Eli's Rehab Report

READER QUESTIONS: Subject Your Multiple Injections to NCCI

Question: My doctor typically uses these two sets of codes:

(1) 99212 or 99213, 20610, 64475, and 64476
(2) 99212 or 99213, 20553, 64405, and 64418

No matter how I arrange the codes, no matter what modifiers I attach to the codes, no matter how I try to split the few diagnoses he gives me, Blue Cross Blue Shield (BCBS) won't pay the injections. Often, the denial states that the trigger point and/or arthrocentesis is included in the payment for other surgical procedures, when in reality they didn't pay anything. Does BCBS look upon these injections as regional anesthesia because the physiatrist is doing another procedure?

North Carolina Subscriber

Answer: Have you checked to see if BCBS follows the current-quarter National Correct Coding Initiative edits? NCCI considers 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]) a component code of 64475 (Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level). Unless your documentation supports that your physiatrist injected a separate and distinct major joint different from the paravertebral facet joint, your payer should not and will not reimburse you for this service.

Typically, you'll have different diagnosis codes to support the medical necessity for the large joint injection. For example, a patient with lumbar facet arthropathy may require facet injections, but she also has shoulder pain. The physiatrist may also inject her shoulder at the same setting. In this situation, your diagnosis for the facet injections will be different from the shoulder injection.

Note: This edit can be bypassed only if the documentation supports using a modifier, such as modifier 59 (Distinct procedural service). This documentation must show how: (1) The physician performed services he does not normally provide together on the same day, but the services were necessary under the circumstances and (2) the procedure codes fit into any of five situations: different sessions or encounters, different sites/organ systems, separate incisions/excisions, separate lesions, or separate injuries.

Likewise, NCCI considers 20553 (Injection[s]; single or multiple trigger points[s], three or more muscles) a component of both the occipital nerve injection (64405, Injection, anesthetic agent; greater occipital nerve) and the suprascapular nerve injection (64418, ... suprascapular nerve). You can bypass this edit with a modifier like modifier 59, but again, you'll need documentation that supports its use.

Note: NCCI created some of these bundling edits because providers reported the injection of local anesthetic to numb the needle track prior to the main procedure and called it a trigger point injection.

Keep in mind: BCBS can decide which NCCI edits it will follow. In other words, this BCBS may have its own internal edit software. You will need to review the documentation for the services before you appeal to determine that these truly are separate and distinct services. This may not be an issue of coding but more an issue of correct use of modifiers, supporting documentation, and appealing if you've coded the services compliantly and have documentation to support your coding.

Many payers get concerned when providers perform multiple diagnostic injections on the same date of service. When your provider injects multiple sites, payers will struggle to determine what is causing the patient's pain and whether the injections are helpful.