Master Facet Joint Injection Essentials With These Tips

Count each level and check for your payers’ preferences.

When reporting facet joint injections, make sure you know the spinal levels that the pain management specialist treated and also what your payers’ preferences are for the maximum number and frequency of the injections that can be given. Whether the facet injections are diagnostic or therapeutic, you should count each level and/or both sides. Read on for more advice on reporting these common procedures.

Don’t Let Intent Throw You

You’ll notice that the terms ‘diagnostic’ and ‘therapeutic’ are already in facet joint injection code descriptors, as follows, but don’t be too overzealous about those descriptors:

- 64490 (Injection[s], diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint [or nerves innervating that joint] with image guidance [fluoroscopy or CT], cervical or thoracic; single level)
- 64493 (Injection[s], diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint [or nerves innervating that joint] with image guidance [fluoroscopy or CT], lumbar or sacral; single level).

The reason why the injection was given is not important when billing the procedure. You report the same code irrespective of whether the injection was given for diagnosis or therapy. “From a coding aspect they are both the same codes either way,” confirms Marilyn Glidden, CPC, Neuroscience and Spine Associates in Naples, Fla.

Reckon Each Level and Side

The rule of thumb is to count each spinal level the pain management physician treats. You report 64490 when the physician is injecting at the cervical or thoracic level and 64493 when the injection involves the lumbar or sacral level. You do not separately code for multiple injections at the same spinal level. “Code 64490 is reported once for the first level (C3-4), 64491 is reported once for the second level (C4-5) and 64492 is reported once for any additional levels,” says Jennifer Schmutz, CPC, health information coder at the Neurosurgical Associates, LLC in Salt Lake City.

Tip: Append modifier 50 (Bilateral procedure) when the injections are given bilaterally. You count two units for bilateral injections at a level. “Some carriers want it 64490-50; others want 2 line items 64490 on the first line 64490-50 on the second,” cautions Glidden, so check with your payer to avoid delays and denials.

The key is to check for your payer’s preferences,” says Marvel Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO, owner of MJH Consulting in Denver. “You
do not typically bill bilateral injections as 2 units. You would rather bill them as either the single line item with modifier 50 and 1 unit of service or 2 line items — 1 line item with modifier RT and 1 unit of service AND 1 line item with modifier LT and 1 unit of service.”

For coding purposes, a par vertebral facet (zygapophyseal) joint level is the joint and the two medial nerve branches that originate from two different spinal segments. The injection coding is the same regardless if the physician injected intra-articularly into the facet joint itself or injected the two medial nerve branches. “It is pretty unusual to perform multiple injections on the same site. In contrast, it is quite common for physicians to block the medial branches, i.e. block both sensory nerves that provide innervation to the facet joint,” says Hammer.

For an additional level in the cervical or thoracic region, you report +64491 (Injection[s], diagnostic or therapeutic agent, paravertebral facet [zygapophyseal] joint [or nerves innervating that joint] with imaging guidance [fluoroscopy or CT], cervical or thoracic; second level [List separately in addition to code for primary procedure]) in addition to 64490. For the third level and beyond, you report +64492 (Injection[s], diagnostic or therapeutic agent, paravertebral facet [zygapophyseal] joint [or nerves innervating that joint] with imaging guidance [fluoroscopy or CT], cervical or thoracic; third and any additional level[s] [List separately in addition to code for primary procedure]) in addition to 64490.

**Example:** If you read that the pain management specialist performed intra-articular joint injections at T4/T5 and T5/T6 bilaterally, these injections would be reported with 64490-50 and 64491-50. Likewise, if the physician injected the T3, T4 and T5 medial branches bilaterally, the coding would be the same, in that two facet joint levels (T4/T5 and T5/T6) would be blocked.

**Avoid Overlap in Block and Destruction**

Make sure your physician is doing a facet joint block and not a neurolysis which involves destruction of the nerve. A block is a temporary interruption of the nerve conduction while destruction is a permanent cessation of activity in the nerve when neurolytic agents like heat, radiofrequency techniques, or chemicals are used to destroy the nerve. “The block only numbs the area for a period of time. Neurolysis destroys the nerve & the nerve slowly regenerates,” explains Glidden. Codes for destruction are distinct and separate, 64622 (Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level)-64627 (Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level [List separately in addition to code for primary procedure]).

**Confirm Your Payer’s Restriction**

Many payers describe a number of code units that can be reported for a particular session or the numbers that can be done in a particular period of
time. “Most insurers will only cover one injection per level but they can be bilateral,” says Glidden.

**Example:** You read in the operative note that a 45-year-old woman describes lancinating left neck and scalp pain without history of prior trauma, and the CT reveals severe unilateral C2-C3 facet arthropathy for which a fluoroscopically-guided right C2-C3 diagnostic facet injection was given to determine whether or not an inflammatory facet arthropathy is causing occipital neuralgia. In this instance, you would submit 64490 with modifier RT appended as an informational modifier and use diagnosis 721.0 (*Cervical spondylosis without myelopathy*) or 723.8 (*Other syndromes affecting cervical region*). “It is important that these codes require image-guidance, which is bundled into each code and not separately reportable. The limited published evidence regarding diagnostic or therapeutic injections of more than three levels prompted the development of CPT® descriptors that bundle all injections beyond the third into the second additional level (64492 for cervicothoracic region and 64495 for lumbosacral region),” says Dr. Gregory Przybylski, MD, director of neurosurgery, New Jersey Neuroscience Institute, JFK Medical Center, Edison.

**ICD-9/ICD-10 Crosswalk**

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**Coding Tips**

Get Your Routine And Extended EEG Coding Into Gear With These Pointers

Precise timing of EEG monitoring is the key, frequency is not important.

When reporting EEG recording, the most crucial factor is to time the procedure. If your physician uses advanced techniques, video and digital recordings, you may be faced with additional coding challenges for these services. Read on to equip yourself on how to precisely time the procedure and code the routine, extended, and special monitoring.

Look For How Long the Diagnostic Study Lasted

When reporting EEG, you should look for how long your neurologist did the monitoring. Monitoring that lasts 20 to 40 minutes is said to be routine. You will report codes for extended monitoring if the procedure exceeds 40 minutes in duration. For EEG recording that lasts 41 to 60 minutes, you report 95812 (*Electroencephalogram [EEG] extended monitoring; 41-60 minutes*), and if it lasts more than an hour, you report 95813 (*Electroencephalogram [EEG] extended monitoring; greater than 1 hour*).

“**Important note:** You can report 95812 or 95813 in place of 95816 (*Electroencephalogram [EEG]; including imaging*) with modifier RT appended as an informational modifier and use coding tips as needed for an extended EEG recording. For EEG recording that lasts more than 60 minutes, you report 95815 (*Electroencephalogram [EEG] extended monitoring; greater than 1 hour*).

**Exception:** CPT® excludes EEG codes 95824 (*Electroencephalogram [EEG]; cerebral death evaluation only*), 95827 (*Electroencephalogram [EEG]; all night recording*), and 95829 (*Electrocoorticogram at surgery [separate procedure]*) from a time component as these are unique services rendered by the physician to monitor a certain pathological condition or diagnose one.
recording awake and drowsy). 95819 (… including recording awake and asples) or 95822 (… recording in coma or sleep only), but you cannot report them together. There is a narrow line between drowsy and asleep. You report 95819 when the patienst actually slept during the monitoring. If the patient did not attain sleep in a procedure that intended monitoring in sleep, you report 95816 instead.

If the neurology specialist performs the global diagnostic service, i.e., owns the equipment, employs the technical staff and also interprets the diagnostic findings, then the EEG code would be billed without any modifiers. However, you would append modifier 26 (Professional component) to the EEG CPT® code, if your neurologist only performs the professional interpretation of the diagnostic study. In the latter scenario, the hospital or center owns the equipment and employs the technical staff used to complete the EEG diagnostic study.

Scan For Video and Channels in Extended Monitoring

For 24-hour EEG monitoring, you should assess codes 
95950 (Monitoring for identification and localization of cerebral seizure focus, electroencephalographic [e.g., 8 channel EEG] recording and interpretation, each 24 hours)-
95953 (Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic [EEG] recording and interpretation, each 24 hours, unattended) or 95956 (Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic [EEG] and video recording and interpretation [e.g., for presurgical localization], each 24 hours).

Your neurologist may like to obtain a day and night monitoring for say localization of seizures. Be sure to look for the number of channels and also if your neurologist used a video. If he does video EEG monitoring, you would report 95951 (Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic [EEG] and video recording and interpretation [e.g., for presurgical localization], each 24 hours).

If, however, 16 or more telemetry channels were used, but the neurologist does the EEG without video, you report 95956. CPT® describes these long term monitoring codes for ‘special EEG tests’ that last 24 hours. If the patient was sent home with an EEG holter monitoring, you report 95953.

Tip: If your neurologist completes the EEG testing in less than 12 hours, you append modifier 52 (Reduced services) to 95951-95953 or 95956. Thus, the 24 hour codes are applicable if the time period for the testing is more than 12 hours up to 24 hours.

The American Academy of Neurology and the American Clinical Neurophysiology Society agree with the 2011 CPT® Instructions — “A unit of time is attained when the mid-point is passed” and adopt the monitoring timeline of more than half of the 24 hours of monitoring as adequate to report these codes. Make sure to record the actual number of hours for the monitoring and adequately document the same.

Caution: Carriers may differ in reporting of long-term monitoring that lasts less than 24 hours. Confirm with your carriers for policies and preferences to ensure you report appropriate codes. Some may select monitoring time frame of more than 15 hours as appropriate to report these codes.

“In the AMA book ‘Principles of CPT® Coding,’ 5th edition, the time frame is 12 hours, not 15 hours,” says Hammer. “For recording 12 hours or less, you use modifier 52.”

Important note: You count the 24-hour time frame from when the EEG monitoring begins. Example, if you read that the neurologist performed the EEG monitoring overnight, you look for the exact timing when the procedure began. If the test begins at 9 p.m., then you count 24 hours if it lasted till 9 p.m. on the next day. If your neurologist began the monitoring at 9 a.m. on Monday, and it lasted till 10 p.m. on Tuesday, you report 95951 for Monday and 95951 without a modifier for Tuesday; since the monitoring time was 13 hours.

Editor’s note: Read more about reporting EEG in the next issue of Neurology Coding Alert.
Regions Are Important To Report Radiculopathy

Single ICD-9 code spans to eight codes in ICD-10.

Radiculopathy is site-specific for spinal regions in ICD-10. To ensure that your provider will be ready when the Oct. 1, 2013 deadline hits, you can reinforce the need for specific region notes in the documentation. Make sure your provider mentions the involvement of one or more of the specific spinal regions.

Review Anatomical Locations

The spine is divided into five regions, namely the cervical, thoracic, lumbar, sacral, and coccygeal regions. There are 33 vertebrae that encase the spinal cord. These include the 7 cervical (C1-C7), 12 thoracic (T1-T12), 5 lumbar (L1-L5), 5 sacral (S1-S5), and 4 coccygeal bones (Figure 1). The last two are fused together and the rest are separated by intervertebral spaces. The coccyx is also called the tail bone. The nerves emerge in the intervertebral spaces and the initial segment of the nerves close to the site of their origin from the spinal cord is called ‘nerve root’. There are 31 pairs of spinal nerve roots.

Look For the Anatomical Region(s) Involved

Radiculopathy occurs when or more spinal nerve roots become inflamed, compressed, or suffer a compromise in blood supply. This may result in pain, weakness or numbness in the dermatome or region that is supplied by the individual spinal nerve(s).

When you report the code(s) for the radiculopathy, you should look for the spinal region involved. The anatomical localization of the patient’s symptoms is your best guide.

The regions may overlap though the nerve roots are discrete. You may often come across a numerical representation in your provider’s notes. For example, your physician may report the involvement of the nerve roots at the junction of the last lumbar and first sacral region as L5-S1. In this case, you would report the lumbosacral regional involvement.

ICD-10 Has 8 Specific Codes

In ICD-9, the codes that you use to report radiculitis is 723.4 (Brachial neuritis or radiculitis NOS) or 724.4 (Thoracic or lumbosacral neuritis or radiculitis, unspecified). This sole code covers the radiculopathy in the thoracic, lumbar, and sacral regions. In ICD-10, there are eight possible codes that are used for the specific involved spinal region. These are as follows:

- M54.11 (Radiculopathy, occipital-atlanto-axial region)
- 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).

Remember: Code 724.2 (Lumbago) refers to lumbago or low back pain. Radiculopathy in the lumbosacral region can present as low back pain and it is important that you determine the cause of the low back pain. Low back pain has myriad causes. “The common causes include disc degeneration, spondylosis, sprain, muscle trigger point, fibromyalgia, compression fracture, injury,” says Marvel Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO, owner of MJH Consulting in Denver. “For many payers, 724.2 does support the medical necessity for several pain management procedures, i.e. intralaminar epidural, facet joint injections, and even transforaminal epidural injections for some payers,” says Hammer. “In ICD-10, the only ‘Excludes 1’ codes for radiculopathy are neuralgia and neuritis NOS (M79.2), radiculopathy with cervical disc disorder (M50.1), radiculopathy with lumbar and other intervertebral disc disorder (M51.1-) and radiculopathy with spondylosis (M47.2-).”

Figure 1: Five regions of the spine.

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Focus on Start Date for Overnight Sleep Study Billing

**Question:**
A patient came to our office for a sleep study at 9 p.m. on Monday; the study ended the next day at 7 a.m. The neurologist wrote the report on a different day. We split the bill between professional and technical components. Since we have three different dates (start, end, and report), what date of service should we assign for the technical and professional bills?

**Answer:**
If your neurologist conducts a sleep study overnight, use the initial start date of the procedure as the date of service billed.

**Explanation:** Always report the same date as the technical charges (which you report with the appropriate diagnostic study code and modifier TC, *Technical component*). Insurers look at the date a procedure is performed, not the date the physician completes the report. For that reason, the physician’s professional component would be reported with the same diagnostic study code and modifier 26 (*Professional component*) appended with the date of service for the Monday start date.

Report 77003 With 27096 Now, But Not In 2012

**Question:**
Our pain management specialist often administers bilateral sacroiliac injections. I’m new to pain management coding but am not sure our previous biller reported the service correctly. What is the correct way to submit bilateral injections with fluoroscopic guidance?

**Answer:**
Begin with 27096 (*Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid*) for the SI injection. Because your specialist administered bilateral injections, check the payer’s policy regarding how to report the service. Some payers require you to append modifier 50 (*Bilateral procedure*) to 27096 to indicate bilateral injections. Other payers require 27096 on two separate lines on the claim, with modifier LT (*Left side*) appended to one and modifier RT (*Right side*) appended to the other.

Report the fluoroscopic guidance with 77003 (*Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures [epidural, subarachnoid, or sacroiliac joint], including neurolytic agent destruction*). CPT® guidelines direct you to report 77003 once per spinal region (cervical, thoracic, lumbar, sacral). Correct Coding Initiative (CCI) guidelines direct you to report 77003 once per procedure. You should only report 77003 once in this situation, no matter which guidelines you’re following.

**Heads up:** Coding for this situation will change once CPT® 2012 goes into effect on Jan. 1, 2012. The services represented by 77003 will be included in the code descriptor for 27096, so you’ll only report 27096.

You Be the Coder

Marcaine Anesthetic Before Injection Usually Means No Pay

(Question on page 84)

**Answer:**
Physicians typically use Marcaine as an anesthetic for the procedure. If you look in your CPT® book under “CPT® surgical package definition,” it outlines that, “local infiltration, metacarpal/metatarsal/digital block or topical anesthesia” is included in the CPT® surgical code. Therefore, you shouldn’t report S0020 (*Injection, bupivicaine hydrochloride, 30 ml*) when your provider uses the Marcaine as an anesthetic prior to the injection.

Second, check whether your physician is injecting dexamethasone acetate (J1094, *Injection, dexamethasone acetate, 1 mg*) or dexamethasone sodium phosphate (J1100, *Injection, dexamethasone sodium phosphate, 1mg*). You might need to change the dexamethasone code on your claim.

In addition, J2010 (*Injection, lincomycin hcl, up to 300 mg*) is for the antibiotic Lincomycin, not the local anesthetic lidocaine. The only HCPCS code for lidocaine is J2001 (*Injection, lidocaine HCl for intravenous infusion, 10 mg*), which is for IV administration only. As noted above, most payers don’t separately reimburse for the local anesthetic used in injections. Whether you transposed the digits “0” and “1” on your claim and reported Lincomycin by mistake or whether you reported Lidocaine, the payer probably won’t reimburse.

If the claim is for a Medicare patient, remember that Medicare doesn’t accept any of the HCPCS “S” codes such as S0020. If you want to bill bupivacaine to Medicare, you would need to use submit J3490 (*Unclassified drugs*). However, most Medicare contractors do not pay separately for bupivacaine (Marcaine) unless it is in an implanted infusion pump.
Extra Time Can Be Part of 99241-99245 Consult Codes

Question: Our neurologist provides pre-op consultations for requesting surgeons. He completed the consult with a recent patient, but also spent quite a bit of time discussing and focusing on some of the patient’s health issues. Can we bill that separately as education or counseling (for a problem-focused visit), or is it included in the consult? Illinois Subscriber

Answer: Anything discussed as part of a consult is included in that encounter’s consultation code. That’s one difference between consultations and preventive visits, when you might be able to code separately for discussing “problems.” For the consultation code, choose from 99241-99245 (Office consultation for a new or established patient, which requires these three components …). You can code consultations based purely on time if the physician spends more than 50 percent of his face-to-face time with the patient on counseling or coordination of care. Because of this, the extra time your physician spent discussing the patient’s hypertension might allow you to report a higher-level code. Another option depending upon the total amount of time is the prolonged services code(s). The time needs to be at least 30 minutes longer than the time associated with the E/M code.

Yes, You Can List Multiple PQRS Measures

Question: Can we report more than one PQRS code measure on the same claim? West Virginia Subscriber

Answer: Yes. You aren’t limited to reporting just one Physician Quality Reporting System (PQRS) code per visit. “EPs [eligible professionals] may submit multiple codes for more than one measure on a single claim,” CMS states in its PQRS Implementation Guide. “Multiple CPT® Category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim,” CMS adds.

Details: You can read the complete Physician Quality Reporting System (PQRS) on ‘How to Get Started’ at https://www.cms.gov/PQRS/03_How_To_Get_STARTED.asp

Point to 64405 for GON Blocks

Question: How should I code a left GON block? Washington Subscriber

Answer: Use 64405 (Injection, anesthetic agent; greater occipital nerve) and modifier LT (Left) to report the unilateral greater occipital nerve (GON) block. Neurologists often use occipital nerve blocks for patients with 723.8 (Occipital neuralgia). This condition produces an aching, burning, or throbbing pain, or a tingling or numbness, along the back of the head. The GON originates from the C2 spinal nerve and provides sensory innervation to the back of the scalp extending to the top of the head. Your neurologist will typically inject the GON just above the base of the skull for occipital or cervicogenic headaches or neck pain.

Tip: You’ll find it helpful to note that GON blocks are different from facial nerve blocks, which you report with 64402 (Injection, anesthetic agent; facial nerve). Facial nerve blocks are often administered just in front of the ear.

Your neurologist should clearly indicate the injection location in his documentation. In fact, some providers include in their documentation a small illustration that can be marked with the various injection sites. You can then ensure that you’re choosing the correct nerve block code each time.

Clinical and coding expertise for You Be the Coder and Reader Questions provided by Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO, owner of MJH Consulting in Denver.
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