

## Eli's Rehab Report

### Reader Questions: Billing for Injection, Drug and Drug Amount

**Question:** We would like to bill for lidocaine ( [J2000](#) , lidocaine hydrochloride) and triamcinolone (J3302, triamcinolone diacetate) along with the actual injection procedures (20550, 20600, 20605, 20610), but the Medicare descriptions of the two codes indicate amounts much higher than normally would be injected. We inject, maybe, 1-4 cc at a time, while Medicare states that we must inject 50 cc of lidocaine or 5 mg of triamcinolone to be reimbursed. Should we consider using the unclassified drug code (J3490), or is the solution injected always part of the injection itself?

Ohio Subscriber

**Answer:** Medicare will allow you to bill for the drug itself and the administration if you dont do any other services at the time of the visit (and if the injection meets the criteria of allowable ICD-9 codes; see below).

Coverage by Medicare is limited to only one type of procedure on the same day (e.g., epidural block, multiple facet joint injections or sympathetic blocks).

The Correct Coding Initiative (CCI) version 6.0 contains edits for comprehensive codes 20550 (injection, tendon sheath, ligament, trigger points or ganglion cyst), 20600 (arthrocentesis, aspiration and/or injection; small joint, bursa or ganglion cyst, e.g., fingers, toes), 20605 (arthrocentesis, aspiration and/or injection; intermediate joint, bursa or ganglion cyst, e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) and 20610 (arthrocentesis, aspiration and/or injection; major joint or bursa, e.g., shoulder, hip, knee joint, subacromial bursa). In the CCI edits, 20550 is listed as a component of 20610.

Billing for amounts less than specified on Medicare's quantity alert could prove to be a problem, especially with the lidocaine. As you know, J2000 refers to 50 cc of lidocaine, and in fact, most Medicare carriers will not accept claims for this drug when billed with any ICD-9 code other than those related to cardiac arrhythmias and emergencies. For example, Georgia Medicare's policy for lidocaine states, The dosage indicated by the code description is specific to the treatment of cardiac arrhythmias and emergencies only. The billing of J2000 is not appropriate for the 1-2 cc usually required for a local anesthetic. The policy goes on to state, When used as a local anesthetic, Lidocaine will be considered part of the materials included in the procedure and will not be separately reimbursable. Billers should check their state Medicare policies to find out whether this policy applies to their practice.

Triamcinolone, a corticosteroid, often is allowable by Medicare for conditions such as bursitis (727.3) or joint effusion (719.00-719.09), but practices should always check their local Medicare policies before using and billing for triamcinolone.

If you are billing private insurers for therapeutic injections, you should always check to see whether the insurer allows you to bill for the administration of the injection in addition to the drug itself.

Although the J codes describe common dosages of medications, often they dont list the exact dose that may be used. For J codes that dont have a national policy, some payers will allow you to bill the dosage described by the J code even if it overstates what is actually used. Some payers request that in addition to billing the J code, you communicate the exact amount of the dose (typically by producing a paper claim and writing in the dosage).

Still others request that you use 99070 (supplies and materials [except spectacles] provided by the physician over and above those usually included with the office visit or other services rendered [list drugs, trays, supplies or materials provided]) and communicate the exact name of the drug and dosage used.

Many private insurance carriers accept J codes, but this is a carrier-specific billing policy and should be individually verified with the carriers that you bill most frequently.