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# Internal Medicine Coding Alert

## Knee Injections: When Coding Trigger Points, Count Muscles, Instead of Injections

**Here's your guide to success with TPI versus other knee injections.**

All knee injections -- and coding for them -- aren't created equal, especially when you're coding for trigger points versus a standard joint injection. Keep our experts' top advice on differentiating procedures in mind, and you'll be flexing your coding muscles with correct claims.

**Report TPI Based on Muscle Numbers**

Physicians administer trigger point injections (TPI) to treat painful muscle areas that contain trigger points, or knots of muscle that form when muscles do not relax. The most important factor when coding TPIs is to focus on the number of muscles your physician injects, not the total number of injections. Consider the descriptors for CPT®'s current TPI codes:

- 20552 -- Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
- 20553 -- ... single or multiple trigger point(s), 3 or more muscle(s).

Example: A runner who is an established patient for your physician complains of bilateral knee pain (719.46, Pain in joint; lower leg). The physician injects the popliteus muscles in the back of each knee. Although he injects both knees, he only treats a total of two muscles. Therefore, you'll submit one unit of 20552. If the physician had administered TPIs to both knees and another muscle group (such as the patient's hip), you would report 20553 instead.

**Choose Joint Injection Code by Size**

For joint injection -- also known as arthrocentesis -- you select codes based on the joint size. For a knee injection, choose 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]).

Difference: Report joint injection procedures by the number of injections administered, not the muscles or areas treated. That means modifiers and different numbers of units can come into play when filing your claim, unlike when you report TPI.

When the internist administers knee joint injections, she should indicate whether she performs the procedure on the right, left, or both knees. You'll include documentation with the claim, as needed, and append the appropriate modifier to 20610:

- Modifier RT -- Right side
- Modifier LT -- Left side
- Modifier 50 -- Bilateral procedure.

Tip: Check your local payer policies for details regarding joint injection coding and reimbursement. For example, current guidelines for Blue Cross/Blue Shield of Mississippi state, "Reimbursement for arthrocentesis, aspiration and/or injection of major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa), CPT 20610, will **not** exceed **four** (4) services per site within a thirty (30) day period."

**Check for Correct Modifier Reimbursement**

The Medicare Physician Fee Schedule indicates that a 150 percent payment adjustment applies to procedure codes with

a bilateral indicator of "1" (such as code 20610) when you submit the claim with modifier 50.

"If you've been using modifier 50, look at your payments to see if the insurer has been paying you unilaterally (at 100 percent) instead of bilaterally (at 150 percent)," advises **Joanne Schade-Boyce, RDH, MS, CPC, ACS, PCS,** vice president of FairCode Associates LLC in Germantown, Md. Audits frequently reveal documentation and coding that supports a bilateral procedure that the insurer has paid unilaterally.

The insurer might incorrectly process Medicare's preferred method of a one-line entry with modifier 50 (such as 20610-50). Private payers might want bilateral procedures on either two lines, with modifier 50 on the second line (20610, 20610-50), or no modifier with two units on a single line item (20610 x 2).

**Determine Whether E/M Applies**

Some office visits for knee injections qualify for an E/M code, but others don't. If the patient comes to your office specifically for a scheduled injection, you'll only report the injection code. If, however, the physician completes another service during the visit, an E/M code might apply.

Example: The physician completes and documents an appropriate history and thorough examination of an established patient. He advises the patient to go through a series of knee injections, and the patient agrees. You can report an E/M code from 99212-99215 (Office or other outpatient visit for the evaluation and management of an established patient ...) in addition to 20610. Append modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code.