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Welcome to the November issue of Maxim Coding Corner<sup>SM</sup>! As a leader in the HIM industry, [Maxim Health Information Services](#) is committed to providing you with updates on coding-related topics that matter to you. This month, we are focusing on coding for Pain. Read on below to learn more.

#### Coding for Pain

**Effective Oct. 1st, 2006, new codes for generalized pain, postoperative pain and central pain syndrome were approved for ICD-9.** In the nervous system chapter, a new category was created to differentiate between acute pain, chronic pain and central pain syndrome. In addition, there are now specific codes for postoperative, post-thoracotomy and neoplasm related pain.

#### The new codes related to pain are:

- 338.0, Central pain syndrome
- 338.11, Acute pain due to trauma
- 338.12, Acute post-thoracotomy pain
- 338.18, Other acute postoperative pain
- 338.19, Other acute pain
- 338.21, Chronic pain due to trauma
- 338.22, Chronic post-thoracotomy pain
- 338.28, Other chronic postoperative pain
- 338.29, Other chronic pain
- 338.3, Neoplasm-related pain (acute) (chronic)
- 338.4, **Chronic pain syndrome**- this condition is different than "chronic pain" and therefore should only be used when it is specifically documented as this condition.

#### Generalized pain is coded to 780.96.

A thorough review of the guidelines is important for correct coding and can be located in the Official ICD-9-CM Guidelines for Coding and Reporting and in CC 4th Quarter 2007 pg. 158-162. Several established guidelines provide guidance on these codes as well. Examples of these underlying principles are:

- Signs and symptoms- codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.
- Conditions that are an integral part of a disease process-

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signs and symptoms that are integral to the disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

**Codes from category 338 can be used in conjunction with codes that identify the site of the pain (this includes Chapter 16 codes) if the 338 code provides additional information. When sequencing category 338 codes, it is dependent on the circumstance of the encounter. Examples of this are:**

- If the encounter is for pain control or pain management, assign the category 338 code followed by the specific site of pain. For example, an encounter for pain management for acute back pain and presents for an injection of Toradol. This would be coded to 338.11 and 724.5.
- If the encounter is for any reason other than pain control or management, and a related definitive diagnosis has not been established by the provider, assign the code for the specific site of pain followed by the appropriate code from category 338. For example, an encounter for acute back pain presents to the ER and a urinalysis is performed. This would be coded to 724.5 and 338.11.
- A code from 338.1 and 338.2 should **not** be assigned if the underlying (definitive) diagnosis is known, unless the encounter is for pain control or pain management. For example, a patient is seen for chronic abdominal pain due to chronic cholelithiasis. This would be coded to 574.20. While a patient is being treated with epidural injections for chronic pain syndrome due to a displaced intervertebral disc. This would code to 338.4 and 722.10.

**Postoperative and Post-Thoracotomy pain are classified to subcategories 338.1 and 338.2.** It is important to verify that it is *not* associated with a specific postoperative complication. If it is associated with a specific postoperative complication, it would be appropriate to use the codes for Chapter 17, Injury and Poisoning. If appropriate, codes from category 338 may be used to identify if it is acute or chronic. (CC 2nd Quarter 2007 pg. 15) If the postoperative pain is not associated with a specific postoperative complication or if the encounter is for pain management or pain control, a code from category 338 should be assigned as the principal diagnosis or the first listed diagnosis.

**Neoplasm related pain is classified to subcategory 338.3.** If the encounter is for control of the pain related to, due to, or associated with malignancy, code 338.3 would be assigned. The underlying malignancy should be reported as an additional diagnosis. (CC 2nd Quarter 2007 pg. 13-14)

Coding pain codes correctly is extremely important for correct coding and reimbursement. When determining the use of codes from category 338, remember that the reason for the encounter and the physician documentation is key.

#### **References**

National Center for Health Statistics (NCHS). "ICD-9-CM Official Guidelines for Coding and Reporting," Section I. C. 6. November 15, 2006. Available online at

[www.cdc.gov/nchs/datawh/ftpserv/ftpiced9/ftpiced9.htm#guide](http://www.cdc.gov/nchs/datawh/ftpserv/ftpiced9/ftpiced9.htm#guide)

Zeisset, Ann. "Coding Guidelines for Pain." Journal of AHIMA 78, no. 3 (March 2007) pages 78-79

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