



PAIN MANAGEMENT REIMBURSEMENT PROCEDURES

Frequently Asked Questions (FAQs)

I Coverage for Specific Pain Management Procedures

Q: Are there certain guidelines for pain management providers?

A: Primary guidelines for reimbursements apply to all providers, not just pain management providers. These guidelines include medical necessity, standard of care versus experimental/investigational, appropriate coding, claims submission time lines, etc. There are prior authorization requirements for invasive pain management procedures such as nerve blocks, facet blocks, epidural injections, RFAs. This information was distributed to providers effective 1/1/07 and will be addressed in another part of this FAQ summary.

Q. Does OSU MHCS cover Radiofrequency Ablation?

A. The OSU coverage for Radiofrequency Ablation is limited to the conventional/standard method RFA. Pulsed RFA is considered experimental at this time and is not covered. Also, RFAs and percutaneous facet denervation require prior authorization for medical necessity.

Q. Does OSU MHCS cover Sarapin injections?

A. No. The use of Sarapin in joint injections is currently considered experimental/investigational.

Q. What are the prior authorization requirements for pain management procedures?

A. Epidural injections, nerve blocks, and facet blocks for chronic pain management require a review and prior authorization for medical necessity after the 3rd injection per plan year. Providers should submit the request for prior authorization to OSU MHCS by contacting (614) 292-4700 and asking for a case manager. Claims received at NGS American without the required prior authorization at the time the claim is received will be denied.

Q. Are repeat or serial pain injection procedures covered?

A. Yes, as long as medical necessity and appropriateness are established for repeat or serial injection procedures. Medical documentation must support medical necessity for repeat interventions by indicating response to previous injections, the patient's functional status prior to recurrence of pain, and whether the repeat intervention is part of a comprehensive treatment plan that includes other non-invasive pain management treatment modalities.

Q. What other guidelines does NGS use when reviewing medical necessity and appropriateness of procedures?

A. One primary reference used is the Trilogy Claims Administration Handbook. NGS also references CMS guidelines and recommendations, as well as recommendations by various specialty organizations such as the American Pain Society, the American Society of Anesthesiologists, and the American Medical Association.

II Claims Submission and Processing

Q. What is the turnaround time on a clean claim?

A. It is the goal of NGS American to process 90 percent of all “clean” claims within 14 days.

Q. Should I submit records with every claim? How do I know if and when I need to submit records?

A. No. Records are not normally required for submission with every claim, even for repeat injections or serial intervention procedures. NGS will notify you when records are necessary for review.

Q. What records should I send when NGS requests for records?

A. The letter from NGS should indicate what records are being requested. In general, any and all medical documentation pertinent to the particular claim should be submitted, i.e. records that will establish medical necessity, such as the most recent evaluation, diagnostic tests, pain scale logs, and records that will confirm the services that are being billed (CPT/HCPCS codes, units), such as the operative report, drug administration record, PT logs, if applicable.

Q. How do I submit an electronic claim along with records?

A. At this time, NGS does not accept attachments with electronic claims.

Q. Is there a time limit on submitting requested records?

A. To facilitate processing of claims within the prompt pay guidelines, requested records must be submitted within **30 days** from the date the records were requested.

Q. Are unlisted or unclassified codes allowed for reimbursement?

A. Yes, as long as there is an explanation with the claim as to what the code is being billed for, otherwise, the code will be denied. This could mean inclusion of NDC # on the claim for unlisted/unclassified drugs (J3490), a description of the procedure for unlisted procedure codes, or a description of the actual supply or material in the case of 99070. In some instances, NGS will request medical records to confirm that the unlisted code was appropriately billed.

Q. What about needles (A4215) and surgical trays (A4550) – are these covered items?

A. Needles, surgical trays, syringes, sterile gloves and other materials normally supplied by the physician during a covered office procedure

such as nerve blocks, trigger point injections, etc. are considered included with the payment for the primary procedure. Separate reimbursement for supplies is limited to those used over and above those usually included with a procedure. Pain pumps, epidural catheters, and contrast material are separately payable.

Q. I billed four CPT procedure codes and only two were paid. The Explanation of Benefits indicated that the two denied procedures were considered included in the payment for the primary procedure. How was this determination made?

A. NGS utilizes code review software in the claims adjudication process. This software, provided by Claimsguard and McKesson, examine and recognize claims data in the context of CMS' CCI edits, coding guidelines, as well as historical data to identify duplicate billing and questionable billing patterns. Unbundled procedures, invalid use of modifiers, unlikely code combinations, and incidental procedures are some of the most common scenarios captured by this software that result in the denial of some codes in a claim. For additional information on NGS' effort to detect and guard against possible fraud and abuse, log on to www.ngs.com and type in "Fraud and Abuse" on the search box.

III Adverse Determinations and Appeals

Q. How does the appeal process work on claim denials?

A. Adverse claim determinations (denials) can be appealed by submitting an appeal to NGS American, P.O. Box 7676, St. Clair Shores, MI 48080. The appeal must include a cover letter indicating the specific issue being appealed and must include any documentation or records pertinent to the claim being appealed. Appeals submitted within 90 days from the date of the claim denial will be reviewed by a separate department that specializes in appeals.

Q. If a claim was denied, can the patient be billed for the denied amount?

A. It depends on the circumstances of the claim and the reason for the denial. Claims denied for a cosmetic procedure, for example, become the liability of the member (patient). Claims denied for inappropriate billing (bundling, invalid place of service, ICD9 inconsistent with the procedure, etc), or not supported by documentation, become the liability of the provider so the member cannot be billed for the denied amount. Claims by a network provider denied for the lack of a required prior authorization become the liability of the provider while claims by a non-network provider denied for lack of a required prior authorization become the member's liability. The EOB indicates the reason for a denial.