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Part B Insider (Multispecialty) Coding Alert

INJECTIONS: 3 Tips Add Almost $50 to Your Trigger Point Pay

If you're in doubt whether to reap payments for office visits or extra muscle-injections with your trigger point injection (TPI) encounters, then doubt no further. You can ethically maximize TPI-related reimbursement if you code based on three expert-approved guidelines:

1. Charge E/M With Unscheduled TPI Service. You should submit an E/M code, such as 99201-99215, when a patient presents for an unscheduled TPI as long as the visit meets all the requirements of an E/M code. To charge $36 or more for the separate office visit (the approximate fee for **CPT 99201**), the E/M must meet the criteria for modifier -25 (Significant, separately identifiable evaluation and management service), says **Amy S. McCreight**, compliance research analyst at **Ohio Health** in Columbus.

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. Make sure you don't separately bill the minor E/M that the TPI includes.

Suppose a doctor tells a patient to return in a month for a TPI if his oral pain medication doesn't work. Because the physician already performed a preinjection workup at the prior visit, she shouldn't bill separately for the office visit at the followup TPI encounter.

But if the patient returns for his scheduled injection and also complains of sneezing, congestion and watery eyes, the physician may perform a separate service from the scheduled TPI, to assess the patient's rhinitis symptoms.

2. Don't Bill Anesthetic. If you're not sure what 20552-20553's surgical packages contain, you're not alone. "I never know if I should report a topical anesthetic with a TPI," says **Rita Michelek**, practice operations director at **Partners in Primary Care** in Berlin, N.J.

You shouldn't separately report a numbing anesthetic that an physician administers prior to a TPI. "The TPI cost includes the anesthetic," McCreight says.

3. Count Muscles. About $7.50 is at stake when you choose between 20552 and 20553. You should submit the higher-paying code 20553 ($61.98, Medicare's geographically unadjusted rate) when your FPinjects three or more muscles. Reserve 20552 ($54.51) for TPIs into one or two muscles.

For example, a female runner shows up with abdominal pain and receives a full workup followed by three TPIs in separate abdominal areas. In that case, you should submit 20553.

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