are limited to a maximum of four (4) sessions per spinal region in a rolling twelve (12) month period.[7]

8. It is not considered medically reasonable and necessary to perform TFESIs at more than two (2) nerve root levels during the same session.

12. Steroid dosing should be the lowest effective amount, it is recommended not to exceed 80 mg of triamcinolone, 12 mg of betamethasone, 15 mg of dexamethasone per session.[16]

Limitations– Continued …

# Limitations - III

13. It generally would not be considered medically reasonable and necessary for treatment with ESI to extend beyond 12 months.[19,20] Frequent continuation of epidural steroid injections over 12 months may trigger a focused medical review. Use beyond twelve months requires the following:

    a) Pain is severe enough to cause a significant degree of functional disability or vocational disability.

    b) ESI provides at least 50% sustained improvement of pain and/or 50% objective improvement in function (using same scale as baseline).

    c) Rationale for the continuation of ESIs including but not limited to patient is high-risk surgical candidates, the patient does not desire surgery, recurrence of pain in the same location relieved with ESIs for at least three months

    d) The primary care provider **must be notified** regarding continuation of procedures and prolonged repeat steroid use.

# Coding Guidance - I

- When reporting CPT codes 64479 through 64484 for a unilateral procedure, use one line with one unit of service. For bilateral procedures regarding these same codes, use one line and append the modifier-50.
    - For services performed in the ASC, modifier -50 should not be utilized. Report the applicable procedure code on two separate lines, with one unit of service each and append the -RT and -LT modifiers to each line.
- It is not medically reasonable and necessary to perform caudal ESIs or interlaminar ESIs bilaterally, therefore CPT 62321 and 62323 are not bilateral procedures.

- **KX modifier requirements:**
    - A diagnostic selective nerve root block (DSNRB) is identically coded as an epidural Injection. Therefore, when performing a DSNRB.
    - The -KX modifier should be appended to the appropriate line to distinguish the procedure from an epidural injection.
    - Aberrant use of the -KX modifier may trigger focused medical review.

# LCD - Facet Joint Interventions for Pain Management

| State name | Effective Date (For services performed on or after) |
|---|---|
| **CGS Administrators, LLC**<br>Kentucky, Ohio | 5/2/2021 |
| **First Coast Service Options, Inc**<br>Florida | 4/25/2021 |
| **National Government Services, Inc.**<br>Connecticut, Illinois, Maine, Massachusetts, Minnesota, New Hampshire, New York, Rhode Island, Vermont, Wisconsin | 4/25/2021 |
| **Noridian Healthcare Solutions, LLC**<br>Alaska, Arizona, California, Idaho, Montana, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming | 4/25/2021 |
| **Palmetto GBA**<br>Alabama, Georgia, North Carolina, South Carolina, Tennessee, Virginia, West Virginia | 4/25/2021 |
| **Novitas Solutions, Inc.**<br>Arkansas, Colorado, Delaware, District of Columbia, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania, Texas | 4/25/2021 |
| **Wisconsin Physicians Service Insurance Corporation**<br>Indiana, Iowa, Kansas, Michigan. Missouri, Nebraska | 4/25/2021 |

# An Algorithmic Approach to Facet Joint Interventions

- Diagnostic blocks
  = 4 components
  - Axial pain > 5
  - 3 months duration
  - Failed with conservative methods
  - No untreated radiculopathy
- First block >= 80% relief

Mild sedation is permitted.

No opioids for Diagnostic Blocks.

Contraindicated in patients with anterior lumbar interbody fusion or ALIF

Negative → Stop Facet Joint Interventions

Positive ↓

- Second block >=80% relief

Negative (false positive) → Stop Facet Joint Interventions

Positive ↓

Radiofrequency or Therapeutic facet joint nerve blocks

- Bilateral at the same time
- No other procedures with facet joint interventions
- 3 months or 6 months relief

Diagnostic blocks must be repeated if there is not treatment performed in 2 years

# Coverage Indications - I

Facet Joint Interventions generally consist of four types of procedures: Intraarticular (IA) Facet Joint Injections, Medial Branch Blocks (MBB), Radiofrequency Ablations (RFA) and Facet cyst rupture/aspiration:

Facet Joint Interventions are considered medically reasonable and necessary for the diagnosis and treatment of chronic pain in patients who meet **ALL** the following criteria:

1. Moderate to severe chronic neck or low back pain, predominantly axial, that causes functional deficit measured on pain or disability scale*
2. Pain present for minimum of 3 months with documented failure to respond to noninvasive conservative management (as tolerated)
3. Absence of untreated radiculopathy or neurogenic claudication (except for radiculopathy caused by facet joint synovial cyst)
4. There is no non-facet pathology per clinical assessment or radiology studies that could explain the source of the patient's pain, including but not limited to fracture, tumor, infection, or significant deformity.

*Pain assessment must be performed and documented at baseline, after each diagnostic procedure using the **same** pain scale for each assessment. A disability scale must also be obtained at baseline to be used for functional assessment (if patient qualifies for treatment).

# Coverage Indications - II

## A. Diagnostic Facet Joint Procedures (IA or MBB):

- The primary indication of a diagnostic facet joint procedure is to diagnose whether the patient has facet syndrome.
  - Intraarticular (IA) facet block(s) are considered reasonable and necessary as a diagnostic test only if medial branch blocks (MMB) cannot be performed due to specific documented anatomic restrictions or there is an indication to proceed with therapeutic intraarticular injections.
  - These restrictions must be clearly documented in the medical record and made available upon request.

# Coverage Indications - III

**A. Diagnostic Facet Joint Procedures (IA or MBB):**

- Diagnostic procedures should be performed with the intent that if successful, radiofrequency ablation (RFA) procedure would be considered the primary treatment goal at the diagnosed level(s).
- A second diagnostic facet procedure is considered medically necessary to confirm validity of the initial diagnostic facet procedure when administered at the same level.
  - The second diagnostic procedure may only be performed a minimum of 2 weeks after the initial diagnostic procedure.
  - Clinical circumstances that necessitate an exception to the two-week duration may be considered on an individual basis and must be clearly documented in the medical record.

# Coverage Indications - IV

**For the first diagnostic facet joint procedure:**

a. For the first diagnostic facet joint procedure to be considered medically reasonable and necessary, the patient must meet the criteria outlined under indications for facet joint interventions.

b. A second confirmatory diagnostic facet joint procedure is considered medically reasonable and necessary in patients who meet **ALL** the following criteria:

   i. The patient meets the criteria for the first diagnostic procedure; **AND**

   ii. After the first diagnostic facet joint procedure, there must be a consistent positive response of at least 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used)

**Frequency limitation**: For each covered spinal region no more than four (4) diagnostic joint sessions will be reimbursed per rolling 12 months, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure.

# Coverage Indications - V

## B. Therapeutic Facet Joint Procedures (IA):

Therapeutic facet joint procedures are considered medically reasonable and necessary for patients who meet **ALL** the following criteria:

a. The patient has had two (2) medically reasonable and necessary diagnostic facet joint procedures with each one providing a consistent minimum of 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used); **AND**

b. Subsequent therapeutic facet joint procedures at the same anatomic site results in at least consistent 50% pain relief for at least three (3) months from the prior therapeutic procedure **or** at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale; **AND**

c. Documentation of why the patient is not a candidate for radiofrequency ablation (such as established spinal pseudarthrosis, implanted electrical device)

**Frequency Limitations**: For each covered spinal region no more than four (4) therapeutic facet joint (IA) sessions will be reimbursed per rolling 12 months.

# Coverage Indications - VI

## C. Facet Joint Denervation:

The thermal radiofrequency destruction of cervical, thoracic, or lumbar paravertebral facet joint (medial branch) nerves are considered medically reasonable and necessary for patients who meet **ALL** the following criteria:

a. Initial thermal RFA:

i. After the patient has had at least two (2) medically reasonable and necessary diagnostic MBBs, with each one providing a consistent minimum of 80% sustained relief of primary (index) pain (with the duration of relief being consistent with the agent used) **AND**

ii. Repeat thermal facet joint RFA at the same anatomic site is considered medically reasonable and necessary provided the patient had a minimum of consistent 50% improvement in pain for at least six (6) months **or** at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale;

**Frequency Limitation**: For each covered spinal region no more than two (2) radiofrequency sessions will be reimbursed per rolling 12 months.

# Coverage Indications - VII

**D. Facet Cyst Aspiration/Rupture**

Intra-articular facet joint injection performed with synovial cyst aspiration is considered medically necessary when both of the following criteria are met:

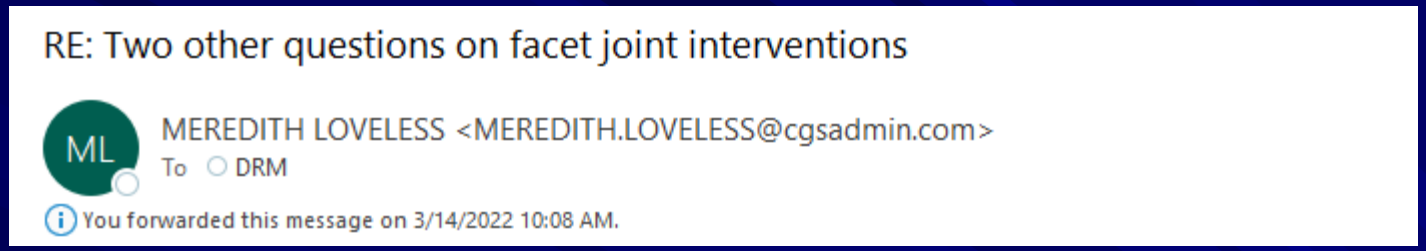
1. Advanced diagnostic imaging study (e.g. MRI/CT/myelogram) confirm compression or displacement of the corresponding nerve root by a facet joint synovial cyst; **AND**
2. Clinical and physical symptoms related to synovial facet cyst are documented

**Frequency Limitation:** Cyst aspiration/rupture may be repeated **once** and only if there is 50% or more consistent improvement in pain for at least three (3) months.

# Limitations - I

1. Facet joint interventions done without CT or fluoroscopic guidance are considered not reasonable and necessary. This includes facet joint interventions done without any guidance, performed under ultrasound guidance, or with magnetic resonance imaging (MRI).
2. General anesthesia is considered not reasonable and necessary for facet joint interventions. Neither conscious sedation nor monitored anesthesia care (MAC) is routinely necessary for intraarticular facet joint injections or medial branch blocks and are not routinely reimbursable. Individual consideration may be given on redetermination (appeal) for payment in rare, unique circumstances if the medical necessity of sedation is unequivocal and clearly documented in the medical record. Frequent reporting of these services together may trigger focused medical review.
3. It is not expected that patients will routinely present with pain in both cervical/thoracic and lumbar spinal regions. Therefore, facet joint interventions (both diagnostic and therapeutic) are limited to one spinal region per session.

Limitations – Continued …




I answered the questions below in red and happy to address questions.
Meredith

1. Under limitations, #2 reads as follows:

**It means that general anesthesia, MAC and moderate-deep sedation are not allowed. Light sedation to relieve anxiety is allowed but should not be so deep as the alter patients awareness.**

2. Next questions is #4. This question relates to providing multiple blocks, e.g., epidural injections, sympathetic blocks, trigger point injections, etc.

Multiple blocks in the same session (day of service) are not allowed. This is based on session not regions. Exceptional circumstances must be documented in the medical record as they may require review on appeal. The exception is synovial cyst rupture where facet cyst rupture and epidural injection may be indicated in the same session.

**From:** Medical Affairs <MedicalAffairs@guidewellsource.com>
**Sent:** Friday, January 14, 2022 1:22 PM
**To:** Laxmaiah Manchikanti, MD <drcm@asipp.org>
**Subject:** JH-C-OY02-0114-201 Questions regarding sedation and definition of facet joint injections or medial branch blocks to include radiofrequency neurotomy

Dr. Manchikanti

We have discussed and agree with Novitas's response below and our initial response to this question remains unchanged. We concur sedation is not restricted for RFA. If you have any further questions to let us know.

Cordially,

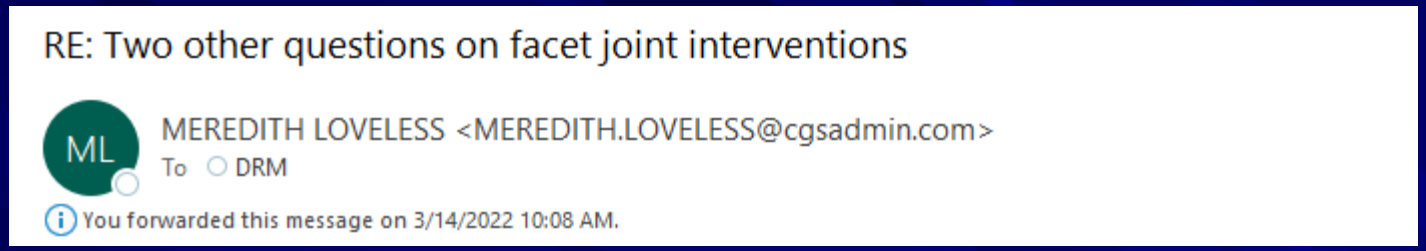
*Patricia (Patti) Reidenbach*
CMD Research Analyst, Medical Affairs
Novitas Solutions, Inc.
Website: www.novitas-solutions.com

# Limitations - II

4. It is not routinely necessary for multiple blocks (e.g., epidural injections, sympathetic blocks, trigger point injections, etc.) to be provided to a patient on the same day as facet joint procedures. Multiple blocks on the same day could lead to improper or lack of diagnosis. If performed, the medical necessity of each injection (at the same or a different level[s]) must be clearly documented in the medical record. For example, the performance of both paravertebral facet joint procedures(s) and a transforaminal epidural injection (TFESI) at the same or close spinal level at the same encounter would not be expected unless a synovial cyst is compressing the nerve root. In this situation, TFESI may provide relief for the radicular pain, while the facet cyst rupture allows nerve root decompression. **Frequent reporting of multiple blocks on the same day may trigger a focused medical review.**

6. One to two levels, either unilateral or bilateral, are allowed per session per spine region. The need for a three or four-level procedure bilaterally may be considered under unique circumstances and with sufficient documentation of medical necessity on appeal. A session is a time period, which includes all procedures (i.e., medial branch block (MBB), intraarticular injections (IA), facet cyst ruptures, and RFA ablations that are performed during the same day.
7. If there is an extended time, two years or more, since the last RFA and/or there is a question as to the source of the recurrent pain then diagnostic procedures must be repeated.

**Limitations – Continued …**

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Multiple blocks in the same session (day of service) are not allowed. This is based on session not regions. Exceptional circumstances must be documented in the medical record as they may require review on appeal. The exception is synovial cyst rupture where facet cyst rupture and epidural injection may be indicated in the same session.

# Limitations – III

8. **Therapeutic intraarticular facet injections are not covered unless there is justification in the medical documentation on why RFA cannot be performed**. Facet joint procedures in patients for the indication of generalized pain conditions (such as fibromyalgia) or chronic centralized pain syndromes are considered not reasonable and necessary. Individual consideration may be considered under unique circumstances and with sufficient documentation of medical necessity on appeal.
9. In patients with implanted electrical devices, providers must follow manufacturer instructions and extra planning as indicated to ensure safety of procedure.

| | | |
|---|---|---|
| 3 | **Diagnostic facet joint procedures: (IA or MBB)** - The second sentence under this section is as follows:<br><br>Diagnostic procedures should be performed with the intent that if successful, radiofrequency ablation procedure would be considered the primary treatment goal at the diagnosed level(s).<br><br>**ASIPP**- The commenter state that the decision between therapeutic blocks and radiofrequency ablation should be based on patient choice and medical condition with shared decision making. They state there is extensive evidence supporting therapeutic facet joint nerve blocks, both MBB and IA. they recommend changing the language to allow treatment with either therapeutic blocks or radiofrequency ablation.<br><br>They state based on the evidence, therapeutic facet joint procedures, both intraarticular injections and medial branch blocks are effective. With emerging evidence without overwhelming negative evidence, we believe that it would be inappropriate to issue a noncoverage policy for one or both procedures. This comment also discusses cost of the procedures. | The controversy is evident among the subject matter experts. In the contract advisory committee meeting, the experts were divided on this topic. While most experts did not support the routine use of therapeutic injections, it was clear the experts felt there is a clinically significant role in select patients. Based upon this feedback and emerging evidence without overwhelming negative evidence, we ensured access to care by allowing therapeutic injections for this population, allowing the provider to make that judgment if they can provide a rationale for their decision.<br><br>In terms of documentation of why a patient is not a candidate for RFA, it must be determined by the provider and patient. There are examples in the LCD, but this is not an inclusive or restrictive list. In all cases, we require documentation to explain the rationale for proceeding with therapeutic injections, which would be a standard part of shared decision-making discussions and expected in medical documentation. |

# Medical Necessity

The following are considered **not reasonable and necessary and therefore will be denied**:

1. Intraarticular and extraarticular facet joint prolotherapy
2. Non-thermal modalities for facet joint denervation including chemical, low-grade thermal energy (less than 80 degrees Celsius), laser neurolysis, and cryoablation.
3. Intra-facet implants
4. Facet joint procedure performed after anterior lumbar interbody fusion or ALIF.
5. Definitive clinical and/or imaging findings pointing to a specific diagnosis other than facet joint syndrome
6. Diagnostic injections or MMB at the same level as the previously successful RFA procedure

# Documentation, Coding and Compliance

# Epidural Steroid Injections
# Documentation Requirements - I

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.

2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.

3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.

# Epidural Steroid Injections
# Documentation Requirements - II

4. The procedural report should clearly document the indications and medical necessity for the blocks along with the pre and post percent (%) pain relief achieved immediately post-injection.
5. Films that adequately document (minimum of 2 views) final needle position and contrast flow should be retained and made available upon request.
6. The patient's medical record should include, but is not limited to:
    - The assessment of the patient by the performing provider as it relates to the complaint of the patient for that visit
    - Relevant medical history
    - Results of pertinent tests/procedures
    - Signed and dated office visit record/operative report (Please note that all services ordered or rendered to Medicare beneficiaries must be signed.)
    - Documentation to support the medical necessity of the procedure(s).

**8. Pain Status (Mandatory to complete specific regions or all if same):**

1 ☐ _____ Relief for _____

2 ☐ _____ Relief for _____

3 ☐ _____ Relief for _____

4 ☐ _____ Relief for _____

5 ☐ _____ Relief for _____

**9. Numeric Pain Scores**

| | Baseline | Average | Today's |
|---|---|---|---|
| *Example* | *9 or 8 or 7* | *7 or 6 or 5 or 4 or 3 or 2* | *2 or 3 or 4 or 5 or 6* |
| Cervical | | | |
| Lumbar | | | |
| Thoracic | | | |
| | | | |
| | | | |
| | | | |

Preop Pain score: same as above in today's score

Post of pain score –

Document - Differentiate needle insertion pain vs radicular pain

# Epidural Steroid Injections
# ICD-10-CM Codes that Support Medical Necessity

| Code | Description |
|---|---|
| M54.12 | Radiculopathy, cervical region |
| M54.13 | Radiculopathy, cervicothoracic region |
| M54.14 | Radiculopathy, thoracic region |
| M54.15 | Radiculopathy, thoracolumbar region |
| M54.16 | Radiculopathy, lumbar region |
| M54.17 | Radiculopathy, lumbosacral region |
| M54.18 | Radiculopathy, sacral and sacrococcygeal region |
| M96.1 | Postlaminectomy syndrome, not elsewhere classified |
| M99.21 | Subluxation stenosis of neural canal of cervical region |
| M99.22 | Subluxation stenosis of neural canal of thoracic region |
| M99.23 | Subluxation stenosis of neural canal of lumbar region |
| M99.31 | Osseous stenosis of neural canal of cervical region |
| M99.32 | Osseous stenosis of neural canal of thoracic region |
| M99.33 | Osseous stenosis of neural canal of lumbar region |
| M99.41 | Connective tissue stenosis of neural canal of cervical region |
| M99.42 | Connective tissue stenosis of neural canal of thoracic region |
| M99.43 | Connective tissue stenosis of neural canal of lumbar region |
| M99.51 | Intervertebral disc stenosis of neural canal of cervical region |
| M99.52 | Intervertebral disc stenosis of neural canal of thoracic region |
| M99.53 | Intervertebral disc stenosis of neural canal of lumbar region |
| M99.61 | Osseous and subluxation stenosis of intervertebral foramina of cervical region |
| M99.62 | Osseous and subluxation stenosis of intervertebral foramina of thoracic region |
| M99.63 | Osseous and subluxation stenosis of intervertebral foramina of lumbar region |
| M99.71 | Connective tissue and disc stenosis of intervertebral foramina of cervical region |
| M99.72 | Connective tissue and disc stenosis of intervertebral foramina of thoracic region |
| M99.73 | Connective tissue and disc stenosis of intervertebral foramina of lumbar region |

# Epidural Steroid Injections

## ICD-10-CM Codes that Support Medical Necessity

**Group 1**

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

The following ICD-10 codes support medical necessity and provide coverage for **CPT codes 62321, 62323, 64479, 64480, 64483, and 64484:**

| Code | Description |
|---|---|
| B02.23 | Postherpetic polyneuropathy |
| B02.7 | Disseminated zoster |
| B02.8 | Zoster with other complications |
| B02.9 | Zoster without complications |
| G89.3 | Neoplasm related pain (acute) (chronic) |
| M47.22 | Other spondylosis with radiculopathy, cervical region |
| M47.23 | Other spondylosis with radiculopathy, cervicothoracic region |
| M47.24 | Other spondylosis with radiculopathy, thoracic region |
| M47.25 | Other spondylosis with radiculopathy, thoracolumbar region |
| M47.26 | Other spondylosis with radiculopathy, lumbar region |
| M47.27 | Other spondylosis with radiculopathy, lumbosacral region |
| M48.061 | Spinal stenosis, lumbar region without neurogenic claudication |
| M48.062 | Spinal stenosis, lumbar region with neurogenic claudication |
| M50.121 | Cervical disc disorder at C4-C5 level with radiculopathy |
| M50.122 | Cervical disc disorder at C5-C6 level with radiculopathy |
| M50.123 | Cervical disc disorder at C6-C7 level with radiculopathy |
| M50.13 | Cervical disc disorder with radiculopathy, cervicothoracic region |
| M51.14 | Intervertebral disc disorders with radiculopathy, thoracic region |
| M51.15 | Intervertebral disc disorders with radiculopathy, thoracolumbar region |
| M51.16 | Intervertebral disc disorders with radiculopathy, lumbar region |
| M51.17 | Intervertebral disc disorders with radiculopathy, lumbosacral region |

# Facet Joint Interventions Coding Information

## CPT/HCPCS Codes

### Group 1 Codes

| Code | Description |
|---|---|
| 64490 | Inj paravert f jnt c/t 1 lev |
| 64491 | Inj paravert f jnt c/t 2 lev |
| 64493 | Inj paravert f jnt l/s 1 lev |
| 64494 | Inj paravert f jnt l/s 2 lev |
| 64633 | Destroy cerv/thor facet jnt |
| 64634 | Destroy c/th facet jnt addl |
| 64635 | Destroy lumb/sac facet jnt |
| 64636 | Destroy l/s facet jnt addl |

*Group 2*

**The following CPT/HCPCS codes are non-covered*:**

* this is not an inclusive list of non-covered codes

*Note: 64492 or 64495 describes a third and additional levels and should be listed separately in addition to the code for the primary procedure and the second level procedure and cannot be reported more than once per day. 64492 should be reported in conjunction with 64490/64491 and 64495 should be reported in conjunction with 64493/64494. Codes 64492 and 64495 will only be covered upon appeal if sufficient documentation of medical necessity is present.

### Group 2 Codes

| Code | Description |
|---|---|
| 64492 | Inj paravert f jnt c/t 3 lev |
| 64495 | Inj paravert f jnt l/s 3 lev |
| 0213T | Njx paravert w/us cer/thor |
| 0214T | Njx paravert w/us cer/thor |
| 0215T | Njx paravert w/us cer/thor |
| 0216T | Njx paravert w/us lumb/sac |
| 0217T | Njx paravert w/us lumb/sac |
| 0218T | Njx paravert w/us lumb/sac |
| 0219T | Plmt post facet implt cerv |
| 0220T | Plmt post facet implt thor |
| 0221T | Plmt post facet implt lumb |
| 0222T | Plmt post facet implt addl |

# Facet Joint Interventions
# CPT/HCPCS Modifiers

| Code | Description |
|---|---|
| **50** | BILATERAL PROCEDURE: UNLESS OTHERWISE IDENTIFIED IN THE LISTINGS, BILATERAL PROCEDURES THAT ARE PERFORMED AT THE SAME OPERATIVE SESSION SHOULD BE IDENTIFIED BY ADDING THE MODIFIER -50 TO THE APPROPRIATE FIVE DIGIT CODE OR BY USE OF THE SEPARATE FIVE DIGIT MODIFIER CODE 09950 |
| **KX** | REQUIREMENTS SPECIFIED IN THE MEDICAL POLICY HAVE BEEN MET |
| **LT** | LEFT SIDE (USED TO IDENTIFY PROCEDURES PERFORMED ON THE LEFT SIDE OF THE BODY) |
| **RT** | RIGHT SIDE (USED TO IDENTIFY PROCEDURES PERFORMED ON THE RIGHT SIDE OF THE BODY) |

# Facet Joint Interventions

# ICD-10-CM Codes that Support Medical Necessity

***Group 1***

**Note:** It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

Medicare is establishing the following limited coverage for CPT/HCPCS codes: **64490, 64491, 64493, 64494, 64633, 64634, 64635, and 64636.**

**Note:** ICD-10 Codes M71.30 or M71.38 are allowed for facet cyst rupture procedures only.

| Code | Description |
|---|---|
| **M47.812** | Spondylosis without myelopathy or radiculopathy, cervical region |
| **M47.813** | Spondylosis without myelopathy or radiculopathy, cervicothoracic region |
| **M47.814** | Spondylosis without myelopathy or radiculopathy, thoracic region |
| **M47.815** | Spondylosis without myelopathy or radiculopathy, thoracolumbar region |
| **M47.816** | Spondylosis without myelopathy or radiculopathy, lumbar region |
| **M47.817** | Spondylosis without myelopathy or radiculopathy, lumbosacral region |
| **M47.892** | Other spondylosis, cervical region |
| **M47.893** | Other spondylosis, cervicothoracic region |
| **M47.894** | Other spondylosis, thoracic region |
| **M47.895** | Other spondylosis, thoracolumbar region |
| **M47.896** | Other spondylosis, lumbar region |
| **M47.897** | Other spondylosis, lumbosacral region |
| **M48.12** | Ankylosing hyperostosis [Forestier], cervical region |
| **M48.13** | Ankylosing hyperostosis [Forestier], cervicothoracic region |
| **M48.14** | Ankylosing hyperostosis [Forestier], thoracic region |
| **M48.15** | Ankylosing hyperostosis [Forestier], thoracolumbar region |
| **M48.16** | Ankylosing hyperostosis [Forestier], lumbar region |
| **M48.17** | Ankylosing hyperostosis [Forestier], lumbosacral region |
| **M71.30** | Other bursal cyst, unspecified site |
| **M71.38** | Other bursal cyst, other site |

# Epidural & Facet policies

- Similarities
  - Only mild sedation
  - No multiple procedures
  - RFT – Monitored Anesthesia Care  or Sedation permitted
- Differences
  - Duration of pain
    - Facets – 3 months
    - Epidural – 4 weeks
  - Severity of disability
    - Facets – pain causes functional disability
    - Epidural – Severe enough to greatly impact quality of life or function

Oswestry Disability Index (ODI)

Neck Disability Index (NDI)

## Interpretation of scores

| | |
|---|---|
| **0% to 20%: minimal disability**: | The patient can cope with most living activities. Usually no treatment is indicated apart from advice on lifting sitting and exercise. |
| **21%-40%: moderate disability**: | The patient experiences more pain and difficulty with sitting, lifting and standing. Travel and social life are more difficult and they may be disabled from work. Personal care, sexual activity and sleeping are not grossly affected and the patient can usually be managed by conservative means. |
| **41%-60%: severe disability**: | Pain remains the main problem in this group but activities of daily living are affected. These patients require a detailed investigation. |
| **61%-80%: crippled**: | Back pain impinges on all aspects of the patient's life. Positive intervention is required. |
| **81%-100%:** | These patients are either bed-bound or exaggerating their symptoms. |

# Documentation Requirements

4B. **Why RFT cannot be performed:** ☐ **Lumbar** ☐ **Thoracic** ☐ **Cervical**

☐ Pacemaker ☐ Defibrillator ☐ Implant ☐ Anterior lumbar interbody fusion

☐ Pseudoarthrosis ☐ Previous surgery with fusion ☐ Obesity ☐ Morbid obesity

☐ Unable to stop anticoagulation or Antithrombotic medicines

☐ Difficulty with positioning in prone position ☐ Medical condition

☐ Lack of response to radiofrequency in the past ☐ Anxiety about the procedure

☐ Side effects with radiofrequency in the past with irritation, swelling, burning, increasing pain

☐ Transportation issues ☐ Financial hardship ☐ Patient's refusal to consent

_____

_____

4C. **Indications for multiple procedures on same day**:

☐ Financial issues ☐ Health Coverage ☐ Transportation ☐ Medical condition

☐ Anxiety about the repeated procedures ☐ Stopping Antithrombotic or Anticoagulant therapy repeatedly

In terms of documentation of why a patient is not a candidate for RFA, it must be determined by the provider and patient. There are examples in the LCD, but this is not an inclusive or restrictive list. In all cases, we require documentation to explain the rationale for proceeding with therapeutic injections, which would be a standard part of shared decision-making discussions and expected in medical documentation.

## B. Therapeutic facet joint Procedures (IA):

Therapeutic facet joint procedures are considered medically reasonable and necessary for patients who meet **ALL** the following criteria:

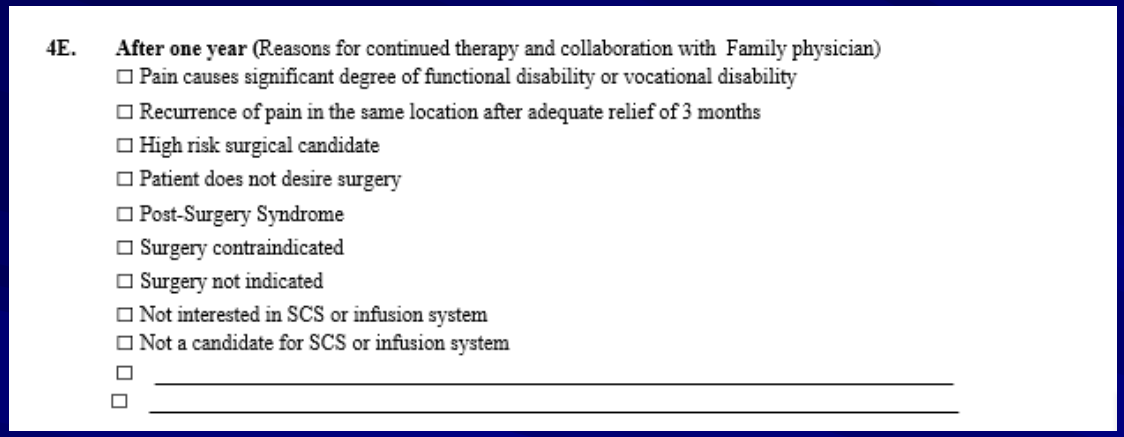
a. The patient has had two (2) medically reasonable and necessary diagnostic facet joint procedures with each one providing a consistent minimum of 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used); **AND**

b. Subsequent therapeutic facet joint procedures at the same anatomic site results in at least consistent 50% pain relief for at least three (3) months from the prior therapeutic procedure **or** at least 50% consistent improvement i the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale; **AND**

c. Documentation of why the patient is not a candidate for radiofrequency ablation (such as established spinal pseudarthrosis, implanted electrical device)

Frequency Limitations: For each covered spinal region no more than four (4) therapeutic facet joint (IA) sessions will be reimbursed per rolling 12 months.

# Documentation Requirements



**4E.** **After one year** (Reasons for continued therapy and collaboration with Family physician)

- ☐ Pain causes significant degree of functional disability or vocational disability
- ☐ Recurrence of pain in the same location after adequate relief of 3 months
- ☐ High risk surgical candidate
- ☐ Patient does not desire surgery
- ☐ Post-Surgery Syndrome
- ☐ Surgery contraindicated
- ☐ Surgery not indicated
- ☐ Not interested in SCS or infusion system
- ☐ Not a candidate for SCS or infusion system
- ☐ _____
- ☐ _____

A letter was sent to the referring physician indicating reasons for continued therapy due to: Pain causes significant degree of functional disability or vocational disability, recurrence of pain in the same location after adequate relief for 3 months, She does not desire surgery. We have not used steroids.

# Evaluation and Management Services

# E/M Medical Necessity

CMS IOM Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1, *Selection of Level of Evaluation and Management Service*

- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.
- The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.
- The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

# 2021 E/M Revisions Summary: Office or Other Outpatient Services

Eliminate history and physical as elements for code selection

Allow physicians to choose whether documentation is based upon Medical Decision Making (MDM) or Total Time

Modifications to the criteria for MDM

Deletion of CPT code 99201

Creation of a shorter prolonged services code

# 2021 E/M Comparisons

| Component(s) for Code Selection | Office or Other Outpatient Services | Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home) |
|---|---|---|
| **History and Examination** | • As medically appropriate. Not used in code selection | • Use Key Components (History, Examination, MDM) |
| **Medical Decision Making (MDM)** | • May use MDM or total time on the date of the encounter | • Use Key Component (History, Examination, MDM) |
| **Time** | • May use MDM or total time on the date of the encounter | • May use face-to-face or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates.<br>*Time is **not** a descriptive component for E/M levels of emergency department service* |
| **MDM Elements** | • Number and complexity of problems addressed at the encounter<br>• Amount and/or complexity of data to be reviewed and analyzed<br>• Risk of complications and/or morbidity or mortality of patient management | • Number of diagnoses or management options<br>• Amount and/or complexity of data to be reviewed<br>• Risk of complications and/or morbidity or mortality |

# Selecting a Level of Service

Effective January 1, 2021, the appropriate level of service for Office or Other Outpatient E/M Service is based on the following:

- The level of the MDM as defined for each service

**OR**

- The total time on the date of the encounter

# Medical Decision Making

Office or other outpatient services include a medically appropriate history and/or physical examination, when performed.

The extent of history and physical examination is not an element in selection of office or other outpatient services.

One element in the level of code selection for an office or other outpatient service is the number and complexity of the problems that are addressed at an encounter.

- Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition.
  - Low back and leg pain
  - Neck pain with headache and arm pain

# Medical Decision Making

| Office and Other Outpatient E/M Services 2021 |
| --- |
| • Number and Complexity of Problems **Addressed** at the Encounter |
| • Amount and/or Complexity of Data to be **Reviewed and Analyzed** |
| • Risk of Complications and/or Morbidity or Mortality of **Patient Management** |

# Problems Addressed

- Noting chronic conditions, that another specialist manages, in the patient's medical record does not alone qualify as being a problem addressed.

Reference: https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

# MDM Definition Examples

**Stable, Chronic Illness**

- Conditions are treated as chronic whether or not stage or severity changes
  - Controlled or uncontrolled pain condition
    - Chronic low back pain
    - Chronic neck pain
- Stable
  - Defined by the specific treatment goals for an individual patient.
    - Not at treatment goal is not stable, if the condition does not change
    - The risk of morbidity (return of pain and disfunction without treatment is crucial)

# MDM Definition Examples

**Acute, Uncomplicated Illness or Injury**

- A recent or new short-term problem with low risk of morbidity for which treatment is considered.
  - There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected.
  - A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness.
    - Examples may include:
    - Cervical, lumbar strain
    - Twisting of ankle

# Total Time

| Office and Outpatient E/M Services 2021 |
| --- |
| • Used for code selection when using time |
| • Includes total time on the date of the encounter |
| • May be used to select a code level whether or not counseling and/or coordination of care dominates the service |
| • Includes physician/other qualified healthcare provider (QHP) face-to-face and non-face-to-face time |
| • Count only 1 person per minute when more than one clinician is addressed |

# Total Time: Physicians and QHP

Physician/other QHP time includes the following activities (when performed):

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not reported separately)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- Care coordination (not reported separately)

**DO NOT COUNT time spent on separately reported services**

# Risk

- its a major or minor risk and not a major or minor procedure?
  - The provider needs to assess and clearly document the patient's individual risk factors along with the procedure's risk factors to determine the overall risk.
  - The risk determination is also based upon the "usual behavior" of a physician or QHP within that specialty.

**Interventional Techniques**

**=**

**Modrerate Risk**

# Risk

- The AMA defines risk as:
  - The probability and/or consequences of an event.
  - The assessment of the level of risk is affected by the nature of the event under consideration.
  - The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.
    - A low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk.
  - For the purposes of medical decision making, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated.
  - Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

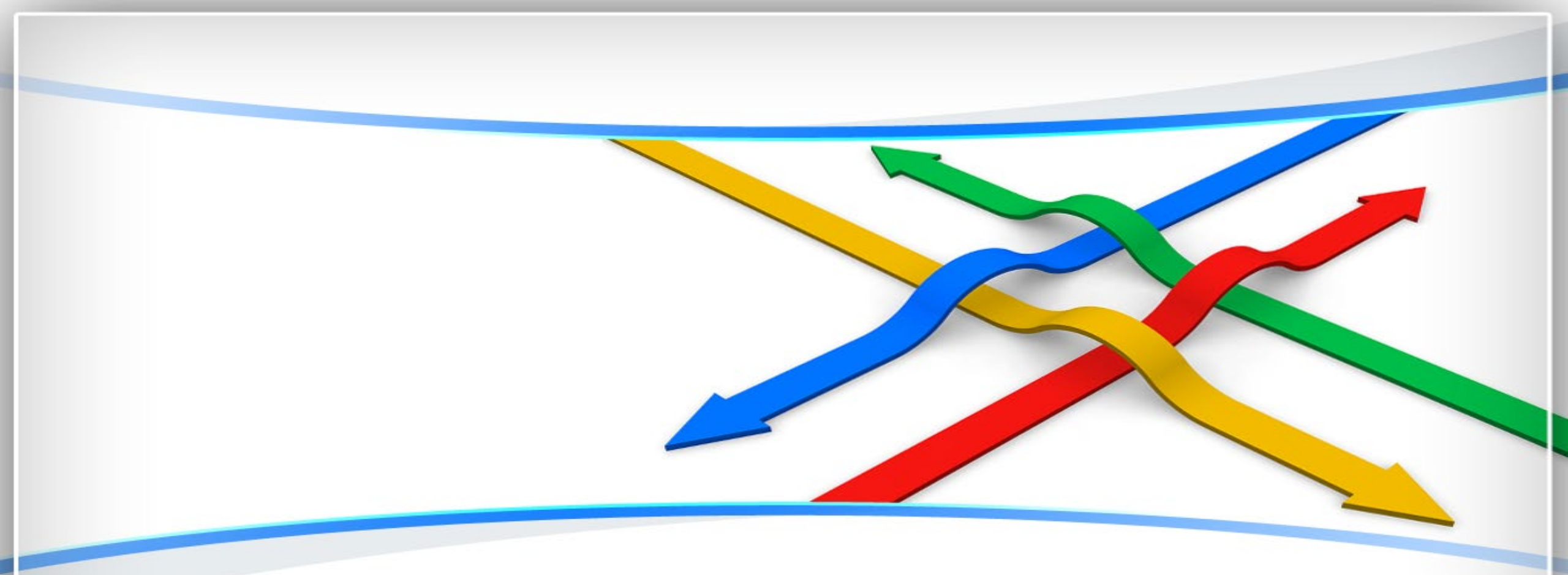
# MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

- Straightforward
  - Minimal risk from treatment (including no treatment) or testing. (Most would consider this effectively as no risk)
- Low
  - Low risk (ie, very low risk of anything bad), minimal consent/discussion
- Moderate
  - Would typically review with patient/surrogate, obtain consent and monitor, or there are complex social factors in management
- High
  - Need to discuss some pretty bad things that could happen for which physician or other qualified health care professional will watch or monitor

# Prescription Drug Management

Please clarify that Prescription Drug Management in the Moderate Row of the MDM chart does NOT include refills or continue current medication(s). It appears from the Q & A this would only include increasing or decreasing a medication or a new medication. Would you please clarify how a refill or continue current medication (without a refill being needed at that visit) would be considered by CGS?

- Only documenting 'reviewed' on the medication list does not support Prescription Drug Management.
- Prescription drug management includes a dosage increase or decrease (or the addition of a new medication) based upon clear documentation of a problem addressed and data reviewed for patient management.
- If the provider is addressing a problem that includes continuing a prescription drug (or refill) in their education and medical decision making to manage the diagnosis, then it may be included in Prescription Drug Management.
- The provider may also choose to use qualifying factors of Total Time when choosing the E/M level of service.



# An Algorithmic Approach To Keeping It Simple, Safe, and Successful

# Overview of Major E/M Revisions for 2021: Office or Other Outpatient Services Compared to Other E/M Codes

| Component(s) for Code Selection | Office or Other Outpatient Services | Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home) |
|---|---|---|
| **History and Examination** | • As medically appropriate. Not used in code selection | • Use Key Components (History, Examination, MDM) |
| **Medical Decision Making (MDM)** | • May use MDM or total time on the date of the encounter | • Use Key Component (History, Examination, MDM) |
| **Time** | • May use MDM or total time on the date of the encounter | • May use face-to-face or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates.<br><br>*Time is **not** a descriptive component for E/M levels of emergency department services* |
| **MDM Elements** | • Number and complexity of problems addressed at the encounter<br>• Amount and/or complexity of data to be reviewed and analyzed<br>• Risk of complications and/or morbidity or mortality of patient management | • Number of diagnoses or management options<br>• Amount and/or complexity of data to be reviewed<br>• Risk of complications and/or morbidity or mortality |

## The most significant changes include:

- MDM has always been part of the algorithm for choosing a level of service but will now be the sole determinant of level of service (unless the provider intends to bill based on time).

## MDM in 2021 will be based on:

- Number and complexity of problems addressed
  - Including status (*e.g.* uncomplicated, exacerbation) and timeline (*e.g.* acute, chronic)
- Amount and/or complexity of data reviewed and analyzed
  - This category attempts to quantify the amount of data, efforts to gather data, and communications utilized to evaluate a patient. Collection of more data leads to a higher level of MDM.
- Risk of complications and/or morbidity or mortality

| LEVEL OF RISK | PRESENTING PROBLEM(S) |
| --- | --- |
| **Moderate** | • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment<br>• Two or more stable chronic illnesses<br>  ○ Chronic low back pain<br>  ○ Chronic neck pain<br>  ○ Bilateral chronic knee pain<br>• Undiagnosed new problem with uncertain prognosis (for example, disc herniation) |

| LEVEL OF RISK | DIAGNOSTIC PROCEDURE(S) ORDERED |
| --- | --- |
| **Moderate** | • Physiologic tests under stress (for example, cardiac stress test, fetal contraction stress test)<br>• Diagnostic endoscopies with no identified risk factors<br>• Deep needle or incisional biopsy<br>• Cardiovascular imaging studies with contrast and no identified risk<br>• factors (for example, arteriogram, cardiac catheterization)<br>• Obtain fluid from body cavity (for example,<br>• lumbar puncture,<br>• thoracentesis, culdocentesis)<br><br>None for Pain management<br>? Diagnostic nerve blocks |

| LEVEL OF RISK | MANAGEMENT OPTIONS SELECTED |
| --- | --- |
| **Moderate** | • Minor surgery with identified risk factors and interventional techniques<br>• Prescription drug management<br>  ○ Opioids<br>  ○ NSAID's<br>  ○ Antiepileptic drugs (AEDs)<br>  ○ Benzodiazepines |

| LEVEL OF RISK | PRESENTING PROBLEM(S) | DIAGNOSTIC PROCEDURE(S) ORDERED | MANAGEMENT OPTIONS SELECTED |
|---|---|---|---|
| **High** | • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment<br>• Acute or chronic illnesses or injuries that pose a threat to life or bodily function (for example, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure)<br>• An abrupt change in neurologic status (for example, seizure, TIA, weakness, sensory loss) | • Cardiovascular imaging studies with contrast with identified risk factors<br>• Cardiac electrophysiological tests<br>• Diagnostic endoscopies with identified risk factors<br>• Discography | • Elective major surgery (open, percutaneous or endoscopic) with identified risk factors<br>• Emergency major surgery (open, percutaneous or endoscopic)<br>• Parenteral controlled substances<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis |

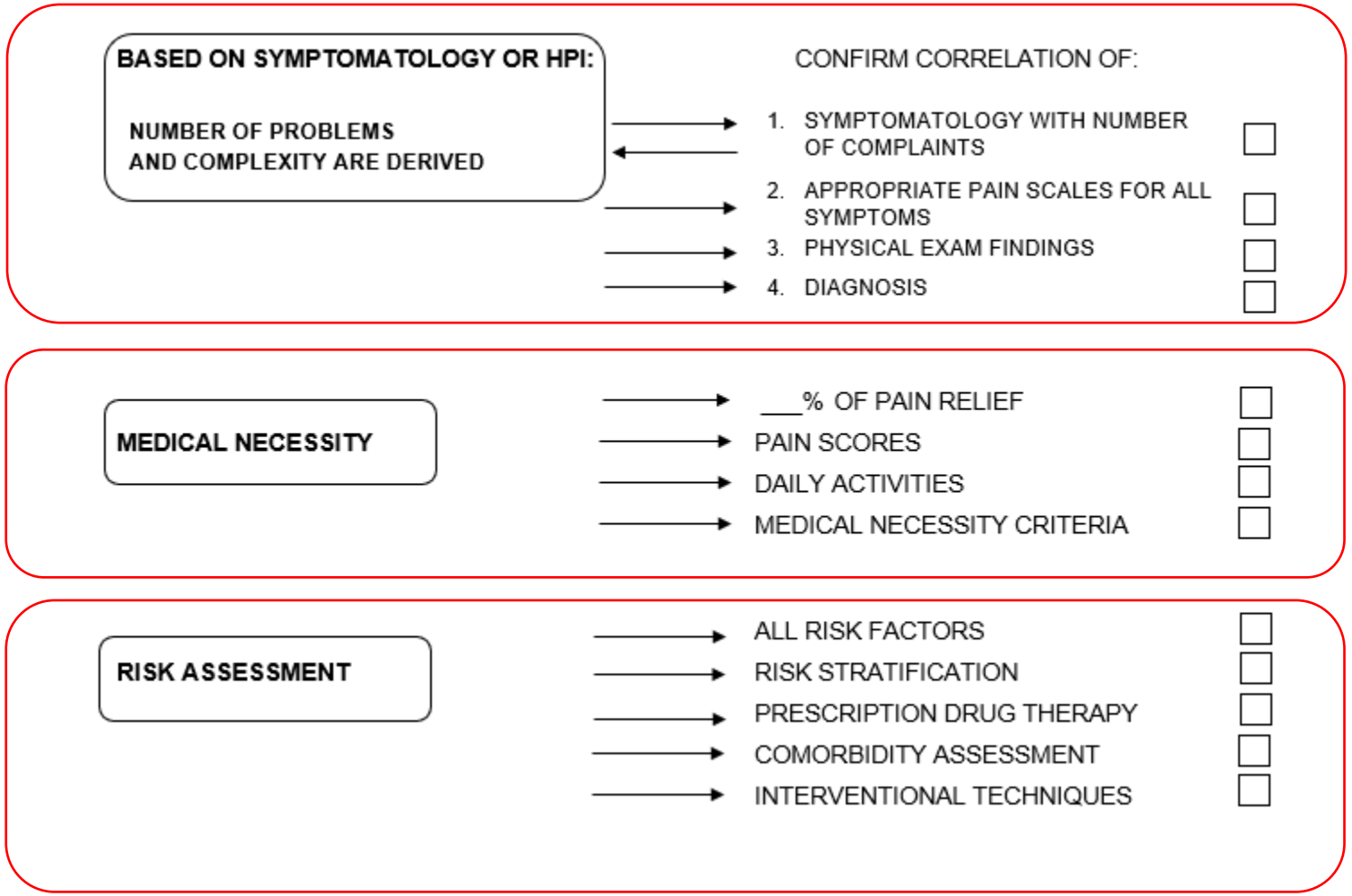
| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making | | |
|---|---|---|---|---|
| | | **Number and Complexity of Problems Addressed at the Encounter** | **Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*** | **Risk of Complications and/or Morbidity or Mortality of Patient Management** |
| **99211** | **N/A** | N/A | N/A | N/A |
| **99202**<br>**99212** | **Straightforward** | **Minimal**<br>• **1** self-limited or minor problem | **Minimal or none** | **Minimal risk of morbidity from additional diagnostic testing or treatment** |
| **99203**<br>**99213** | **Low** | **Low**<br>• **2** or more self-limited or minor problems;<br>**or**<br>• **1** stable chronic illness;<br>**or**<br>• **1** acute, uncomplicated illness or injury<br><br>Example: Chronic low back pain<br>- Characteristics etc. | **Limited**<br>*(Must meet the requirements of at least 1 of the 2 categories)*<br><br>**Category 1: Tests and documents**<br>• **Any combination of 2 from the following:**<br>• Review of prior external note(s) from each unique source*;<br>• review of the result(s) of each unique test*;<br>• ordering of each unique test*<br>**or**<br>**Category 2: Assessment requiring an independent historian(s)**<br>*(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)* | **Low risk of morbidity from additional diagnostic testing or treatment**<br>• Exercise program<br>• Physical therapy<br>• NSAID's<br>• Ordering X-Rays<br>• Referral |

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making | | |
|---|---|---|---|---|
| | | **Number and Complexity of Problems Addressed at the Encounter** | **Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*** | **Risk of Complications and/or Morbidity or Mortality of Patient Management** |
| **99204**<br>**99214** | **Moderate** | **Moderate**<br>• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;<br>**or**<br>• **2** or more stable chronic illnesses;<br>**or**<br>• **1** undiagnosed new problem with uncertain prognosis;<br>**or**<br>• **1** acute illness with systemic symptoms;<br>**or**<br>• **1** acute complicated injury<br><br>Examples:<br>○ Chronic Low back pain<br>○ Chronic neck pain<br>○ Chronic low back pain with exacerbation or worsening<br>○ Chronic chest wall pain | **Moderate**<br>*(Must meet the requirements of at least 1 out of 3 categories)*<br><br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>• Review of prior external note(s) from each unique source*; - ER, MD<br>• Review of the result(s) of each unique test*; - Imaging, UDI<br>• Ordering of each unique test*; - MRI, UDI<br>• Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | **Moderate risk of morbidity from additional diagnostic testing or treatment**<br><br>*Examples only:*<br>• Prescription drug management<br>○ Opioids<br>○ Adherence mentoring<br>○ Referral<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health<br>○ Housing, transportation, income, racism, discrimination etc. |

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Elements of Medical Decision Making | | |
|---|---|---|---|---|
| | | **Number and Complexity of Problems Addressed at the Encounter** | **Amount and/or Complexity of Data to be Reviewed and Analyzed** **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.* | **Risk of Complications and/or Morbidity or Mortality of Patient Management** |
| **99205**<br>**99215** | **High** | **High**<br>• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;<br>**or**<br>• 1 acute or chronic illness or injury that poses a threat to life or<br>Examples:<br>○ Chronic Low back pain<br>○ Chronic neck pain<br>○ Chronic low back pain with exacerbation or worsening<br>○ Chronic chest wall pain | **Extensive**<br>*(Must meet the requirements of at least 2 out of 3 categories)*<br><br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following**:<br>• Review of prior external note(s) from each unique source*;<br>• Review of the result(s) of each unique test*;<br>• Ordering of each unique test*;<br>• Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | **High risk of morbidity from additional diagnostic testing or treatment:**<br><br>*Examples only:*<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Concurrent opioid therapy<br>• Methadone<br>• High Doses<br>• Intrathecal fusion systems<br>• Decision regarding elective major surgery (SCS) with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Epidural hematoma |

# ALGORITHMIC APPROACH TO DOCUMENTATION: E/M SERVICES

## New Patient



# New Patient Evaluation Documentation

- History
- Symptomatology:
  - Relevant past history
  - Review and analysis of data
  - Relevant review of systems
- Physical examination
- Risk of complications and/or morbidity and mortality
- Amount and complexity of data review
  - Medical necessity
  - Risk of complications & management

# Four Components of Relevant History


1. Chief complaint (CC)
2. History of present illness (HPI)
3. Past, family, social history (PFSH)
4. Review of systems (ROS)

# Eight Dimensions of HPI

1. Location – Low back pain
2. Quality – aching, burning, etc.
3. Severity – VAS or NRS
4. Duration – started on 3/6/2020
5. Timing – intermittent, constant, etc.
6. Context – MVA, gradual, etc.
7. Modifying Factors – better or worse with
8. Associated Signs and Symptoms – numbness, tingling, etc.

Document at least four dimensions
Preferably all eight

# PHYSCIAL EXAMINATION
# Documentation Guideline(s)

Affected or Symptomatic

body areas / organ systems

Document specific abnormal & relevant negative findings

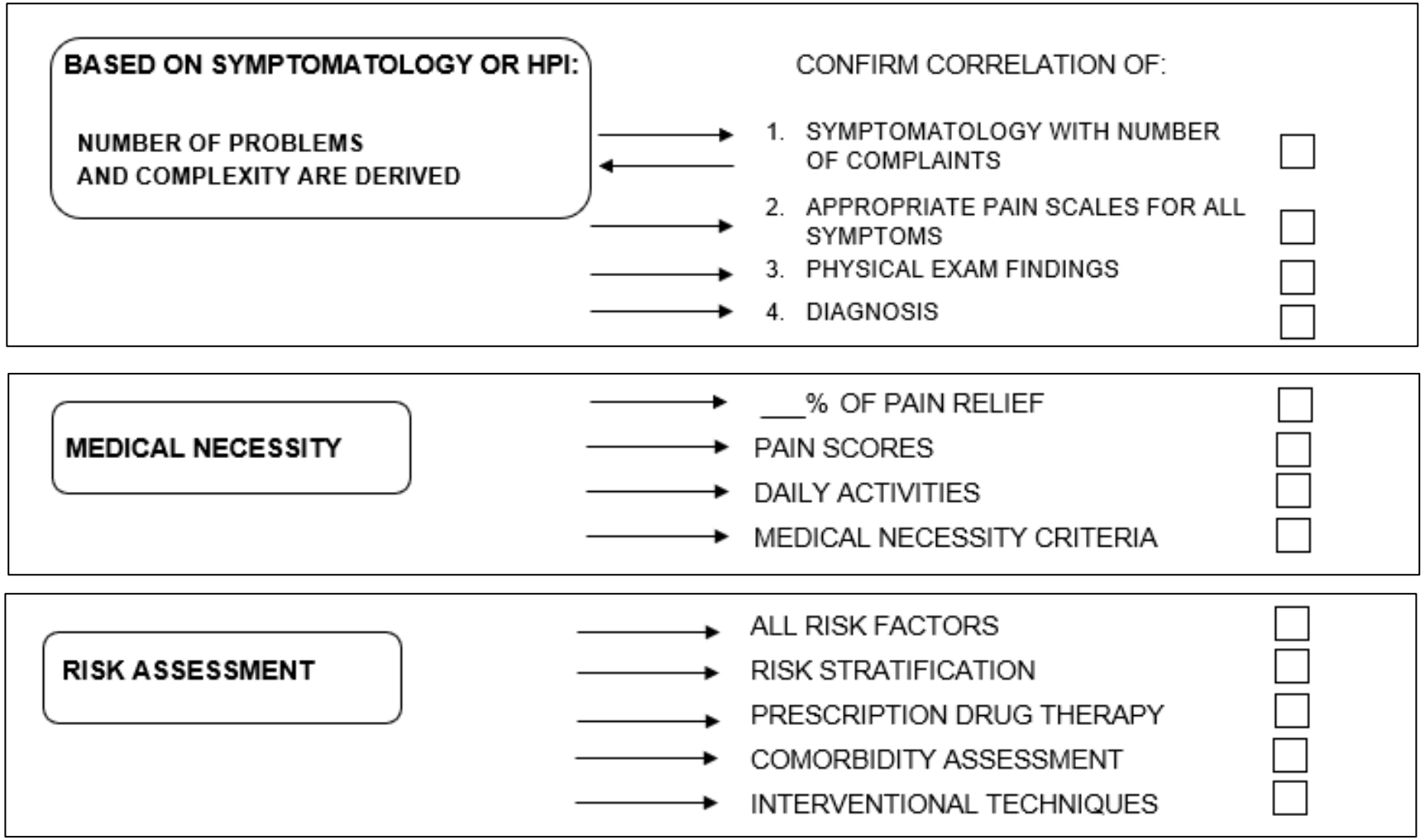
# Examination FOR IPM

- Examination of gait and station
- Spine & Extremities
  - ROM
  - Motor / Sensory
  - Reflexes
- Examination of joints, bones, muscles, and tendons

# MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

- **Straightforward**
  - Minimal risk from treatment (including no treatment) or testing. (Most would consider this effectively as no risk)
- **Low**
  - Low risk (ie, very low risk of anything bad), minimal consent/discussion
- **Moderate**
  - Would typically review with patient/surrogate, obtain consent and monitor, or there are complex social factors in management
- **High**
  - Need to discuss some pretty bad things that could happen for which physician or other qualified health care professional will watch or monitor

# ALGORITHMIC APPROACH TO DOCUMENTATION: E/M SERVICES
## Established Patient



## F-E-A-R: has two meanings:

1. Forget Everything And Run

or

2. Face Everything And Rise


The Choice is Yours!

**SURVIVAL is 100% dependent on FEAR**

# Thank You

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# Presenting complaint: use of language that disempowers patients

***Caitríona Cox*** and ***Zoë Fritz*** argue that outdated medical language that casts doubt, belittles, or blames patients jeopardises the therapeutic relationship and is overdue for change

Caitríona Cox, [1] Zoë Fritz[1]

http://dx.doi.org/10.13039/100010269

Wellcome Trust

Language is important. It is a vehicle for sharing knowledge and understanding, and a means by which we can express and communicate our values to others. In a medical context, language does more than transfer information between patients and healthcare providers—it has the potential to shape therapeutic relationships.[1 2] Indeed, specific word choices and phrases affect how patients view their health and illness,[3] reflect healthcare workers' perceptions of their patients,[4 -6] and influence medical care and treatments offered.[5 7] Language in medical narratives also shapes how trainees think, talk, and act, perpetuating any ingrained biases.[8]

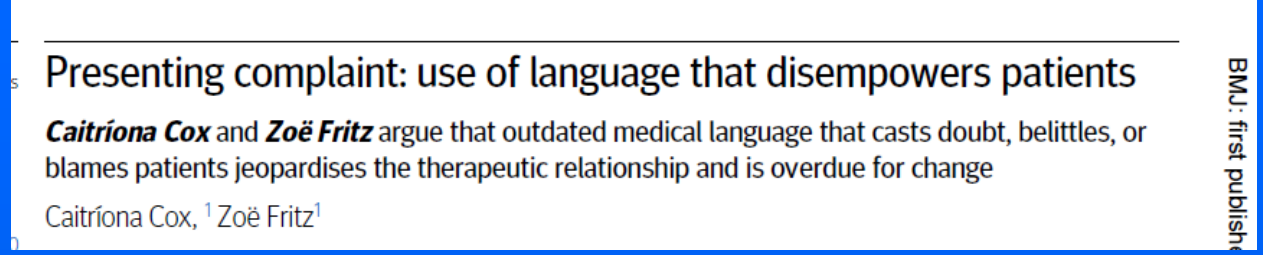
In the UK, guidance by the UK National Institute for Health and Care Excellence (NICE) on shared decision making focuses on the importance of communicating risks, benefits, and consequences of interventions to patients.[9] Yet some language used either to communicate directly with patients, or when discussing patient care with other healthcare professionals, might inadvertently disempower concern.[3] A patient may, for example, be seeking to understand the cause of an untroublesome lump. It would be more neutral to refer to a patient's reason for engaging with healthcare (which could include diagnosing or treating a symptom, managing a condition, proactively planning for life changes, or preventing future complications).

In medical documentation, doctors sometimes use language that questions the authenticity of a patient's symptoms.[15] For example, they often translate the reported absence of symptoms or experiences as the patient "denying" symptoms—for example, "patient denies fever, chills, or night sweats." To deny is to refuse to admit the truth or existence of something, and the term can hint at untrustworthiness. In a study examining reactions to outpatient notes, patients responded negatively to language that questioned the validity of their experiences. One patient stated: "I did not deny these things. I said I didn't feel them. Completely different. Language matters."[16] Similarly, writing, "patient claims pain is 10/10" instead of "patient experiencing 10/10 pain" implies a degree of disbelief. Other phrases that cast doubt on the validity of the patient's experience have also been criticised.[5 8 16 17]



## Suggested changes to terminology

| Problematic term | Suggested replacement |
|---|---|
| Denies chest pain | Reports no chest pain |
| Patient claims pain is x/10 | Patient reports pain is x/10 |
| Compliance | Barriers to adherence |
| Presenting complaint | Reason for attendance |
| Patient failed on x | X was not effective for the patient |
| Patient refused x | Patient declined x |



## Presenting complaint: use of language that disempowers patients

***Caitríona Cox*** and ***Zoë Fritz*** argue that outdated medical language that casts doubt, belittles, or blames patients jeopardises the therapeutic relationship and is overdue for change

Caitríona Cox, [1] Zoë Fritz[1]

BMJ: first publish

The authors describe how such language, while often taken for granted, can insidiously affect the therapeutic relationship and suggest how it could be changed to foster a relationship focused on shared understanding and collective goals.

- Language that belittles patients
  - Some language used in clinical practice implicitly casts doubt on patients' experiences or infers a degree of petulance. One such term—presenting complaint—is so central to the patient-doctor encounter that many will have stopped hearing the words for what they are. Complain has negative connotations, and use of "problem" or "concern" instead has been suggested as more sympathetic.
- Language that emphasises the patient as passive or childlike
  - Much of the language used in clinical medicine inappropriately renders the patient the object of the doctor's action, conferring passivity to the patient while emphasising the doctor's position of power. For example, doctors "take" a history, or "send" patients home.
- Language that blames patients
  - Another problematic category of language is that which implicitly places the blame on patients for poor outcomes.
- What's in a word?
  - Language that belittles, infantalises, or blames patients runs counter to the collaborative relationships we are trying to foster through initiatives such as shared decision making.
- 
- The negative effect of stigmatising language on the attitudes of healthcare professionals towards patients is well studied in the context of chronic pain and sickle cell disease.
  - For example, "substance abuser" vs "having a substance use disorder," "not tolerating oxygen mask" *vs "* refuses oxygen mask

**Authors Conflict of interest statement**

Competing interests: We have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

The New York Times

BREAKING NEWS

# Medicare Advantage plans deny needed care that should be covered to tens of thousands of people a year, federal investigators found.

Thursday, April 28, 2022 9:35 AM EST

Federal investigators urged Medicare officials to strengthen oversight of these private insurance plans, which provide benefits to 28 million older Americans, and called for increased enforcement against plans with a pattern of inappropriate denials.