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Internal Medicine Coding Alert

The Proper Modifier Will Optimize Payment for Multiple Trigger Point Injections

As part of a pain management program, an internist may perform multiple trigger point injections on a patient during the same session. Some Medicare carriers, however, will not reimburse for multiple injections in the same part of the body on the same day, while others require the use of specific modifiers to designate that the procedures are distinct and separate. To receive proper reimbursement and thwart denials, internal medicine coders need to pay attention to carrier-specific diagnosis codes and other billing requirements that may affect payment for these services.

A trigger point is a hypersensitive area of the body that evokes pain elsewhere in the body when stimulated. Injections into the trigger point attempt to block the pain at its source, rather than at the site of the discomfort. Because the procedure is similar to acupuncture, which is not a Medicare-covered service, many carriers have set up detailed reimbursement policies to avoid overuse of the procedure.

Code 20550* (injection, tendon sheath, ligament, trigger points or ganglion cyst) is used to report trigger point injections, says **Kathy Pride, CPC,** coding supervisor for Martin Memorial Medical Group, a hospital in Stuart, Fla. This code also can be used to report three other types of injections: tendon sheath, ligament and ganglion cyst. But it is most commonly used to report a trigger point injection.

Using Modifier -59 for Multiple Injections

Some Medicare carriers, such as Empire Medicare Services of New York, do not provide additional reimbursement for multiple injections given in the same site because they are considered one injection. If injections are given at additional sites, then modifier -59 (distinct procedural service) should be attached to the subsequent injection codes to indicate that they are separate procedures.

First Coast Service Options, the Part B carrier for Florida, states in its local medical review policy (LMRP) that multiple injections are allowed by the same provider on the same day. The injections may be modified with -RT (right side) and -LT (left side) when appropriate (such as when a left shoulder or right shoulder is injected). The Florida policy also states that modifier -76 (repeat procedure by same physician) can be used to indicate multiple injections when -RT and -LT do not apply.

Pride, however, bills the Florida carrier for multiple injections with modifier -59 and still receives reimbursement. I dont feel that modifier -76 is the appropriate modifier to use in this situation because the internist is performing the procedure in a different area, not repeating it, she says. I have 57 physicians and 30 coders to supervise, and I dont want to teach them to make an exception for just one payer. So I use modifier -59 for both Medicare and commercial payers.

Some Carriers Dont Pay for Multiple Injections

Some carriers are very specific with their definition of what is considered a separate or additional site. Noridian of Iowa, the local Medicare carrier, states in its LMRP that it recognizes eight regions of the body for trigger point injections: head, cervical spine, left and right upper extremities including shoulders (counts as two regions), thoracic spine, lumbo-sacral spine, and left and right lower extremities including hips (counts as two regions).

Multiple injections into one body region should be billed as one injection under Noridians guidelines. Trigger point injections into multiple regions may be billed to reflect the number of body regions injected. For injections of tendon sheaths, ligaments and ganglion cysts, multiple units may be billed if different locations are injected.

By contrast, the LMRP that covers Alaska, Arizona, Hawaii, Nevada, Oregon and Washington does not provide extra reimbursement for any multiple trigger injections. The policy reads, [T]he injection of trigger points is considered one service and may be billed only one per visit, regardless of the number of injections. Multiple injections of tendon sheaths, ligaments or ganglion cysts may be billed with modifier -59.

Other carriers may require the use of modifier -51 (multiple procedures) to report multiple trigger point injections under certain circumstances. **Jim Stephenson,** billing manager at Premium Medical Management, a multispecialty practice in Elyria, Ohio, reports that he uses modifier -51 to report multiple injections in the same area of the body.

Pride points out that when multiple injections are billed, the multiple-surgeries payment rules in the Medicare Carriers Manual apply. This means that the first injection will be reimbursed at 100 percent of its standard fee, while subsequent injections will be reimbursed at 50 percent of their standard fees.

Medication Injected Must Be Reported on Claim

The medication that is injected into the trigger point is usually separately reimbursable, Pride says. Common medications that are used with the injection and are reim-bursable include celestone (J0702) and Depo-Medrol (J1030).

Lidocaine (J2000), a local anesthetic, also may be injected either by itself or in combination with another medication. This drug, however, usually is not reimbursed by Medicare.

Even if the medication is not billed for reimbursement, some carriers, such as Empire, require documentation that some sort of medication was used to prevent claims for dry needling. This is a technique in which no material is injected into the trigger point and consequently is not covered by most carriers. The New York LMRP states that the provider must include the drug name on the same claim as the trigger point injection procedure, or it will be denied. When the internist does not bill for the agent, an attachment must be submitted with the claim that identifies the drug and dosage.

Be Specific With Diagnosis Codes

Internists also should try to be as specific as possible when assigning a diagnosis code to the claim. One of the most common diagnoses given in our practice is shoulder pain (719.41), which isnt covered by Florida Medicare, says Pride. But a more specific diagnosis like rotator cuff syndrome of shoulder (726.10-726.19) is covered.

Another tip that Pride offers to internists is to be clear in the documentation as to what was done. Sometimes the internist will just write shoulder injection in the documentation, and the coder wont know if its a trigger point injection or arthrocentesis (20600), which is an injection into the joint, not a trigger point, she explains. The internist needs to be specific as to whether it was a joint, tendon sheath, trigger point, etc., that was injected. With this concise information, coders can easily choose the correct procedural coding scenario that will ethically maximize reimbursement for trigger point injections.