Internal Medicine Coding Alert

Are You Reporting Trigger Point Injections Correctly?

3 tips ensure proper reimbursement for 20552-20553

You'll report trigger point injections (20552-20553) with confidence if you know what muscle groups the internist treated maintain solid documentation and avoid using Modifier -59 coding experts say. Our experts offer three tips for improving your trigger point coding:

1. Bill One Injection Per Muscle Group

To properly use **CPT 20552** (Injection[s]; single or multiple trigger points[s] one or two muscle[s]) and 20553 (... single or multiple trigger point[s] three or more muscles) you should know the muscles the internist treated. Typically patients have back pain (724.5x) that originates in one muscle group. Even so they feel discomfort throughout their back and in other parts of the body such as the legs and neck. But if your physician treats the pain with multiple trigger point injections and focuses on just one muscle you cannot bill for each injection.

You should report 20552 and 20553 once per session regardless of the number of injections or per muscle says **Brett Baker** third-party payment specialist for the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in Washington D.C.

For example a patient who has lower back pain also complains that her arms and legs ache. During the examination your physician discovers three trigger points in the multifidus muscle to the left of the L5 spinous process. The physician injects each trigger point in the multifidus muscle. You report 20552 because the physician treated only one muscle (multifidus) even though he administered three injections.

Also notice that 20552's descriptor represents single or multiple trigger points. Therefore billing 20552 lets the insurer know that your physician may have performed more than one injection although the insurer will pay the same rate.

When reporting 20553 make sure your physician treated multiple muscles. For example a patient recovering from an auto accident presents with neck pain (723.1 Cervicalgia) and shoulder pain (726.1x). The internist identifies three trigger points: the right trapezius left trapezius and the right sacroiliac muscles. In this instance you should submit 20553 once for your physician injecting three muscles.

2. Check Your 20552-20553 Documentation

If your carrier rejects your 20552 or 20553 claim check the documentation - it should clearly state which muscles the internist treated. Most likely insurers will reject claims based on documentation that ambiguously refers to muscles or focuses on the number of injections.

Physicians can no longer simply report that they injected three muscles says **Jean Ryan-Niemackl LPN CPC** an application specialist with QuadraMed Government Programs Division Fargo N.D. The physician must also include which muscles he injected and list the most specific ICD-9 code she adds.

For example the physician treats a patient with chronic hip pain (726.5). The physician performs three trigger point injections in the patient's hip scar. In the documentation the internist notes that he or she administered the injections in the scar's mid portion and mid-superior portion. Because the doctor didn't name muscles you should not list a code higher than 20552. In addition you would link 726.5 to 20552 to support medical necessity.

Also if the internist's documentation indicates how he discovered the patient's trigger point you may be able to bill for an E/M service. But make sure the physician performed a separately identifiable E/M service Ryan-Niemackl says.

Suppose a patient comes in for a diabetes (250.xx) evaluation. During the visit the patient complains of back pain and the internist administers a trigger point injection. You could report 20552 for the injection but you'll need modifier -25 (Significant separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to report the appropriate E/M code. Modifier -25 informs Medicare that the physician performed an E/M service separate from the injection. With sufficient documentation you could use 99212-25 (Office or other outpatient visit ... established patient; Significant separately identifiable evaluation and management service ...) for instance.

Remember however if the patient presents only for the injection you cannot report an E/M code. For example the internist instructs the diabetes patient to take oral medication to treat the back pain. A month later the patient returns and his back hasn't improved. Therefore the internist gives the patient the trigger point injection. For the initial visit you would report only the appropriate level of E/M service. And for the second visit report 20552.

3. You Can't Unbundle Trigger Point Codes

Don't even think about attaching modifier -59 (Distinct procedural service) to either 20552 or 20553 no matter how well your internist documents the treatment. Because both trigger point codes refer to ""single or multiple trigger point(s) "" you cannot claim one injection as distinct from another.

Medicare assigns a zero-day global period to 20552 and 20553. This means that Medicare bundles payment for all related services and procedures on the same date into the payment for 20552 and 20553 Baker says.

Therefore when the internist injects three different muscles you can only report one code 20553. Before CPT introduced 20552-20553 in 2002 internal medicine coders could use modifier -59 to report 20550 (Injection; tendon sheath ligament or ganglion cyst) multiple times for trigger point injections in different sites.

"