Codify
BY AAPC

Internal Medicine Coding Alert

Follow TPI Do's and Don'ts for Pay You Can Keep

Documentation detailing these injection encounters can fortify claim.

Counting the right items, knowing insurer-allowed diagnoses, and documenting affected muscles will get your trigger point injection (TPI) claims paid while protecting you from paybacks.

Further, knowing each insurers' covered diagnoses for TPIs is vital to healthy coding.

Do Count Muscles Injected

Coders should report 20552 (Injection[s]; single or multiple trigger point[s], 1 or 2 muscles) when the internist injects one or two muscles, confirms **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO,** of MJH Consulting in Denver.

When the internist injects three or more muscles, opt for 20553 (... single or multiple trigger point[s], 3 or more muscle[s]).

Remember, "coding is based on the number of muscles injected, not the number of trigger points in those muscles OR the number of injections into those muscles," Hammer relays.

Do Check for Acceptable ICD-9s

Patients suffering from muscle pain receive TPIs for relief; however, the types of pain that justify TPIs are entirely up to the payer. Diagnoses that prove medical necessity for TPIs vary greatly. Some insurers cover only 729.1 (Myalgia and myositis, unspecified), while others have expanded the list of ICD-9 codes that support medical necessity for TPIs.

Best bet: Check with your payer for its specific list of acceptable ICD-9s on TPIs.

In addition to 729.1, 728.85 (Spasm of muscle) and 729.4 (Fasciitis, unspecified) are also common diagnoses for TPI, Hammer explains.

Here is a sampling of other acceptable ICD-9s for TPIs from the local coverage determination [LCD] for First Coast Service Options, a Florida Medicare carrier:

• 726.30-726.39 -- Enthesopathy of elbow region

• 726.70-726.79 -- Enthesopathy of ankle and tarsus

• 727.00-727.09 -- Synovitis and tenosynovitis

Don't Skimp on TPI Documentation

When reporting TPI encounters, experts recommend including a list of the muscles the internist injects. "Since the coding is based on number of muscles, the provider should absolutely document the specific muscles injected," Hammer explains.

"Otherwise, the most that you could code is 20552, as the documentation could not support that three or more separate muscles were injected," she says.

Providers should also include documentation of the drug(s) that were injected to clarify that the procedure was an injection and not "dry-needling," which some payers do not cover, says Hammer.

You should check with your carrier if you are unsure of the specific substances your payer will accept on TPIs.

Use these J codes for drugs the internist might inject during TPI:

• J1020 (Injection, methylprednisolone acetate, 20 mg) for Depo-Medrol

• J1030 (Injection, methylprednisolone acetate, 40 mg) for DepoMedalone40, Depo-Medrol, or Sano-Drol

• J1040 (Injection, methylprednisolone acetate, 80 mg) for Cortimed, DepMedalone, DepoMedalone80, Depo-Medrol, Duro Cort, Methylcotolone, Pri-Methylate, or Sano-Drol.