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Eli's Rehab Report

Select the Appropriate Injection Code in 4 Easy Steps

Hint: Look for these key words in the documentation

Most PM&R practices submit injection claims daily, but if you don't know your trigger point from your bursa, be prepared for denials -- and shorting your practice up to $15 per injection. Follow these four steps to pinpoint the appropriate injection code for your physiatrist's services.

Step 1: Don't Use 90782 as a 'Catchall' Injection Code

Say the word "injection" to most general practice coders and they'll recommend 90782 (Therapeutic, prophylactic or diagnostic injection [specify material injected]; subcutaneous or intramuscular), but physiatrists report this code very rarely. According to Medicare data, physiatrists reported this code fewer than 1,000 times in 2000, whereas general practitioners reported 90782 five times that.

"A lot of coders use 90782 as a catchall injection code," says **Tammy Roesner**, billing assistant at Forman Rehab in Illinois. "If the physician doesn't document his injection clearly enough to select an appropriate trigger point or joint injection code, the practice might assign 90782, but this is a bad idea." First, she says, automatically assigning 90782 isn't correct coding. Second, reporting 90782 every time costs the practice money because 90782 only reimburses about $26.

"PM&R practices can make up to $75 for some of the joint injection codes where I live," Roesner says. "Why would you risk losing this by submitting 90782 instead of the right code?" Report 90782 only if the physician administers a subcutaneous or intramuscular injection, such as a Demerol shot for a migraine headache.

Step 2: Bill One TPI Per Muscle Group

Physiatrists perform trigger point injections (TPIs) more often than any other injection procedure, but CPT has changed the descriptors several times in the past few years, making it difficult to keep track of the correct code. To properly use 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), you should know that a trigger point is a muscle or fascia. If the physician documents an injection into a joint or ligament, he did not perform a TPI.

Examine the physiatrist's documentation to determine how many muscle groups he injected -- don't simply count how many actual injections he performed. For example, back-pain (724.5x) patients typically have discomfort that originates in one muscle group, but they may feel discomfort throughout their back and in other parts of the body, such as the legs and neck. If your physician treats the pain with multiple trigger point injections and focuses on just one muscle, you cannot bill for each injection.

Suppose, for example, that the back-pain patient also complains that her arms and legs ache. During the examination, the physiatrist 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 **CPT 20552** because the physician treated only one muscle (multifidus), even though he administered three injections.

If you report 20553, the documentation should reflect that your physician injected multiple muscles. For example, a patient recovering from an auto accident presents with neck pain (723.1, Cervicalgia) and shoulder pain (726.1x). The physiatrist identifies three trigger points: the right trapezius, left trapezius, and the right sacroiliac muscles. In this case, you should report only one unit of 20553.

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If your physiatrist'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, says **Jean Ryan-Niemackl, LPN, CPC**, an application specialist with QuadraMed Government Programs Division in Fargo, N.D. The physician must document which muscles he injected and list the most specific ICD-9 code, she adds.

Suppose the physician treats a patient with chronic hip pain (726.5). He performs three trigger point injections into the patient's hip scar. In the documentation, the physiatrist notes that he administered the injections to the scar's mid portion and mid-superior portion. Because the doctor didn't name muscles, you should not list a code higher than 20552. In addition, you should link 726.5 to 20552 to support medical necessity.

Step 3: Differentiate Joint Sizes for 20600 Series

Physicians sometimes administer bursa injections to treat joint pain. Select a code from the 20600-20610 range (Arthrocentesis, aspiration and/or injection...) for these procedures. Use 20600 for small joints, 20605 for intermediate joints, and 20610 for major joints.

You might find it tricky to choose the right code for the joint size. For example, although many people think that the wrist is a small joint, it is actually considered intermediate, Roesner says.

Finger and toe joints are considered small, while wrists, elbows and ankles are intermediate. Major joints are the shoulder, hip and knee, Roesner says.

Note: In addition to the proper CPT code for the injection, don't forget to also report the J code for the drug or substance that the physiatrist administers. Remember, though, that lidocaine is considered an inherent part of any procedure, so you can't report it separately.

Some physicians try to use the joint injection codes for acupuncture, but this is not only incorrect coding; it could be construed as fraud because Medicare does not cover acupuncture under any circumstances. Some private payers may cover acupuncture, for which you should report 97780 (Acupuncture, one or more needles;
without electrical stimulation) or 97781 (... with elec-trical stimulation).

Step 4: Append -25 to E/M With Injection

If the physiatrist's documentation indicates that he performed a separate E/M service, you may be able to report both the office visit and the injection, but make sure the documentation shows that the E/M service is separately identifiable, Ryan-Niemackl says.

Suppose a patient presents for a bursitis evaluation. During the visit, the patient complains of back pain, and the physiatrist administers a trigger point injection. You should report 20552 for the injection, but you should append modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the appropriate E/M code. Modifier -25 informs Medicare that the physician performed an E/M service that is separate from the injection.

Remember that if the patient presents only for the injection, however, you cannot report an E/M code. For example, the physiatrist instructs the bursitis patient to take oral medication to treat the back pain. One month later the patient returns and her back hasn't improved, so the physiatrist gives the patient a trigger point injection.

For the initial visit, you would report only the appropriate level of E/M service. And for the second visit, report 20552.

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