Internal Medicine Coding Alert

Mythbuster: Trigger Point Injection (TPI) Reporting Made Easy

Warning: Watch for bundling edits when reporting other codes with TPI.

When you are reporting trigger point injections (TPI) that your internist performs, it is easy to fall into the trap of confusion over understanding whether to count the number of muscle groups or the number of injections that your clinician administered.

Bust these four common myths about TPI reporting that will provide you with up-to-date information about appropriate reporting for this procedure.

Myth 1: Count Number of Injections for Apt TPI Reporting

Reality: When your internist performs TPI, you will have to count the number of muscle groups that your clinician injected rather than checking the actual number of injections that was administered into each muscle group. Counting the number of muscle groups will help you select the right code for the TPI procedure. You will have to choose from one of the two codes depending on the number of muscle groups into which your physician administered the injection(s):

- 20552 (Injection[s]; single or multiple trigger point[s], one or two muscle[s])
- 20553 (...three or more muscle[s])

So, if your physician performed a TPI in one or two muscle groups, you will report the procedure with 20552. If three or more muscle groups were treated with TPI, you report it with 20553, regardless of the actual number of injections.

Example: Your physician performed two trigger point injections into the supraspinal muscle and two injections into the paraspinal muscle. Even though he administered four injections, he only treated two muscles, namely the supraspinal muscle and the paraspinal muscle. As he treated only two muscles, you will report the TPI with 20552.

Coding tip: When your internist performs a procedure called "dry needling" that involves the introduction of only a needle into the trigger point without administering any corticosteroid, anesthetic or any other drug (that are commonly used with trigger point injections), you cannot use 20552/ 20553 for the procedure. Instead, you will have to use an unlisted code, namely, 20999 (Unlisted procedure, musculoskeletal system, general) while providing documentation mentioning that your internist performed dry needling.

Myth 2: 20552 Can be Reported With 20553

Reality: When reporting TPI, you should bear in mind that 20553 is a standalone code and not an add-on code for 20552. So, you will not report 20552 for reporting TPI provided into two muscle groups and then report 20553 for the TPI provided into additional muscle groups. Instead, when the number of muscle groups into which the TPI was provided is more than two, you will just have to report one unit of 20553.

As per guidelines laid down by CMS, you cannot report 20552 and 20553 together on the same calendar date of service. You can only report one of the codes for a patient on one date of service. Also, Correct Coding Initiative (CCI) edits bundle the two codes with modifier indicator '0,' which means you cannot unbundle the two codes under any circumstances.

"These edits are consistent with the CPT® definitions and the CMS guidance," observes an internal medicine auditor. "If you do try to report 20552 and 20553 for the same patient on the same date, you will only be paid for 20553, since it is the column one code in the edit pair," she adds.

Example: A patient presents to your internal medicine specialist with complaints of severe pain in her shoulder and neck regions. Your physician identifies trigger points and decides to perform TPI. He administers two trigger point injections each in the right and left subscapularis muscles, three injections in the right sternocleidomastoid muscle, and two injections each into the right upper and lower trapezius muscles.

In this example, the physician administered the TPI into five muscles. In this instance, you will not report the administration of the TPI into the first two muscles with 20552 and the other three muscles with 20553. Instead, you will report only 20553 for the TPI into all five muscles.

Myth 3:Always Report the Drug Administered Separately

Reality: When an internist performs a TPI, he will administer an anesthetic, a corticosteroid, saline, neurolytic agents, or botulinum toxin into the trigger points. Commonly, your clinician will use saline, local anesthetic, or a corticosteroid into the site.

If he administers a local anesthetic such as bupivacaine or lidocaine, you will not report the anesthetic solution separately. The reimbursement for the solution is not made separately and is included in the practice expense component of 20552 and 20553. Also, there is no separate J code for these drugs used for this purpose that you can use to report the drug component separately.

However, if your clinician is using a corticosteroid such as Kenalog for the TPI, you can report a code such as J3301 (Injection, triamcinolone acetonide, not otherwise specified, 10 mg) for every 10 mg of solution used during the procedure. If your clinician is instead using Depo-Medrol, you can report J1020 (Injection, methylprednisolone acetate, 20 mg), J1030 (. . .40 mg), or J1040 (. . .80 mg), depending on the quantity used during the procedure.

Best bet: Although Medicare will not provide you any separate reimbursement for local anesthetics like bupivacaine or lidocaine, some other payers might. In such a case, you can consider using J3490 (Unclassified drugs) and document the type of anesthetic used while mentioning the quantity."You should clarify this with the payer before attempting to report the anesthetic in this manner," suggests Moore.

Myth 4: Don't Ever Report E/M Codes With TPI

Reality: As a norm, you are not allowed to report an E/M code with 20552/ 20553. Also, you will face bundling edits that will generally not allow you to report an E/M code with a TPI code. However, the modifier indicator for this bundling edit is '1,' which means you can unbundle the codes if you use a suitable modifier. Since the E/M code is the column 2 code in the edit bundle, you will have to append a modifier to the E/M code. The modifier that you will use with the E/M code is 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service).

However, you can only report an E/M service if and only if the E/M service is a significant, separately identifiable service from the injection. If the physician performs a history, examination, and medical decision-making beyond that associated with the TPI administration, you should report both the TPI and the E/M service.

Caveat: If the patient presents for a scheduled TPI, you typically shouldn't report an office visit. For instance, a patient with back pain presents for a single TPI, because, at a previous visit, your provider told the patient to return in a month for a TPI if his oral pain medication didn't work.

Because the physician already performed a pre-injection workup at the prior visit, he does not document a significant, separately identifiable service at the TPI encounter. So, in this instance you will only report the TPI code and not the E/M code.

However, in case your clinician had to assess the patient for some other complaint during a scheduled TPI visit, you can report an E/M code for that part of the service in addition to the TPI code that you will report for the encounter.