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Internal Medicine Coding Alert

Follow Specific Payer Guidelines to Get Paid for Trigger Point Injections and Dry Needling

Although several physicians perform trigger point injections and dry needling (see description below), getting paid for them can be difficult because there is not much clinical data to support their use. And even though some payerslike Medicarecover the procedures, different guidelines and reporting requirements make getting paid a headache.

Internists treating patients who suffer from chronic pain often employ a therapeutic technique known as trigger point injections. This involves injections at set trigger points on the patients body to block the referral of pain along the nerve paths.

Trigger point injections may include lidocaine or cortisone, but sometimes no material is injected into the site. This is known as dry needling.

Trigger point injections are often done without actually injecting anything, advises **Jim Stephenson,** billing manager for Premium Medical Management Inc., a multi-specialty physician group in Elyriah, OH. Its supposed to put an obstacle in the way of pain referral from the trigger point to the outer-lying muscle tissue. It is similar to acupuncture.

The reason they are so hard to get covered is because there really hasnt been enough controlled research to prove that they are a good source of treatment, Stephenson says. Accordingly, there are only a select few diagnosis codes that they will get paid with.

Basically, a trigger point is the source of pain but not the actual site of the pain, he explains. The trigger point refers pain to the tissue around that particular area, it is not the actual site of the pain itself. By doing these injections, it blocks the referral of pain, alleviating it in that general area.

To find out how to get proper reimbursement for trigger point injections, we looked up the local medical policies for this procedure at two separate Medicare carriersCahaba Government Benefits Administrators Inc., the carrier for Georgia, and Empire Medicare Services, the carrier for New York and New Jersey. Heres what we found out.

Clinical and Documentation Requirements

According to both Empire and Cahaba, trigger point injections are considered a valid service. But the two carriers have different requirements for coding the proced-ure and slightly different policies regarding which ICD-9 codes support the medical necessity of the injections.

The local coverage policies published by both carriers indicate: Trigger point injection is one of the many modalities utilized in the management of chronic pain. Myofascial trigger points are self-sustaining hyperirritative foci that may occur in any skeletal muscle in response to strain produced by acute or chronic overload. These trigger points produce a referred pain pattern characteristic for that individual muscle. Each pattern becomes part of a single muscle myofascial pain syndrome (MPS); and each of these single muscle syndromes is responsive to appropriate treatment, which includes injection therapy. Injection is achieved with needle insertion and the administration of agents such as local anesthetics, steroids, and/or local inflammatory drugs.

Both carriers give specific examples of how a diagnosis requiring the use of trigger point injections is to be determined:

The diagnosis of trigger points requires a detailed history and thorough physical examination. The following clinical

features are present most consistently and are helpful in making the diagnosis:

1. History of onset of the painful condition, and its presumed cause (injury, sprain, etc.).

2. Distribution pattern of pain consistent with the referral pattern of the trigger points.

3. Restriction of range of motion.

4. Muscular deconditioning in the affected area.

5. Focal tenderness of a trigger point.

6. Palpable taut band of muscle in which trigger point is located.

7. Local taut response to snapping palpation.

8. Reproduction of referred pain pattern upon stimulation of the trigger point.

For the service to be covered, both carriers also stipulate that the patients medical record must contain the following documentation elements:

9. Documentation of proper evaluation leading to diagnosis of trigger point (see indications above.).

10. Identification of the affected muscle(s).

11. Documentation of reasons for selecting this therapeutic option.

12. Documentation of the reason for the trigger point injection, and documentation indicating whether it is being used as an initial or subsequent treatment for myofascial pain.

Overcome CPT Coding Challenges

According to Empire Medicare Services Medicare News Brief sent to its providers on April 3, 1999, four codes can be used to report trigger point injections:

- 20550Injection, tendon sheath, ligament, trigger points or ganglion cyst

- 97780*Acupuncture, one or more needles; without electrical stimulation

- 97781*With electrical stimulation

- J-codeWhere applicable, (in addition to procedure code) to indicate agent being injected, such as J0704 (injection, betamethasone sodium phosphate)

Empire indicates that 97780 and 97781 are not covered by Medicare. The Cahaba policy only indicates code 20550 as the procedure code applicable for trigger point injections.

Both policies also note that trigger point injections do not have their own CPT code. Code 20550 also covers four other procedures.

In addition to the correct code, internists should note what codes cannot be reported with the trigger-point injection code.

Both carrier policies state that codes 10160 (puncture aspiration of abscess, hematoma, bulla, or cyst) or any of the nerve block injection codes (64400-64530) must not be coded on the same day as code 20550 due to edits in the Correct Coding Initiative (CCI).

To report trigger point injections, the Cahaba policy instructs, Use CPT code 20550 in column 24D of the HCFA 1500 form and link it to the applicable ICD-9-CM code in box 24E. For billing multiple trigger points injected on the same day or during the same session, use 20550 with modifier -51 for the second and subsequent injections. Indicate the number of additional injections given in column 24G of the form.

Empires policy states a similar coding procedure but requires that modifier -59 (distinct procedural service) be used instead of modifier -51 (multiple procedures) for additional trigger point injections on the same day.

Cahabas policy notes that trigger point injections often are given in a series, usually no more than eight in one day. If more than eight trigger points are injected in a given day, a special report must be submitted with the claim explaining the reason for the additional injections.

These may be processed and paid under individual consideration, the policy states.

Coders Tip: A series of trigger point injections, given on the same day, must be in different sites. Both Empire and Cahaba specify that When a given site is injected, it will be considered one injection service, regardless of the number of injections administered.

Valid ICD-9 Code Required

Both carriers also have a list of valid diagnosis codes that indicate the medical necessity of a trigger point injection (see chart at right). And the ICD-9 codes are linked to specific muscle groups, so injections into a certain site must be supported by the ICD-9 code corresponding to that site.

For example, Empire lists the ICD-9 code 720.1 (spinal enthesopathy) with the corresponding muscle groups serratus anterior, serratus posterior, quadratus lumborum, longissimus thoracis, lower thoracic iliocostalis, rectus abdominalis (upper & lower), upper lumbar iliocostalis multifidus, external oblique, McBurneys Point.

Empires policy stipulates that claims submitted

without a listed diagnosis code will be rejected. The Cahaba policy says that claims submitted with an ICD-9 code other than one on the list should be accompanied by documentation of the visit, however, and that these claims will be considered individually. All electronic claims should have the phrase medical necessity documented in patients record in the comment line, both carriers say.

Remember J Code for Injectable Agent

In addition to getting paid for the injection, Empires policy indicates it will reimburse for the injected agent as well, if there is one. But the J code for the agent must be reported with the CPT code for the injection on the same claim.

As the policy states, The provider must submit on the same claim when billing for CPT 20550, the agent being administered with the trigger point injection, using an appropriate J-code. Claims for CPT code 20550 without the corresponding J-code will be denied.

Note: This is true for all injections except those with the ICD-9-CM code 726.32 (lateral epicondylitis). This condition is also covered when treated with dry needling and no injectable is used in that procedure.

Cahabas policy does not indicate any reimbursement for the injectable agent or coverage of a trigger point injection with the ICD-9 code as 726.32.

Policies May DifferCheck With Individual Payers

As you can see from the examples above, individual carriers may have slightly different requirements for reporting trigger point injections. In addition to following the general requirements listed here, internists should obtain the local policy of your carrier.

Getting paid for trigger point injections may be even more difficult with private payers, but the written policy of your Medicare carrier may help to convince them this is a valid service.