

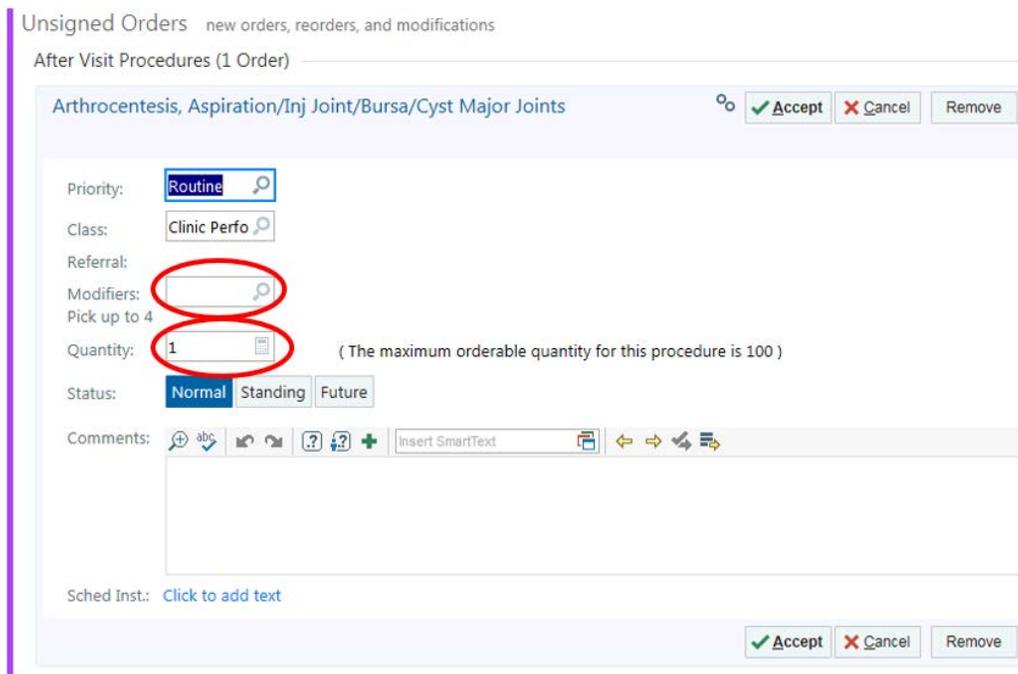
JOINT & TENDON INJECTION

Joint Aspiration/Injection

Report only a single unit of a joint injection code (seen on table below) for each joint treated, regardless of how many aspirations and/or injections occur in a single joint. For example, if the physician administers two injections, one on either side of the right knee, you would report 20610 x 1. The Centers for Medicare & Medicaid Services (CMS) instructs that you should also “Indicate which knee was injected by using the RT (right) or LT (left) modifier on the injection procedure.”

Code	Description
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); without ultrasound guidance
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); with ultrasound guidance, with permanent recording and reporting
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance
20606	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); without ultrasound guidance
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

You may report multiple units only if aspiration/injection is performed in more than one joint (e.g., both knees or left knee and left shoulder). If aspirations and/or injections occur on opposite, paired joints (e.g., both knees), you may report one unit with modifier 50 Bilateral procedure appended, per CMS instruction. Non-Medicare payers may specify different methods to indicate a bilateral procedure.



Unsigned Orders new orders, reorders, and modifications

After Visit Procedures (1 Order)

Arthrocentesis, Aspiration/Inj Joint/Bursa/Cyst Major Joints Accept Cancel Remove

Priority:

Class:

Referral:

Modifiers:

Pick up to 4

Quantity: (The maximum orderable quantity for this procedure is 100)

Status: Normal Standing Future

Comments:

Sched Inst: [Click to add text](#)

Accept Cancel Remove

If the provider performs injections on separate, non-symmetrical joints (e.g., left shoulder and right knee), you may report two units and append modifier 59 Distinct procedural service to the second unit (e.g., 20610, 20610-59) to indicate the second procedure occurred at a different joint.

JOINT & TENDON INJECTION

If the provider performs an aspiration **and** an injection on the same joint during the same session use the appropriate code to reflect the procedure only once, as the code descriptions indicate “*aspiration and/or injection*”

Joint injection and same day E/M services

Joint injection codes have been assigned a zero-day global period. This means the procedure is valued to include an initial assessment and other pre-service work. Therefore, you would not report an E/M service for a planned injection service where the patient presents without complications or a new problem.

CPT® Assistant offers these examples:

1. A patient complained of left knee pain. At a previous visit, the physician evaluated the knee, ordered a prescription of a nonsteroidal anti-inflammatory drug and scheduled a follow-up visit in two weeks for performance of an arthrocentesis if not improved. The patient returned, wherein the physician performed an arthrocentesis and injection of the left knee joint and scheduled a follow-up visit for one month later.

It would not be appropriate to report the E/M service at the two-week follow-up visit because the focus of the visit was related to the performance of an arthrocentesis. Only code 20610 for the arthrocentesis would be reported.

However, if the E/M service is significant and separately identifiable from the typical pre-service work of 20610, you may report the E/M service separately with modifier 25 *Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service* appended. For instance, the provider may justify reporting a separate E/M if the provider first must evaluate the patient during the same visit to determine if the patient is a candidate for the procedure.

2. A patient presents with knee pain. The physician evaluates the knee and determines that the problem may be gout or infectious arthritis. She aspirates the joint and sends the fluid for analysis to confirm a diagnosis. Because the E/M is significant and determines the need for the aspiration, you may report both 20610 and the documented E/M service with modifier 25 appended (e.g., 99213-25 *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity*).

A separate E/M code might also be appropriate if the physician provides the injection and also evaluates the patient for a different and/or exacerbated condition.

3. A patient arrives for a scheduled injection for right shoulder pain, but also has a new complaint of right ankle pain. The physician provides the injection and evaluates the patient for the new complaint. In this case, as long as the E/M service is sufficiently documented, you may report it (with modifier 25 appended) in addition to 20610.

Documentation must substantiate that the E/M service was significant. Only if the E/M service stands on its own may you report it separately with modifier 25.

Tendon Injections

Code	Description
20526	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel
20527	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")
20551	Injection(s); single tendon origin/insertion
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 muscles

Injections for plantar fasciitis are addressed by 20550 and ICD-10-CM M72.2. Injections for other tendon origin/insertions by 20551. Injections to include both the plantar fascia and the area around a calcaneal spur are to be reported using a single 20551. (LCD L34218)

JOINT & TENDON INJECTION

Injection into tendon sheaths, ligaments, tendon origins or insertions, ganglion cysts, neuromas or other areas described by this policy may be indicated to relieve pain or dysfunction resulting from inflammation or other pathological changes. Proper use of this modality with local anesthetics and/or steroids should be short-term, as part of an overall management plan including diagnostic evaluation, to clearly identify and properly treat the primary cause. In some circumstances after diagnosis has been confirmed, injection of a sclerosing or neurolytic agent may be appropriate for longer-term management.

The signs or symptoms that justify these treatments should be resolved or reevaluated after one to three injections. **Injections beyond three to the same tendon origin/insertion, tendon sheath, ganglion, neuroma, ligament or local area in a six-month period** must be justified by the clinical record indicating a logical reason for failure of the prior therapy and why further treatment can reasonably be expected to succeed. A recurrence may justify a second course of therapy.

It is expected that trigger point injections would not usually be performed more often than three sessions in a three-month period. If trigger point injections are performed more than three sessions in a three-month period, the reason for repeated performance and the substances injected should be evident in the medical record and available to the Contractor upon request. (LCD L34211)

Code	Description
20555	Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)
21116	Injection procedure for temporomandibular joint arthrography
23350	Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography
24220	Injection procedure for elbow arthrography
25246	Injection procedure for wrist arthrography
27093	Injection procedure for hip arthrography; without anesthesia
27095	Injection procedure for hip arthrography; with anesthesia
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
27369	Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography
27648	Injection procedure for ankle arthrography

The clinical record should include the elements leading to the diagnosis and treatment decision to use injection. If the number of injections exceeds three to the same site or local area in a six-month period, the record must justify these added injections since the presumed need for further injections should raise the issues of correct diagnosis or correct choice of therapy as well as concerns for adverse side effects. Records must be made available upon request.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits.

Other Injections/Aspirations

Code	Description
20612	Aspiration and/or injection of ganglion cyst(s) any location
20615	Aspiration and injection for treatment of bone cyst

Code	Description
64505	Injection, anesthetic agent; sphenopalatine ganglion
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)
64517	Injection, anesthetic agent; superior hypogastric plexus
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
64530	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring

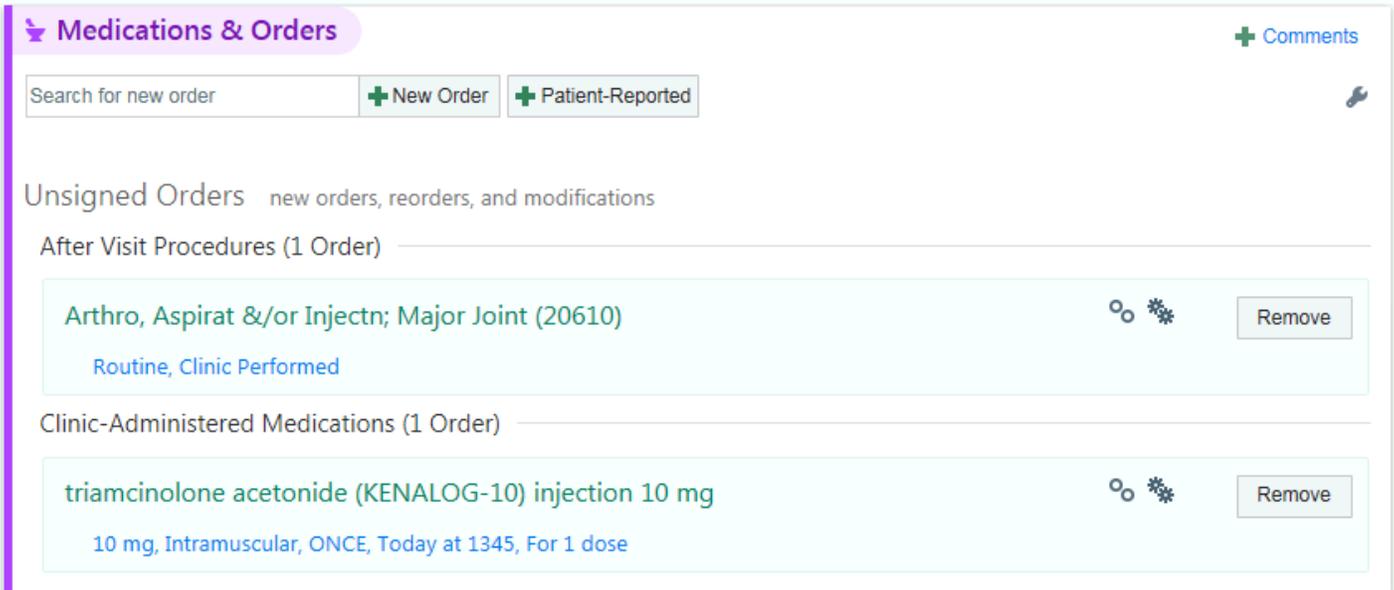
JOINT & TENDON INJECTION

Billing Anesthetic Agents and Steroids

Remember to order the medication to be injected and/or enter the HCPCS code representing the medication.

E.g., for J3301 Injection, triamcinolone acetonide, not otherwise specified, 10 mg

Meds & Orders



Medications & Orders + Comments

Search for new order + New Order + Patient-Reported

Unsigned Orders new orders, reorders, and modifications

After Visit Procedures (1 Order)

Arthro, Aspirat &/or Injectn; Major Joint (20610) ⊙ ⚙ Remove

Routine, Clinic Performed

Clinic-Administered Medications (1 Order)

triamcinolone acetonide (KENALOG-10) injection 10 mg ⊙ ⚙ Remove

10 mg, Intramuscular, ONCE, Today at 1345, For 1 dose

Non-covered Services

Prolotherapy, the injection into a damaged tissue of an irritant to induce inflammation, is not covered by Medicare. Billing this under the trigger point injection codes is misrepresentation.

"Dry needling" of trigger points is a non-covered procedure since it is considered unproven and investigational.

"Dry needling" of ganglion cysts, ligaments, neuromas, tendon sheaths and their origins/insertions are noncovered procedures.

Screening diagnoses will be denied as routine services.

Acupuncture is not a covered service, even if provided for treatment of an established trigger point.

Resources:

- <https://med.noridianmedicare.com/documents/10546/6990981/Trigger+Point+Injections+LCD>
- <https://med.noridianmedicare.com/documents/10546/6990981/Injections+-+Tendon%2C+Ligament%2C+Ganglion+Cyst%2C+Tunnel+Syndromes+and+Morton%27s+Neuroma+LCD>
- <https://www.aapc.com/blog/27495-problem-code-20610/>