

# Pain Management Procedures

The following section contains a number of regularly performed pain procedures ranging from tendon sheath injections to stimulator implants.

One coding area of special concern to pain management practices is the location of the injection. Many codes used for pain management procedures include an anatomical component such as the size of the joint or the number of muscles injected, the specific nerves treated or the two major areas of the spine: cervical/thoracic and lumbar/sacral. When the provider does not document the required information you will not be able to select the appropriate code.

Coders must also know how to report additional levels with add-on codes.

**Example:** There are two codes listed for a transforaminal epidural injection at the cervical/thoracic level:

- **64479** Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
- **+64480** Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

While it is appropriate to bill a single injection with the main code, some coders accidentally submit claims with just the add-on code. It is never appropriate to submit an add-on code alone.

This also illustrates that coders also need to be aware that many pain injections require them to accurately count the number of levels injected during a visit. If a provider performs a transforaminal injection at two levels and only the main code is reported, the practice will lose the additional revenue it is due.

Coders also need to closely read the descriptors for codes. The codes for cervical/thoracic paravertebral facet joint nerve blocks provide a good example:

- **64490** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
- **+64491** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
- **+64492** Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)

Note that the descriptor for 64492 indicates you can never report more than three levels for blocks.

## Tendon Sheath Injections

- **20550** Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar “fascia”)
- **20551** Injection(s); single tendon origin/insertion

These two codes may be reported per site and are not limited in number. Such as an injection into the tendon origin of the right elbow, right shoulder, and right wrist the code would be reported three times with modifier 59 appended.

The next category and/or family would be the trigger point injection codes 20552-20553. These codes are reported just once no matter how many trigger points are injected. When the codes first came out they referenced “muscle groups” but then in later years they removed this and it simply states “muscle(s)” eliminating the tricky “group” reference. Your physicians must list the individual muscle(s) injected—no longer is “injected shoulder” enough to support these codes. Codes 20552 and 20553 would not be reported together during the same encounter.

Documentation should be made in the patient’s record and should include the patient’s history, extenuating circumstances (i.e., level of pain, interruption of activities of daily living), specific diagnosis codes, drugs injected, the specific site of each injection, dosage of the drug, the medical necessity for giving the injection and the expected outcome of the treatment. Improvement of the patient’s condition resulting from the injection must be documented in the patient’s medical record.

## Trigger Point and Injections

- **20552** Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
- **20553** Injection(s); single or multiple trigger point(s), 3 or more muscle(s)

### Description of Procedure

A therapeutic agent is injected into a tight bundle of painful or irritable muscle that is causing twitching, pain or muscle weakness to the patient. Multiple injections may be required to treat one or two muscles. No other service is provided.

### Code Scope

- Multiple injections may be required to treat one or two muscle sites.
- Imaging guidance may be used, and would be separately reported.
- No incision is required.

**Note:** Do not report 20552 with 20553.

Trigger points or trigger zones are hyper-irritative foci that may occur in any skeletal muscle on the body that are particularly sensitive to touch and, when stimulated, become the site of a painful neuralgia. These trigger points produce a referred pain pattern characteristic for that individual muscle and sometimes remote from the point itself and not related to it by anatomically definable pathways. Usually, the involved muscle is felt as a tight palpable band. Frequently affected sites include the trapezius, supraspinatus, infraspinatus, teres major, lumbar paraspinals (two sites) and gluteus and pectoralis muscles. Multiple trigger point injections are assigned by muscle injected (not number of injections into same area). Some payers limit the number of injections at the same session (e.g., two) and then require documentation of medical necessity.

**Tip:** Find out what ICD codes your main payers require for trigger point injection billing. If you are treating a patient without an approved diagnosis, per Medicare's medical necessity policy, you may need to get an ABN so that your patient understands he/she might be responsible for that service.

Below, you'll find a typical procedure note for a single trigger point injection.

## Dictated Report: Trigger Point Injection

### History:

The patient is a very pleasant 71-year-old male who is referred to the Pain Control Center by Doctor X for the evaluation and treatment of neck pain. Upon evaluation, the patient had pain over the right mastoid region and was treated with a trigger point injection. He states the pain did improve somewhat but has returned, although he does not have the pain today. He states that most of the pain has switched over to the left side. He has pain over his left mastoid area and his left interscapular area. The pain, he states, is worse at night.

### Physical Examination:

Upon evaluation, the patient does have a sensitive area over the left mastoid and a palpable trigger point with a positive jump sign over the left interscapular region. I elected to perform trigger point injections for him today. The risks and benefits of the injections were discussed with the patient. I also offered him the cervical epidural, which he states he would rather postpone.

### Procedure:

The areas were prepped. A 1½-inch 25-gauge needle was used to perform trigger points in both areas. A total of 7.5 cc of 0.5% Marcaine and 20 mg of Depo-Medrol were injected into each trigger point. Needling was also performed and the patient experienced good post-procedure pain relief. I will see him back on an as needed basis.

### Trigger point Q & A

**Question:** Which code should we use for a piriformis injection? We can't find a specific code and we've heard contradictory information about whether it is appropriate to use the sciatic nerve code (64445).

**Answer:** It's true CPT has no specific code for that service. However, CPT Assistant, April 2012 directs you to use a trigger point for the injection.

To explain the difference between the services to your clinicians, you should share CPT's explanation of the two services.

## Dry needling

Be careful not to confuse two new codes **20560** (Needle insertion[s] without injection[s]; 1 or 2 muscle[s]) and **20561** ( ... ; 3 or more muscles) that were introduced in 2020, with existing CPT codes for trigger point injections (**20552-20553**) or acupuncture (**97810-97814**).

Like the trigger point injection codes 20560 and 20561 describe needle insertion into trigger points. But unlike the trigger point codes, no medication is administered through the needles for 20560 and 20561.

Note also the difference between dry needling and acupuncture: Dry needling describes needle insertion directly into muscular trigger points, while acupuncture may or may not do so.

Medicare will not cover the procedures in 2020. Coders will need to check private payer policies to determine coverage.