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Part B Insider (Multispecialty) Coding Alert

Reader Questions: Watch Bilaterals and Limits on 20550 With 64450

Question: Medicare denies our claims with codes **CPT 20550** and 64450, stating that the number of units exceeds the maximum. How should we complete these claims?

Answer: The denials could stem from reporting codes multiple times or reporting incorrect modifiers. Code 20550 (Injection[s]; single tendon sheath, or ligament, aponeurosis [e.g., plantar "fascia"]) applies to single or multiple injections to a single tendon sheath or ligament. If your physician injects the same sheath multiple times, you still report **CPT 20550** only once.

You can report 20550 multiple times during an encounter only when the physician injects different tendon sheaths. If you report multiple injections, make sure your provider's documentation clearly indicates the separate and distinct tendons injected. You might need to send the procedure note to explain things to the carrier.

Physicians sometimes perform 64450 (Injection, anesthetic agent; other peripheral nerve or branch) bilaterally. Verify whether you're reporting a bilateral procedure and need to append modifiers accordingly. Some carriers instruct you to append modifier 50 (Bilateral procedure), but other payers prefer LT (Left side) and RT (Right side) to indicate the bilateral injection.

Example: Office notes document injections to the Extensor hallicus longus tendon sheath in the right ankle and Flexor pollicis longus tendon sheath in the right wrist and also bilateral ulnar nerve injections at the elbow. You should code 64450-50 x 1 unit of service and 20550-59 x 2 units of service. Modifier 59 (Distinct procedural service) applies because your physician performed separate, distinct services during the same encounter.

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