Codify
BY AAPC

Eli's Rehab Report

Reader Question: Trigger-Point Injections

Question: I was just hired as a coder at a medical practice and have two questions about their methods. They code all of their trigger-point injections as 97140, which I thought was strictly for therapy. Is this correct?

After the physiatrist sees a patient, I read the office visit notes including how much time he spent with the patient, and circle the appropriate E/M code so I know how much to charge the patient. I dont think this is appropriate, but he says that a good coder can code from chart notes. Is this correct?

Arizona Subscriber

Answer: You are smart to be suspicious because the first habit you discuss is incorrect and the second is questionable. You should definitely not use 97140 (manual therapy techniques) to denote trigger-point injections.

The 2001 code for trigger-point injections is 20550 (injection, tendon sheath, ligament, trigger points, or ganglion cyst), but two new trigger-point injection codes will be effective Jan. 1, 2002, to replace 20550: The new code for injecting one to two muscle groups is 20552 (... injection; single or multiple trigger point[s], one or two muscle group[s]), and the new code for three or more muscle groups is 20553 (injection; single or multiple trigger point[s], three or more muscle groups).

Probably the only reason your practice codes trigger-point claims as 97140 is that the physiatrist is performing prolotherapy (M0076) instead of standard trigger-point injections. Prolotherapy is considered alternative medicine by most insurers because it involves injecting the trigger points to promote healing and new tissue growth and is not the same as a trigger-point injection, which is for pain management. Medicare and most other insurers do not cover prolotherapy.

If you submit claims using 97140 for prolotherapy knowing that Medicare does not cover it, your practice could get into trouble if a file review proved that you used the incorrect code to get the claim paid. Your best bet is to ask a patient to sign an ABN before performing prolotherapy.

As for the physiatrists leaving his E/M coding choices up to you, this is not a recommended practice. It is the physicians responsibility to select the appropriate code because only he or she was in the room with the patient and knows what took place.

Its true that you should **be able to** code a visit by looking at the documentation in such instances as an internal audit, when you are trying to prove that the physician documents visits appropriately, but that doesnt mean you **are supposed to** make a practice of coding all of your claims based solely on the physicians documentation.

The physiatrist alone should determine whether the visit was expanded, problem-focused, etc.

If an audit shows that your practice is upcoding all of your E/M claims, the physician would be responsible for proving that the claims were coded properly, because his name is on the claims, so leave the E/M code selection to him. If, from the documentation, you think he has overcoded or undercoded, you can take the claim to the physician and discuss it, but you should not be choosing CPT codes.

Another school of thought that might agree with your employer says the coder should concentrate on coding while the physician concentrates on treating the patients. But to code the physicians claims yourself from documentation alone requires significant training (such as AAPC or AHIMA certification and additional E/M instruction) and perhaps a month or

two in which you code the claims and then run them past an independent coding consultant for a review to determine whether you coded accurately. A good middle ground would be for the physiatrist to circle the appropriate level of E/M on the superbill and provide the documentation, and have the coder double-check the code against the documentation to ensure that it was assigned accurately.