Pain Management: Coding and Documentation

Pain Definition

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.”

International Association for the Study of Pain (Merskey, 1979)

Introduction

- Pain is always subjective
- Pain is what a patient says it is
- If non-verbal they can express it other ways
- Often have more than one source of pain
- People report pain differently
- The clinician must accept the patient’s self report of pain.

Are you in pain?
Objectives

- Review Spine Anatomy
- Basic principles of pain management
  - Appropriate screening and pain assessment
- Identify types of pain
- Conditions causing pain
- Treatment options
- Common procedures for pain management
- Patient and family education

Determination of Pain

- Patient’s level of pain must guide treatment
- Severe pain to one person can be almost nothing to another
- Anxiety always makes pain worse
- Patient is unable to describe pain the assessment strategies should include:
  - Observable behaviors (facial expressions, body movements, crying, moaning, not eating)
  - Physiological measures (heart rate and blood pressure).
Example: Jane Doe

85 year old female has osteoporosis, renal failure and presents to the clinic for knee and back pain.

What do you want to obtain from her history?

Documentation Requirements

- Thorough evaluation
  - Systemic assessment
  - Location
  - Intensity
  - Pathophysiology of pain
  - Detailed Pain History
  - Prior treatment
  - Response to treatment
  - Impact on daily life
  - Family history
  - Detailed Physical Exam
  - Review of pertinent diagnostic test(s)
  - Patient (and family) expected goals

Acute Pain

- Brief in duration and subsides as healing takes place, usually 6 months or less
- May be sudden or slow in onset
  - Broken bones, strep throat, pain after surgery or injury
- Acute pain is often accompanied by observable objective signs of pain
  - Increased pulse rate or blood pressure
  - Impair immune function
  - Non-verbal signs and symptoms such as facial expressions, negative emotions and tense muscles.
Chronic Pain

- Persistent and recurrent
- Pain has no predictable ending
- Difficult to find specific cause
- Pain persists and it may dramatically decrease the quality of life and function
- Chronic pain rarely has any observable or behavioral signs although persons may appear anxious or depressed.
- Often can’t be cured
- Frequently undertreated

Chronic Pain Facts

- Suffers of chronic pain approx. 100 million
- Healthcare costs range from $560 billion to $635 billion
- More than half of all hospitalized patients experience pain in the last days of their lives
- An estimated 20% of U.S. adults (42 million) have discomfort that disrupts their sleep

Untreated Chronic Pain

- Chronic pain may lead to:
  - Fatigue
  - Anxiety
  - Depression
  - Confusion
  - Increased falls
  - Impaired sleep
  - Decreased physical functioning/deconditioning
Neoplasm Pain

- Expected to have an end, with cure or with death
- Aggressive treatment
- Addiction is not a concern
- May be attributed to
  - Tumor location
  - Chemotherapy
  - Radiation therapy
  - Surgical treatment

Somatic Pain

- Source:
  - Skin, muscle, and connective tissue
- Examples:
  - Sprains, headaches, arthritis
- Description:
  - Localized, sharp/dull, aching, gnawing, worse with movement or touch
- Pain Med:
  - Most pain meds, NSAIDS, acetaminophen, opioids

Visceral Pain

- Source:
  - Internal organs (colon, kidney, heart)
- Examples:
  - Tumor growth, gastritis, IBS, chest pain, heart attack, kidney stone, endometriosis
- Description:
  - Cramping, squeezing, pressure, constant and dull, less affected with movement
- Pain Med:
  - Stronger pain medications, opioids, acetaminophen
Neuropathic Pain

- Source: Nerves
- Examples: Diabetic neuropathy, phantom limb pain, cancer spread to nerve plexus
- Description: Burning, stabbing, pins and needles, shock-like, shooting
- Pain Med: Opiate’s + tricyclic antidepressants or other adjuvant

Bone Pain

- Source: Sensitive nerve fibers on the outer surface of bone
- Examples: Cancer spread to bone, fractures, spinal pain and severe osteoporosis
- Description: Tends to be constant, worse with movement
- Pain Med: Stronger meds, opiates with NSAIDS as adjunct

Post Surgical - Spinal

- Source: Post-laminectomy syndrome or pain following operative procedures of the spine, sometimes known as failed management syndrome
Lifestyle Changes

- Doing relaxing activities
- Good nutrition
- Yoga
- Meditation
- Writing and expressing your thoughts
- Low-impact exercises
- High-intensity exercise
- Behavioral therapy
- Getting enough sleep
- Reducing or stopping smoking and drinking
- Acupuncture (with mixed evidence)
- Osteopathic manipulation therapy (OMT)

Conditions – Spinal Origin Pain

- Disc disruptions
- Facet arthritis
- Post-Surgical – failed back
- Myofascial syndromes
- Sacroiliac joint syndrome
- Degenerative disorders
  - Stenosis
  - Spondylolysis
  - Spondylolisthesis
  - Scoliosis
  - Segmental instability

Pain Codes

- Pain codes are basically in three different areas
  - Specific body systems or diseases
    - Low back pain (M54.5)
    - Testicular pain (N50.8)
    - Cancer locations (C00.- D89.9)
  - Signs and symptoms
    - Abdominal pain (R10.-) over 30 different types
    - Chest pain on breathing, etc. (R07.-)
  - Certain non-specific types of pain
    - Pain, not elsewhere classified (G89)
Osteoarthritis (M13-M19)
- Chronic degeneration of the cartilage that cushions the joints
- Risk is usually over 45 years and mostly in women
- Symptoms
  - Stiffness
  - Swelling
  - Sensation/rubbing of bone on bone
  - Crushing/popping sounds during movement
  - Difficulty walking, moving
  - Unlimited movements especially in the hip
- Treatments
  - Weight loss
  - Hot/Cold/Creams
  - Rest
  - Exercise (physical therapy)
  - Injections
  - Joint replacements

Fibromyalgia Pain (M79.7)
The Seven Types of Fibromyalgia (FM) Pain
- Hyperalgies
- Allodynia
- Paresthesia
- Rattled Nerves
- Sparkler Burns
- Knife in the Voodoo Doll
- Randomly Moving Pain

Pain Management Approach
- Should be interdisciplinary and ongoing
- Care is individualized and may depend on:
  - Pain source and intensity
  - Patient’s age
  - Developmental, physical, emotional and cognitive status
  - Cultural beliefs
  - Treatment preferences
  - Concurrent medical conditions
Interventional Pain Management

- Super-specialty providers
- Devoted to decrease or eliminate pain
- Accomplished by
  - Interrupting the pain signal along a neural pathway
  - Remodeling anatomical source of pain
  - Implantable drug delivery system
  - Injections

Treatments May Include

**Non-pharmacologic Methods**
- Heat/cold
- Relaxation
- Distraction
- Guided imagery
- Acupressure/acupuncture
- Repositioning

**Pharmacologic Methods**
- NSAIDS
- Anti-seizure medications
- Anti-depressants
- Opioid analgesics
- Local anesthetics
- Neurollytics

Acute vs. Chronic Pain Management

**Acute Pain**
- Most often treated with:
  - NSAIDS
  - Opioids
  - Local anesthetics
  - Splinting
  - Positioning changes
  - Ice

**Chronic Pain**
- Most often treated with:
  - Anti-seizure medications
  - Anti-depressant medications
  - NSAIDS
  - Implantable devices
  - Psychological therapy
  - Acupuncture
- When all else fails and benefits outweigh risks
  - Opioids
Consequences of Untreated Pain

- Poor appetite and weight loss
- Disturbed sleep
- Physical and verbal aggression, wandering, acting-out behavior, resists care
- Sadness, anxiety, withdrawal or depression
- Difficulty walking or transferring; may become bed bound
- Skin ulcers
- Incontinence
- Impaired immune function
- Increased risk for use of chemicals

Pain Management Codes

- Treatments offered:
  - Comprehensive evaluations (Office Visits, Consults, etc.)
  - Epidural/Intrathecal implants (62350, 62351, 62360-62362, 99601, 99602)
  - Epidural steroid injections (62281, 62282, 62320-62327)
  - Intravenous therapy (96365-96368, 96374-96379)
  - Spinal injections (62321-62327, 0213T-0229T)
  - Nerve blocks (64400-64530)
  - Psychological evaluation and treatment (90791-90899)
  - Opioid risk evaluation (90863)

Minimally Invasive Techniques

- Trigger Point Injections (CPT 20552-20553)
  - Reason
    - Done when muscles are sensitive in touch
    - Movement of extremity is painful
  - Benefit
    - Initially numbs the affected area to reduce pain
  - Complications
    - May include increased pain (temporary) and allergic reactions
  - After treatment
    - May experience temporary soreness
    - Referred to physical therapy to reduce muscle tension
  - Documentation Requirement
    - Per CMS one trigger point injection per day
Minimally Invasive Techniques

Minimally Invasive Technique

- Sacroiliac Joint Injections (CPT 27096)
  - Reason
    - Buttock or low back pain worse usually in a sitting position
  - Benefit
    - Reduce inflammation and relieve pain
  - Complications
    - Very small risks of bleeding, infections or allergic reactions
  - After treatment
    - May have increased pain for 24-48 hours and soreness at the injection site or fullness in the back
    - Monitor blood sugar if diabetic, may increase blood glucose levels
    - Don't exercise vigorously, but do light activities to assess the effectiveness
  - Documentation Requirement
    - Results of prior therapy or treatments
    - Imaging confirmation of needle placement
    - Results of previous SI treatments

Minimally Invasive Technique

- Facet Joint Injection (CPT 64490-64495)
  - Reason
    - Back or neck pain
  - Benefit
    - Helps to reduce inflammation and relieves pain
  - Complications
    - Backache, headache, nerve irritation or temporary numbness (paralysis), bleeding, or possible allergic reaction to the medication or spinal cord injury (rare)
  - After treatment
    - Increase pain for 24-48 hours
    - Soreness at the injection site or fullness in the back
    - Injection to reduce inflammation takes up to five days to reach maximum effectiveness
    - Monitor blood sugar. Can increase blood glucose levels
    - Perform some light duties that causes pain to assess the effectiveness

Minimally Invasive Technique

- Transforaminal (Epidural) Steroid Injection (CPT 64479-64484) (O228T-0231T)
  - Reason
    - Pain that radiates into an extremity from the neck or low back
  - Benefit
    - Reduces pain and inflammation from the irritated nerves and bulging discs that caused extremity pain
  - Complications
    - Backache, headache, nerve irritation or temporary numbness, bleeding, allergic reaction to the medication (rare), or nerve or spinal cord injury (rare)
  - After treatment
    - Temporary fluctuations or decreased blood pressure
    - Legs may temporarily feel weak or numb; a few hours
    - Soreness at the injection site or fullness in the back
    - Difficulty with urination for a short time after the procedure
  - Documentation Requirement
    - Same level -50 modifier, Different levels Rt and/orLt
    - One code/unit per level
### Minimally Invasive Technique

#### Epidural Steroid Injection (CPT 62320-62323)

- **Reason**
  - A variety of pain symptoms: back, herniated disc disease, post-therapeutic neuralgia, spinal stenosis
- **Benefit**
  - Reduces inflammation and pain of irritated nerves or bulging discs
- **Complication**
  - Backache, headache, nerve irritation or temporary numbness, bleeding, allergic reaction to the medication (rare), or nerve or spinal cord injury (rare).
- **After treatment**
  - Temporary fluctuations or decreased blood pressure
  - Legs may temporarily feel weak or numb; a few hours
  - Soreness at the injection site or fullness in the back
  - Difficulty with urination for a short time after the procedure

### Minimally Invasive Technique

#### Dekompressor discectomy (CPT 0275T)

- **Reason**
  - Decompression of contained lumbar herniated discs.
- **Benefit**
  - Reduces pain from the disc and nerve root

### Minimally Invasive Technique

#### Intercostal Nerve Block (CPT 64420-64421)

- **Reason**
  - Pain from inflammation caused by rib fracture, shingles, and lung/chest trauma
- **Benefit**
  - Reduce inflammation and pain
- **Complication**
  - Collapsed lung, infection, bleeding and allergic reaction from medication (rare)
- **After treatment**
  - Increased pain 24-48 hours, soreness at injection site, perform light activities
Minimally Invasive Technique

- Nerve Blocks (CPT 64400-64530)
  - Trigeminal (face)
  - Ophthalmic (eyelids and scalp)
  - Supraorbital (forehead)
  - Maxillary (upper jaw)
  - Sphenopalatine (nose and palate)
  - Cervical, thoracic, and lumbar (neck and back)
  - Cervical plexus and paravertebral (shoulder and upper neck)
  - Brachial plexus, elbow, and wrist (shoulder/arm/hand, elbow, and wrist)
  - Subarachnoid and celiac plexus (abdomen and pelvis)

Minimally Invasive Technique

- Intrathecal Pump Implant
  - Reason
    - Pain cannot be adequately controlled by conventional oral or systemic analgesics
  - Benefit
    - Reduces pain with delivery of strong painkillers directly into the cerebrospinal fluid

Surgeries

- Discectomy (Micro-disccectomy)
- Laminectomy
- Spinal Fusion
  - Posterolateral
  - Interbody
    - Anterior lumbar interbody fusion
    - Posterior lumbar interbody fusion
Surgeries

- Facetectomy
- Foraminotomy
- Laminoplasty
- Osteotomy

Treatment of Pain

Rule of thumb, common sense rules:

- Use the lowest effective dose by the simplest route
- Start with the simplest single agent and maximize its potential before adding other drugs
- Use scheduled, long-acting pain medications for constant or frequent pain, with prn, short-acting medication available for breakthrough
- Treat breakthrough pain with one-third the 12 hours scheduled dose

Treatment of Pain, cont.

- If three or more prn doses are used in a day, increase the scheduled dose. Increase by quarter or half of the prior dose. Increase the prn dose when increase the scheduled dose
- Be vigilant at assessing the side effects of medication. Treat or prevent side effects, such as constipation and nausea. Change medication as necessary
- Reevaluate and adjust medications at regular intervals and as necessary
- Do not stop pain medication in terminal patients. Change the route if needed
Responsible Opioid Prescribing

• There is a national epidemic occurring involving the misuse, abuse and diversion of prescription opioids.
• The majority of these medications enter circulation through the legitimate prescription by physicians from all specialties.
• Prescribers must be aware that their opioid prescription could potentially end up being used for reasons not prescribed (sold, snorted, traded).

Responsible Opioid Prescribing

• Assess risk for opioid abuse or diversion prior to prescribing opioid.
• Risk factors for misuse or abuse of opioids include the following
  □ Males between 18 and 45.
  □ A personal history of substance abuse
  □ A family history of substance abuse
  □ A personal history of preadolescent sexual abuse
  □ A personal history of psychological disease (depression, anxiety, obsessive-compulsive disorder)

Patient and Family Education

• All patients and family must receive education on their right to effective pain management which may include:
  • How to report pain using the pain scales.
  • Importance of reporting pain as accurately and promptly as possible.
  • Use of pumps and other technologies used in pain control.
  • Use of non-pharmacologic and pharmacologic methods of relieving pain.
  • Importance of notifying staff of unrelieved pain.
  • Identification of an acceptable functional pain level that will allow them to participate in their prescribed activity level.
Patient and Family Education

Â Patients and family are given specific instructions prior to a discharge regarding
  ï Pain control
  ï Pain medications
  ï Management of potential side effects

Summary

Â Assessment of pain
Â Treatments
Â Following up with patient