PainMed PA

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The world's first pain management focused AI model

Denial Trends 2025

Schedule a Free Review

https://painmedpa.com/

Do you believe that pain denials are rising? Get the data.

Top Denial Trends in Interventional Pain Management (2025)

1.

Missing or Invalid Prior Authorization

`#1 denial trend for high-dollar procedures`

COMMONLY DENIED CPTS:

- 63650 – SPINAL CORD STIMULATOR TRIAL LEAD PLACEMENT
- 64483 – LUMBAR TRANSFORAMINAL INJECTION
- 64635 – LUMBAR/SACRAL RF ABLATION
- 64625 – SI JOINT RF
- 22869/22870 – IMPLANTED GENERATOR/LEAD REMOVAL OR REVISION

Causes:

- Authorization was not obtained before procedure
- Auth expired before date of service
- Wrong CPT code was authorized (e.g., single vs. multi-level)
- Payer requires documentation before authorization but it wasn't submitted

2025 Note:

Many payers now require conservative care documentation + imaging studies before granting auth, even for repeat procedures.

2.

Lack of Medical Necessity / Documentation Insufficiency

COMMONLY DENIED CPTS:

- 64633–64636 – RF ABLATIONS (FACET/MEDIAL BRANCH BLOCKS)
- 64490–64495 – FACET INJECTIONS
- 63650/63685 – SCS TRIAL AND IMPLANTATION
- 20552/20553 – TRIGGER POINT INJECTIONS

Triggers:

- Missing documentation of failed conservative care (PT, meds, etc.)
- No imaging to support diagnosis
- Repeated injections/RF without functional outcome data
- Documentation doesn't clearly state pain source or failed prior therapy

2025 Note:

MACs and commercial payers have tightened coverage criteria. LCDs now require specific timelines between procedures, detailed history, and documented response to previous interventions.

3.

Incorrect or Missing Modifiers

`Major issue in multi-level or bilateral procedures`

COMMON MODIFIERS MISUSED:

- -50 (BILATERAL)
- -59 OR -XS (DISTINCT PROCEDURAL SERVICE)
- -LT / -RT (LEFT/RIGHT)
- -22 (INCREASED PROCEDURAL SERVICES)

Examples:

- 64635 billed without -50 or -59 for bilateral facet RF
- 64483 billed twice without correct modifiers to indicate multiple levels
- Missing -59 on fluoroscopic guidance (77003) billed with injection codes

2025 Note:

Payers are applying NCCI edits more aggressively and expect clear modifier use aligned with documentation.

4.

Frequency Limit Exceeded

Common for injections and RFs

PROCEDURES AFFECTED

- FACET INJECTIONS: 64490–64495
- SI JOINT INJECTIONS: 27096
- TRIGGER POINT INJECTIONS: 20552/20553
- EPIDURAL INJECTIONS: 62321, 64483

Denial Reasons:

- 64635 billed without -50 or -59 for bilateral facet RF
- 64483 billed twice without correct modifiers to indicate multiple levels
- Missing -59 on fluoroscopic guidance (77003) billed with injection codes

2025 Note:

Embed automated alerts in your EHR or scheduler to flag potential frequency risks before authorization/submission.

5.

Bundled or Inclusive Services Denied Separately

COMMON MODIFIERS MISUSED:

- 77003 (FLUORO) DENIED WHEN BUNDLED INTO INJECTION
- 95873/95874 (EMG GUIDANCE) DENIED IF INCLUDED IN NEUROSTIM PROCEDURES
- 64493 DENIED WHEN BILLED WITH 64633 ON SAME DATE WITHOUT PROPER MODIFIERS

2025 Note:

CMS and commercial payers are aggressively applying bundling rules, and many require modifier -59 or -XU with documentation to unbundle services.

6.

Non-Covered Services / Experimental Codes

Especially an issue with newer regenerative medicine procedures

COMMONLY DENIED:

- PRP INJECTIONS (0232T)
- STEM CELL THERAPIES
- SOME PERIPHERAL NERVE STIMULATOR CODES (E.G., 64555, 64575)
- EXPERIMENTAL USES OF NEUROSTIMULATION FOR OFF-LABEL CONDITIONS

Solutions:

- Always check payer policy and LCDs for coverage status
- Use ABNs (Advance Beneficiary Notices) for Medicare patients
- Educate patients on potential out-of-pocket responsibility

7.

Incorrect Place of Service or Provider Type

Less common, but seen in hospital-based or ASC billing

COMMON ISSUES:

- POS CODE DOES NOT MATCH DOCUMENTATION (E.G., 11 VS. 22 VS. 24)
- BILLING PROVIDER NOT CREDENTIALED FOR THAT PAYER/PROCEDURE
- PAS/NPS BILLING WITHOUT INCIDENT-TO COMPLIANCE

How to Reduce These Denials in 2025

Proactive Best Practices:

- Automate real-time eligibility + prior auth tracking
- Use checklist-driven documentation templates tied to payer policies
- Train billing teams on modifiers and CCI edits specific to pain procedures
- Regularly audit denials by CARC/RARC codes and procedure type
- Crosswalk high-denial CPTs with documentation and auth workflows
- Leverage tools like Mainer.ai to flag potential denial risks before submission

What's Next?

If you are interested in learning more about PainMedPA or MAINER.AI the world's first pain management focused AI model. Then contact us for a review of your processes.

Our team can help reduce your denials.

POWERED BY MAINER.AI

PainMed-PA

A PROBE PRACTICE SOLUTIONS COMPANY

PainMedPA + Mainer.ai can Help

We combine specialty billing expertise with AI-powered tools to help outpatient pain practices:

- Reduce denials
- Improve documentation & coding compliance
- Automate revenue cycle intelligence
- Maximize revenue from every procedure

Schedule a Free Review

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