Codify
BY AAPC

Internal Medicine Coding Alert

You Be the Coder: Detail What's Not Working to Justify CT Injections

Question: Three months ago, our provider saw a patient complaining of wrist pain, a burning sensation that travelled up her arm, and tingling and numbness in the first three fingers and thumbs of both her hands. While taking the patient's history, the doctor noted that her job involved working all day, every day, on a computer. After trying various treatments in the subsequent months, our doctor has now decided on a course of steroid injections to help alleviate the patient's condition. How should we go about documenting the injections and justifying their necessity when we bill for them?

Indiana Subscriber

Answer: Before billing 20526 (Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel), you will need to provide documentation indicating the patient's response to other forms of treatment, as some payers will only reimburse for steroid injections for carpal tunnel once you have demonstrated that previous treatments have been ineffective.

So, for example, documenting the use of a splint with HCPCS code L3908 (Wrist hand orthosis (WHO), wrist extension control cock-up, non-molded, prefabricated, off-the-shelf) or ibuprofen injections with 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular) and J1741 (Injection, ibuprofen, 100 mg) with exact dates for their applications will certainly help your claim.

It is also important that you document the exact diagnosis code to justify the steroid treatment. Initially, your provider may have provided a preliminary diagnosis from the M25- (Other joint disorder, not elsewhere classified) or M79- (Other and unspecified soft tissue disorders, not elsewhere classified) codes, but a more specific diagnosis, in this case, G56.03 (Carpal tunnel syndrome, bilateral upper limbs), will help you build a strong case, as will documenting Y93.C1 (Activity, computer keyboarding) as the external cause of the injury.

As with most billing issues, you should certainly confirm with your payer that this documentation will be sufficient to prove medical necessity. You should also check with the payer for their modifier preference when you report 20526. Because your patient will be receiving two injections, one for each hand, you have a choice of modifiers for the procedure - either LT (Left side) and RT (Right side) or 50 (Bilateral procedure) - and you may even have a choice of using one or two lines to report the procedure.

For example, if your payer prefers the LT and RT modifiers, you could report 20526 x 2 with both modifiers on one line, or 20526 RT on one line and 20526 LT on the other.

Finally, make sure you document an appropriate level of evaluation and management (E/M) service, such as 99212 (Office or other outpatient visitfor the evaluation and management of an established patient...), for any documented work the physician did over and above that associated with 20526, and the appropriate J code for the drug and the amount your provider administers, such as J1020/J1030/J1040 (Injection, methylprednisolone acetate, 20 mg/40 mg/80 mg). You may need to append modifier 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) to the E/M code to indicate that it was significant and separately identifiable for 20526, especially since Correct Coding Initiative (CCI) edits otherwise bundle the E/M service into 20526.