AAOS Now

Taking the pain out of injection coding

By Mary LeGrand, RN, MA, CCS-P, CPC

Injection coding is often confusing, and the complexity of coding and reimbursement for injections performed in the office setting is compounded by coding rules, payor rules, separate reporting of evaluation and management (E&M) services, and lack of clear documentation.

Remember that common injections administered by orthopaedists from the musculoskeletal section of the American Medical Association's *2009 Current Procedural Terminology* (CPT®) are considered "surgical" injections. This means that reimbursement for these services includes the following:

- any type of local anesthesia, including hematoma blocks
- the E&M service, if it is not a significant, separate service

Overview

Table 1 lists the most common musculoskeletal injections (exclusive of injections for nerve blocks, epidural injections, and other pain management procedures). No global days are associated with these joint injections/minor procedures. If the injection is the only surgical procedure performed or if the patient's visit occurs outside of the global period for other surgical procedures, no modifier is needed for postoperative services.

If the injection is performed on the same day that an E&M service occurs, however, append modifier 25 to the E&M code.

Because injections are considered surgical procedures, they require a procedure note. The procedure note should include a signed consent, documentation of the anatomic location, preparation of the site, local anesthetic administration, name and dosage of drug administered, and patient reaction. Documentation should also include all postoperative instructions related to the minor surgical procedure.

Reporting E&M with injections

Do not automatically bill an E&M with every joint injection. If the E&M is the significant separate

service, the E&M and the injection are both reportable. If the E&M is not the significant service or is not performed for a separate problem/diagnosis, however, and the patient is returning in follow up, the E&M is most likely not separately reportable. Many payors will bundle established patient visits and minor procedures and include the E&M in the surgical procedure.

The following scenarios demonstrate when the E&M should be reported separately.

Scenario 1: You see a patient at the request of Dr. Primary Care for evaluation of right knee pain and swelling. You evaluate the patient and aspirate 30 mL from the joint. The patient returns to Dr. Primary Care for follow-up care. This scenario should be coded as follows:

CPT/Modifier	Description	Diagnosis
9920X-25	New patient visit	Knee pain
20610	Aspiration, joint, major	Effusion, joint

In this case, the E&M and the aspiration are separately reportable because the reason for the visit was the evaluation and management service (consultation) and the decision to perform the aspiration was made following the E&M service.

Scenario 2: A week later, the patient returns to have his knee checked. During the visit, the patient complains of left ankle pain. You take a new history, examine the patient, and aspirate the knee, obtaining 20 mL of fluid. This scenario should be coded as follows:

CPT/Modifier	Description	Diagnosis
9921X-25	Established patient visit	Ankle pain
20610	Aspiration, joint, major	Effusion, joint

The E&M service is reported separately because it is for a separate condition and different anatomic location than the aspiration.

Scenario 3: What if the patient had returned to have his knee checked 2 weeks after an initial aspiration for an effusion? The patient notes that the knee was swelling again. You evaluate the

patient and find no significant change in either the patient's history or the knee, except for the return of the swelling. You do not take any radiographs.

In this scenario, with no significant changes in the patient's condition and the medical decision to perform the exact same procedure (aspiration of the effusion), you can report the aspiration (20610) but not an E&M-25 service.

Frequently asked questions

Q: If the surgeon administers a series of viscosupplementation drugs, can you report E&M services when the subsequent injections are performed?
A: It depends. If the E&M service is performed for evaluation of the affected joint only, it is not separately reportable. If the E&M service is for a different anatomic complaint (such as shoulder pain when the viscosupplementation is administered in the knee), the E&M-25 is separately reportable and must be linked to a diagnosis code.

Q: If the surgeon aspirates a joint and then injects the same joint, can we report 20610 twice?
A: No. CPT code 20610 is defined as "Arthrocentesis, aspiration and/or injection" meaning it describes the work for either or both services.

Q: Payors frequently deny CPT code 20550 when we report this procedure with a major joint injection (20610). Should we append modifier 51 to the code combination?
A: When a tendon sheath injection is performed at a different anatomic location, you must tell the payors that it is a distinctly separate procedure. Append modifier 59 to the lesser valued injection (20550) or the payors will assume you are reporting the injection of the tendon sheath "on your way to the joint" and will bundle the services together.

Q: Why do I need to have a procedure note when doing a joint/tendon sheath injection?
A: Because these injection codes fall within the surgical section of the CPT Manual, they are governed by surgical CPT code rules. All surgical procedures must include either an operative note or a procedure note.

Q: Can I report CPT codes 20552 and 20553 together during the same visit?
A: No. CPT code 20552 includes one or two muscle groups, and CPT code 20553 defines injections to three or more muscle groups. Thus 20553 includes 20552, and 20552 cannot be reported separately by the same physician, on the same day, during the same session.

Q: We frequently cannot tell where the surgeon is performing carpal tunnel injections. The physician typically documents "injection right wrist" with a carpal tunnel diagnosis. How should we code this?
A: This common question supports the importance of physician documentation in a procedure note that identifies the exact site of the injection. CPT code 20526 describes a carpal tunnel injection and has 1.93 RVUs in the office setting; CPT code 20605, wrist injection, has 1.50 RVUs in the office setting. If the surgeon actually injected the carpal tunnel, but the wrist injection CPT code is reported, the surgeon lost 0.43 RVUs or $15.51 based on national Medicare reimbursement (not adjusted for the geographic area).

Q: How do I know when to report CPT code 20550 versus 20551?
A: The answer lies in knowing where the injection was administered and understanding the anatomy. CPT code 20550 defines an injection to the tendon sheath; CPT code 20551 defines an injection to the origin/insertion site of a tendon.

CPT code 20550 is frequently used for a trigger finger injection, where the injection is administered to the tendon sheath. CPT code 20551 is commonly used for lateral epicondylitis, where the injection is administered at the insertion of the tendon. Ideally, the surgeon should document the injection as administered to the "tendon sheath" or to the "origin/insertion site of the tendon." At a minimum the surgeon needs to identify the tendon and the anatomic location.

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