Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 3 Ways to Make the Most of Injection Claims

Train your MD to clearly document the muscles--so you can code correctly

You may be submitting injection claims daily, but if you don't know your trigger point from your bursa, you could be noncompliant with every injection. The next time your physician performs an injection, follow these three steps to pinpoint the appropriate code.

1. Don't Use 90772 as a -Catchall-

Watch out: Say the word -injection- to coders in some specialties, and they-ll recommend 90772 (Therapeutic, prophylactic or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular) every time. But jumping to that conclusion could have you falling flat. For instance, more often than not, in a neurology practice, 90772 is not the right answer.

Many coders used to rely on 90782 as a -catchall injection code,- experts say. CPT 2006 deleted 90782 and introduced 90772 -quot; although you-ll still usually steer clear because the descriptor remained the same.

If your physician doesn't document his injection clearly enough to select an appropriate trigger point or joint/bursa injection code, some coders might assign 90772 for the procedure. More experienced coders, however, say this is usually a bad idea.

Why it doesn't work: First, automatically assigning 90772 isn't correct coding because it doesn't follow CPT coding guidelines. -It is not accurate coding if the procedure is something different from a simple therapeutic injection into a muscle, such as an injection of Toradol versus a procedure that requires higher physician work and malpractice risk,- says **Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO**, owner of **MJH Consulting** in Denver. And second, reporting 90772 every time costs the practice money.

Take note: In 2007, Medicare reimburses only about $23 for 90772 in an office setting--compared to more than $50 for other common injection codes such as 20600 (Arthrocentesis, aspiration and/or injection; small joint or bursa [e.g., fingers, toes]).

When to use it: Report 90772 only if the physician administers a subcutaneous or intramuscular injection, such as a Demerol shot for a migraine headache or a Toradol injection as an anti-inflammatory. Otherwise, dig into the documentation to report a more accurate, site-specific code for the injection.

2. Bill 1 TPI per Muscle Group

To report 20552 (Injection[s]; single or multiple trigger points[s], one or two muscle[s]) and 20553 (... single or multiple trigger point[s], three or more muscles) properly, you should know what you-re dealing with. A trigger point is -a localized area of muscle that causes pain in a remote area when the muscle is firmly pressed on,- Hammer says. If the physician documents an injection into a joint or ligament, for instance, he did not perform a trigger point injection (TPI).

Tip: Examine the physician's documentation to determine how many muscles he injected--don't simply count how many injections he performed.

Common scenario: Low back pain (724.5). Patients typically have discomfort that originates in their paraspinous muscle, but they may feel discomfort throughout their back and in other parts of the body, such as the hips and legs. If

your physician treats the pain with multiple trigger point injections and focuses on just one muscle, you cannot bill for each injection.

Example: When your physician examines a patient with low back pain, he discovers three trigger points in the multifidus muscle to the left of the L5 spinous process. The physician injects each trigger point in the multifidus muscle. You should report only one unit of 20552 because the physician treated only one muscle (multifidus), even though he administered three injections.

Back Multiple Injections With Documentation

If you report 20553, the documentation should reflect that the physician injected three or more muscles. For example, a patient recovering from an auto accident presents with neck pain (723.1, Cervicalgia) and right shoulder joint pain (719.41, Pain in joint; shoulder region). The physician identifies three trigger points: the right trapezius, the right deltoid, and the right levator scapulae muscles. In this case, report one unit of 20553.

Warning: Never report more than one unit of 20553 per session. Because 20553 refers to -single or multiple injections- for -three or more muscles,- a single unit of 20553 will suffice to claim any number of injections in three or more muscles.

If your physician's documentation ambiguously refers to a number of muscles or injections but doesn't name the muscles, your TPI claims might be in jeopardy.
Physicians can no longer simply document that they injected three muscles. Instead, the physician must document which muscles he injected and list the most specific ICD-9 code.

Example:The physician treats a patient with muscle pain in the lower back (729.1, Myalgia and myositis, unspecified) by administering five trigger point injections but doesn't note the muscle(s) targeted. Because you cannot support coding for more than one muscle, you should only report 20552. In addition, you should link 729.1 to 20552 to support medical necessity.

3. Append Modifier 25 to E/M With Injection

If the physician's documentation indicates that he performed a separate E/M service, you may be able to report both the office visit and the injection. Make sure, however, that the documentation shows that the E/M service is separately identifiable.

Example: An established patient arrives for a prescheduled injection for cervicalgia (723.1) but also has a new complaint of muscle weakness in his lower extremities (728.87). The physician performs an expanded, problem-focused history and exam based on this new symptom. He determines that he must proceed with additional diagnostic testing to determine what causes the patient's weakness. In this case, the physician performs the scheduled trigger point injection (20552) for cervicalgia and a separate E/M service to evaluate the muscle weakness. You would report 20552 linked with 723.1, and 99213-25 with 728.87.

Remember: If the patient presents only for the injection, you should not report an E/M code. For example, in the above case, if the patient does not offer a new complaint that prompts a separate E/M service, you would report 20552 only.