Coding Guidelines for Pain

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New codes for generalized pain, central pain syndrome, and postoperative pain were approved for ICD-9-CM in FY 2007 and went into effect October 1, 2006. Previously codes for pain were found in the body system chapters and the symptom chapters. A new category was created in the nervous system chapter for some of these conditions, and the codes differentiate central pain syndrome, acute pain, and chronic pain.

Postoperative pain was previously indexed to "see Pain, by site"; however, coding only the site of the pain did not indicate its postoperative nature. These codes were created because ICD-9-CM did not have specific codes for encounters for pain management or for these specific types of pain.

In addition to specific codes for post-thoracotomy pain and postoperative pain, there is a specific code for neoplasm-related pain (338.3). Generalized pain is coded to 780.96. 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
- 780.96, Generalized pain

Documentation: Key to Coding

Documentation is the key to the correct code assignment when coding these conditions. Several of the codes are similar but vary slightly. Code 338.0 describes central pain syndrome; 338.4, Chronic pain syndrome; and 338.29, Other chronic pain. These conditions are different, and code assignments are based upon physician documentation.

Central pain syndrome is a neurological condition that can be caused by damage to the central nervous system. It can be traumatic (brain or spinal cord) or brain-related (such as stroke, multiple sclerosis, tumors, epilepsy, or Parkinson's disease). The character and extent of the pain differs widely depending on the cause. The pain may affect a large portion of the body or may be restricted to specific areas. Central pain syndrome usually begins shortly after the injury or damage, but it can be delayed, especially if related to post-stroke pain. Patients with central pain syndrome are treated with pain medications and sometimes antidepressants or anticonvulsants. The code for central pain syndrome includes thalamic pain syndrome (previously indexed to code 348.8, Other conditions of brain), Dejerine-Roussy syndrome, and myelopathic pain syndrome.

Chronic pain syndrome (CPS) is common and poses a major challenge to healthcare providers because it is a complex phenomenon. It has many factors associated with it and at this point is poorly understood. Treatments may consist of a rehabilitation program, surgical interventions, or other treatments such as injections, manipulations, biofeedback, or pharmacotherapy. Surgical treatment may consist of nerve blocks, spinal cord stimulation, trigger point injections, and intrathecal morphine pumps. CPS is different than the term "chronic pain," and therefore code 338.4 should only be used when the provider has specifically documented this condition.

Chronic pain is classified to subcategory 338.2. There is no time frame defining when pain becomes chronic pain. The provider's documentation should be used to guide the use of the code, not an interpretation by the coding professional.

Pain Coding Guidelines

With the creation of the new codes, guidelines related to these codes were added to the ICD-9-CM Official Guidelines for Coding and Reporting, effective November 15, 2006. A thorough review of these guidelines (section I. C. 6) is important for correct code assignment. Several established guidelines provide guidance on the use of 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 (I. B. 6).
- Conditions that are an integral part of a disease process-signs and symptoms that are integral to the disease process should not be assigned as additional codes, unless otherwise instructed by the classification (I. B. 7).

Codes from category 338 may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain and neoplasm-related pain. If the pain is not specified as acute or chronic, do not assign codes from category 338, except for post-thoracotomy pain, postoperative pain, or neoplasm-related pain. For example a patient with chronic abdominal pain would be coded to 789.00 and 338.29, while a patient with abdominal pain would be coded to 789.00.

A code from subcategories 338.1 and 338.2 should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control or management and not management of the underlying condition. It is very important that coding professionals review, understand, and apply this guideline so that these codes are not overutilized. For example, a patient diagnosed with chronic abdominal pain due to chronic cholelithiasis would be coded to 574.20, while a patient who is being treated with spinal cord stimulation because of chronic pain syndrome due to thoracic spondylosis with myelopathy would be coded to 338.4 and 721.41.

Principal or First-Listed Diagnosis

Category 338 codes are acceptable as the principal diagnosis (or first-listed code) for reporting purposes in two instances: when the related definitive diagnosis has not been established (confirmed) or when pain control or pain management is the reason for the admission or encounter. Take for example a patient who has a displaced lumbar intervertebral disc and acute back pain and presents for injection of steroid into the spinal canal. This encounter would be coded to 338.19 and 722.10.

Use of Category 338 Codes with Pain Codes

Category 338 should be used in conjunction with site-specific pain codes (including codes from chapter 16) if category 338 codes provide additional information about the pain, such as if it is acute or chronic. The sequencing of category 338 codes along with site-specific pain codes (including chapter 16 codes) depends on the circumstances of the encounter or admission and must follow these guidelines:

- 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 neck pain from trauma would be coded to 338.11 and 723.1.
- 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 neck pain from trauma would be coded to 723.1 and 338.11.

Postoperative Pain

When postoperative pain is not associated with a specific postoperative complication, it is assigned to the appropriate postoperative pain code in category 338. Postoperative pain from a complication (such as a device left in the body) is assigned to the appropriate code(s) found in chapter 17, Injury and Poisoning. In this case the code such as 998.4, Foreign body accidentally left during a procedure, would be the definitive diagnosis, and no additional code would be assigned from category 338. If, however, the patient is being seen for pain control or management, a code from category 338 should be assigned as the

principal or first-listed diagnosis as stated above. If using a code in the 996.7 subcategory, a note indicates that the appropriate pain code should be assigned as an additional code.

Postoperative pain may be reported as the principal diagnosis when the reason for the encounter is postoperative pain control or management. It may be assigned as a secondary diagnosis code when the patient presents for outpatient surgery and develops an unusual or inordinate amount of postoperative pain. Post-thoracotomy pain can be classified as acute (338.12) or chronic (338.22). The default code for post-thoracotomy and other postoperative pain not stated as acute or chronic is to code the acute form.

Special note: Routine or expected postoperative pain immediately after surgery should not be coded, and the provider's documentation should guide the coding of postoperative pain.

Neoplasm-Related Pain

Code 338.3 is used to classify pain related to, associated with, or due to a tumor or cancer whether primary or secondary. This code is used as the principal code when the admission or encounter is for pain control or pain management. In this case, the underlying neoplasm should be reported in addition. When the encounter is for management of the neoplasm and the pain is also documented, it is appropriate to assign code 338.3 as an additional diagnosis. For example, a patient who was admitted for insertion of a pump for control of pain due to liver metastasis from a history of breast cancer would be coded to 338.3, 197.7, and V10.3. In another example, a patient is seen because of lower back pain; the patient has prostate cancer, and a bone scan shows metastasis to bones. The encounter would be coded to 198.5, 185, and 338.3.

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/ftpicd9/ftpicd9.htm#guide.

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Article citation:
Zeisset, Ann M.. "Coding Guidelines for Pain" *Journal of AHIMA* 78, no.3 (March 2007): 78-79.