Codify
BY AAPC

Internal Medicine Coding Alert

You Be the Coder: Ignoring New TPI Rules Is Painful

Question: Insurers keep denying trigger point injection (TPI) claims with 20550. For instance, my family physician performed 13 TPIs into six muscle groups, which I reported as 20550 x 13 units. The payer rejected the procedures. What am I doing wrong?

Colorado Subscriber

Answer: The problem is that you incorrectly coded the trigger point injections (TPIs). Coders used to report TPIs with 20550* (Injection[s]; tendon sheath, ligament). But in 2002, CPT changed the wording for 20550 and added 20552 (single or multiple trigger point[s], one or two muscle[s]) and 20553 (single or multiple trigger point[s], three or more muscles). CPT removed the words "trigger point" from the 20550 definition, which means you should not use it to bill for TPIs. Code 20550 now refers to a tendon or ligament, rather than a trigger point, which is a muscle or fascia. Consequently, you should use only the revised codes (20552-20553) for TPIs.

In addition to updating your injection knowledge, pay attention to the quantities these codes specify. Make sure to choose 20552-20553 based on the number of muscles injected, not the number of injections. In your case, the physician injected six muscles. Because 20553 stipulates "three or more muscles," you should report only 20553 for the injections. The revised code does not allow for additional reimbursement for the additional TPIs.