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Eli's Rehab Report

New Trigger Point Injection Codes Allow Practices More Precision

When CPT Codes 2002 was introduced, PM&R coders were pleased to see new trigger point injection codes (20552-20553), along with new codes for carpal tunnel injections (20526) and tendon origin/insertion injections (20551). Because trigger point injections are among the most commonly performed pain management procedures in PM&R practices, the new codes were significant to physiatrists, particularly since the old trigger point injection code (20550) was vague and confusing, and often resulted in denials when billed for more than one site. Many carriers, however, have yet to release guidelines for billing these new codes, which have been in effect since January 1. Knowing the eight injection sites and how to break down the number of muscles injected will help coders differentiate between these new codes and determine when it is most appropriate to use them.

New Codes Aim to Increase Specificity

The previous trigger point injection code (20550) described various types of injections, such as tendon sheath, ligament, ganglion and trigger point. The new codes were introduced to allow providers more precision when describing the procedure performed, says **Allison Waxler,** policy analyst for practice management at the American Academy of Physical Medicine and Rehabilitation in Chicago. We were part of the CPT process whereby the codes were introduced and we see it as a welcome change " says Waxler.

The new trigger point codes are as follows:

20552 Injection; single or multiple trigger point(s) one or two muscle group(s)
20553 Injection; single or multiple trigger point(s) three or more muscle groups.

Because the new codes break out the specific number of muscle groups injected many coders are interested in determining how CMS defines "muscle groups." A concern is whether each muscle (for example an injection to the left bicep and another to the left deltoid) constitutes two muscle groups or whether they both count toward the same muscle group since they are both on the left upper extremity. The answer says **Mikina Harrison CPC HIPAA** coordinator at the Thomas Jefferson Hospital and University Rehabilitation Department Philadelphia Pa. is that this scenario counts as only one muscle group because both muscles are on the same injection site. Harrison outlines the eight injection sites below:

1. Head
2. Cervical spine
3. Left upper extremity including shoulder
4. Right upper extremity including shoulder
5. Thoracic spine
6. Lumbosacral spine
7. Left lower extremity including hip
8. Right lower extremity including hip.

"All multiple injections in one of these body regions are billed as only one unit of the injection " says Harrison. Therefore if the physiatrist performs three injections to muscles in the cervical spinal region only one unit of 20552 is billed.

However if the physiatrist performed two injections in the left shoulder one injection in the cervical spine and two injections in the thoracic spine the practice could bill 20553 because three muscle groups have been injected.

Some rehab practices are curious about what happens if more than three muscle groups are injected. For instance if a patient presents with severe pain on the left side the physiatrist may inject trigger points in the neck left upper extremity

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thoracic spine and left lower extremity. Many coders erroneously believe that this warrants billing one unit of 20552 to describe one muscle site and one unit of 20553 to code the other three muscle sites. In the past when more than one site was injected coders were accustomed to billing 20550-59 (Distinct procedural service) to indicate that the subsequent trigger point injections were provided to additional sites.

However says Waxler this is not the correct way to code such claims now. "Multiple billing of 20553 was not the AMA's intention when they introduced the code " she advises. "The intention is that the code should be billed once whether three six or more muscle groups are injected."

Since 20553's descriptor cites "three or more muscle groups " any number of muscle groups over three should be coded as only one unit of 20553.

Carpal Tunnel Injections

Carpal tunnel syndrome (CTS) (354.0) is a common reason for patients to visit PM&R practices. The new code 20526 (Injection therapeutic [e.g. local anesthetic; corticosteroid] carpal tunnel) is of particular interest because it applies only to injections to the carpal tunnel region.

For example a patient presents with numbness and tingling in her left wrist. The physiatrist performs an examination and tests for Tinel's sign which most carriers feel is a reliable indication that CTS is present (the test for Tinel's sign is part of the E/M code and is not billed separately). To make sure that the CTS diagnosis is correct the physiatrist performs electromyography (EMG) and bills 95860 (Needle electromyography one extremity with or without related paraspinal areas).

After the CTS diagnosis is confirmed by the EMG the physiatrist prescribes physical therapy and applies a splint (29125 Application of short arm splint [forearm to hand]; static). However the patient returns a month later with the same symptoms which have worsened.

At this point the physiatrist performs a carpal tunnel injection of triamcinolone and the practice bills 20526 with J3301 for the drug.

Ligament Injections

Although PM&R practices will be coding 20550 (Injection; tendon sheath ligament ganglion cyst) less frequently than in 2001 it will still be used. For example suppose a patient presents with pain in his left knee. The physiatrist determines that the patient is suffering from an inflamed medial collateral ligament and performs an injection of Aristospan into the ligament. The coder submits the claim with one unit of 20550 with J3303 (Injection triamcinolone hexacetonide per 5 mg) for
the drug.

Tendon Origin/Insertion Injections

Local tendon injections such as those to the wrist or Achilles tendon are coded as 20551 (... tendon origin/ insertion) which are billed with the appropriate drug (normally a corticosteroid such as depo medrol [J1020 J1030 J1040] or triamcinolone [J3302 triamcinolone diacetate). These injections are usually performed only after physical therapy and nonsteroidal anti-inflammatory drugs such as aspirin ibuprofen etc. have failed. Therefore this code will probably be billed less frequently than the others in this category.

Practices should be careful not to confuse "tendon sheath" with "tendon origin/insertion" in their documentation as it makes the difference between reporting 20550 versus 20551.

Implementation of the New Codes

Although the 2002 codes were introduced last fall many payers are slow in getting new information into their systems.

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"Generally speaking the new CPT codes were effective Jan. 1 2002 and most payers give a 90-day grace period where you can use either code after which only the new codes will be valid " says **C.J. Wolf M.D. CPC CPC-H** senior consultant at Intermountain Health Care in Salt Lake City Utah.

"I have experienced commercial payers who are on the ball and implement the changes in their system quickly as well as those who take forever " says Wolf. "You really need to have someone in your practice call the major payers and ask them when the new codes can and must be used."

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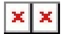

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