# Local Coverage Article:
# Billing and Coding: Pain Management (A52863)

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# Contractor Information

| CONTRACTOR NAME | CONTRACT TYPE | CONTRACT NUMBER | JURISDICTION | STATE(S) |
|---|---|---|---|---|
| National Government Services, Inc. | MAC - Part A | 06101 - MAC A | J - 06 | Illinois |
| National Government Services, Inc. | MAC - Part B | 06102 - MAC B | J - 06 | Illinois |
| National Government Services, Inc. | MAC - Part A | 06201 - MAC A | J - 06 | Minnesota |
| National Government Services, Inc. | MAC - Part B | 06202 - MAC B | J - 06 | Minnesota |
| National Government Services, Inc. | MAC - Part A | 06301 - MAC A | J - 06 | Wisconsin |
| National Government Services, Inc. | MAC - Part B | 06302 - MAC B | J - 06 | Wisconsin |
| National Government Services, Inc. | A and B and HHH MAC | 13101 - MAC A | J - K | Connecticut |
| National Government Services, Inc. | A and B and HHH MAC | 13102 - MAC B | J - K | Connecticut |
| National Government Services, Inc. | A and B and HHH MAC | 13201 - MAC A | J - K | New York - Entire State |
| National Government Services, Inc. | A and B and HHH MAC | 13202 - MAC B | J - K | New York - Downstate |
| National Government Services, Inc. | A and B and HHH MAC | 13282 - MAC B | J - K | New York - Upstate |
| National Government Services, Inc. | A and B and HHH MAC | 13292 - MAC B | J - K | New York - Queens |
| National Government Services, Inc. | A and B and HHH MAC | 14111 - MAC A | J - K | Maine |
| National Government Services, Inc. | A and B and HHH MAC | 14112 - MAC B | J - K | Maine |
| National Government Services, Inc. | A and B and HHH MAC | 14211 - MAC A | J - K | Massachusetts |
| National Government Services, | A and B and HHH | 14212 - MAC B | J - K | Massachusetts |

| CONTRACTOR NAME | CONTRACT TYPE | CONTRACT NUMBER | JURISDICTION | STATE(S) |
|---|---|---|---|---|
| Inc. | MAC | | | |
| National Government Services, Inc. | A and B and HHH MAC | 14311 - MAC A | J - K | New Hampshire |
| National Government Services, Inc. | A and B and HHH MAC | 14312 - MAC B | J - K | New Hampshire |
| National Government Services, Inc. | A and B and HHH MAC | 14411 - MAC A | J - K | Rhode Island |
| National Government Services, Inc. | A and B and HHH MAC | 14412 - MAC B | J - K | Rhode Island |
| National Government Services, Inc. | A and B and HHH MAC | 14511 - MAC A | J - K | Vermont |
| National Government Services, Inc. | A and B and HHH MAC | 14512 - MAC B | J - K | Vermont |

# Article Information

## General Information

**Article ID**
A52863

**Article Title**
Billing and Coding: Pain Management

**Article Type**
Billing and Coding

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### CMS National Coverage Policy

N/A

# Article Guidance

**Article Text:**

This article contains coding and other guidelines that complement the Local Coverage Determination (LCD) for Pain Management.

**Coding Information:**

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare.

For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim.

A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act.

The diagnosis code(s) must best describe the patient's condition for which the service was performed.

All procedures related to pain management procedures performed by the physician/provider performed on the same day must be billed on the same claim.

Acupuncture, a non-covered service, prior to January 21, 2020, is reported with CPT codes 97810 – 97814. Effective January 21, 2020, Medicare will cover all types of acupuncture including dry needling for chronic low back pain within specific guidelines in accordance with NCD 30.3.3.

**TRIGGER POINT INJECTIONS AND INJECTIONS OF TENDON SHEATH, LIGAMENT, GANGLION CYST, CARPAL AND TARSAL TUNNELS**

For trigger point injections, use code 20552 for one or two muscle groups injected, or 20553 for three or more muscle groups. The number of services for either code is one (1), regardless of the number of injections at any individual site, and regardless of the number of sites. Only 20552 or 20553 may be billed, not both. Trigger point injections must be billed on only one line, regardless of the number of sites.

For dates of service prior to 01/01/2020, dry needling should be reported with CPT code 20999 (Unlisted procedure, musculoskeletal system, general).

For dates of service on or after 01/01/2020, dry needling should be reported with CPT code 20560 and/or 20561. Effective January 21, 2020, Medicare will cover all types of acupuncture including dry needling for chronic low back pain within specific guidelines in accordance with NCD 30.3.3.

CPT code 20551 should be used when the origin or insertion of a tendon is injected, in contrast to an injection of the tendon sheath, CPT code 20550.

CPT code 28899 (unilateral procedure, foot or toe) should be billed for the injection of the tarsal tunnel.

Injection of separate sites (tendon sheath, ligament or ganglion cyst) during the same encounter should be reported on a separate line of coding and must have the modifier 59 appended. Multiple surgical rules will apply. Modifier 50 should not be reported with CPT codes 20551, 20552, 20553 or 20612, but may be reported, when appropriate, with CPT codes 20550 and 20526. For an Ambulatory Surgical Center (ASC), the appropriate site modifier (RT and/or LT) should be appended to indicate if the service was performed unilaterally or bilaterally. Bilateral services must be reported on separate lines using an RT and LT modifier (50 modifier should not be used).

Multiple injections per day, at the same site, are considered one injection and should be coded with one unit of service (NOS 001).

Claims for prolotherapy must not be reported with the trigger point codes or other injection codes.

**SACROILIAC (SI) JOINT INJECTIONS**

CPT codes 27096, 64451 and G0260 should not be billed when a physician provides routine sacroiliac injections. They are to be used only with imaging confirmation of intra-articular needle positioning.

Paravertebral Spinal Nerves and Branches – Image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 27096. Do not report CPT code 27096 or G0260 unless fluoroscopic- or CT-guidance is performed.

CPT codes 27096 and 64451 have a bilateral surgery indicator of "1." Thus, it is considered a "unilateral" procedure. Follow the same guidelines for G0260:

- When injecting a sacroiliac joint bilaterally, file with modifier –50.
- When injecting a sacroiliac joint unilaterally, file the appropriate anatomic modifier –LT or –RT.
- Only one (1) unit of service (equals one bilateral injection **or** one unilateral injection) should be submitted for a unilateral or bilateral sacroiliac joint/nerve injection.
- For an Ambulatory Surgical Center (ASC), the appropriate site modifier (RT and/or LT) should be appended to indicate if the service was performed unilaterally or bilaterally. Bilateral services must be reported on separate lines using an RT and LT modifier (50 modifier should not be used).

CPT code G0260 should be billed by facilities paid by OPPS.

Do not bill CPT code 73542 (Radiologic examination, sacroiliac joint arthrography, radiological supervision and interpretation) for injection of contrast to verify needle position. The CPT code 73542 is only to be billed for a medically necessary diagnostic study and requires a full interpretation and report.

Use CPT code 64999 (Unlisted procedure, nervous system) for pulsed radiofrequency and the denervation procedures of the sacro-iliac joint/nerves. Pulsed radiofrequency for denervation is considered investigational and therefore, not medically necessary.

For dates of service prior to 01/01/2020, sacro-iliac joint/nerve denervation procedures using traditional or cooled radiofrequency are also considered investigational and not medically necessary and should be billed with CPT code 64999.

For dates of service on or after 01/01/2020, CPT code 64625 - Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography) should be used to report radiofrequency ablation whether performed using traditional or cooled radiofrequency (<80 degrees Celsius).

Radiofrequency ablation for denervation whether performed using traditional, cooled, or pulsed radiofrequency is considered investigational and therefore, not medically necessary.

CPT code 72275 **Epidurography, radiological supervision and interpretation** represents a formal recorded and reported contrast study that includes fluoroscopy. Epidurography should only be reported when it is reasonable and medically necessary to perform a diagnostic study. It may only be performed with a caudal or intrathecal approach and should not be billed for the usual work of fluoroscopy and dye injection that is integral to the sacroiliac injection(s).

**For claims submitted to the Part B MAC**

**HCPCS DRUG CODES**
A claim for services rendered in the off-campus-outpatient hospital (19), inpatient hospital (21), on campus-outpatient hospital (22) or emergency room, hospital (23), ambulatory surgery center (24), skilled nursing facility for patients in a part A stay (31), comprehensive inpatient rehabilitation facility (61), and comprehensive outpatient rehabilitation facility (62) must indicate the name of the drug and dosage in item 19 or the electronic equivalent. The HCPCS drug code and dose is not required when CPT 20612 is reported for aspiration and not for injection or when the ICD-10-CM codes reported are M77.11 or M77.12 and there is no injection.

The medication being injected, designated by an appropriate HCPCS drug code must be submitted on the same claim, same day of service as the claim for the procedure. Claims for local anesthetic should not be reported. The exceptions to this guideline are:

- When services are rendered in places of services 19, 21, 22, 23, 61, and 62 there should be no claim for the HCPCS drug code. In addition, drugs packaged in ASC payments should not be separately reported.

A claim for services rendered in the office or independent clinic, when the physician does not bill for the injectables, must include the name of the drug and dosage in item 19 or the electronic equivalent.

**Documentation Requirements:**

The patient's medical record must contain documentation that fully supports the medical necessity for services included within the LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

A procedure note must be legible and include sufficient detail to allow reconstruction of the procedure. Required elements of the note include a description of the techniques employed, and sites(s) of injections, drugs and doses with volumes and concentrations as well as pre- and post-procedural pain assessments.

For the treatment of established **trigger point**, the patient's medical record must clearly document:

- The evaluation leading to the diagnosis of the trigger point in an individual muscle, as detailed in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this LCD;
- Identification of the affected muscle(s);
- Reason for selecting the trigger point injection as a therapeutic option, and whether it is being used as an initial or subsequent treatment for myofascial pain.

For **injections of tendon sheaths, ligaments, ganglion cysts, carpal and tarsal tunnels**, the medical record must include a procedural note documenting the reason for the injection at any particular site. If multiple sites are injected, documentation to substantiate that all the injections are reasonable and necessary must be present.

For **SI joint injections**, the following lists specific requirements: Document the total amount of injectate for all medications used. The amount of injectate should be such that the synovial lining of the joint is not burst and the injectate does not disperse beyond the confines of the target joint.

**Utilization Guidelines:**

**Trigger Point Injections:**

- Repeat **trigger point injections** may be necessary when there is evidence of persistent pain. Generally more than three injections of the same trigger point are not indicated. Evidence of partial improvements to the range of motion in any muscle area after an injection, but with persistent significant pain, would justify a repeat injection. The medical record must clearly reflect the medical necessity for repeated injections.

**Injection Tendon Sheath, Ligament, Ganglion Cyst, Carpal and Tarsal Tunnel:**

- Most conditions that require injections into the tendon sheaths, ligaments or ganglion cysts should be resolved with one to three injections.

Frequency and Number of Injections or Interventions:

- In the diagnostic phase, a patient may receive injections at intervals of no sooner than one week or preferably, two weeks.
- The number of injections in the diagnostic phase should be limited to no more than two times.
- Once a structure is proven to be negative, no repeat interventions should be directed at that structure unless there is a new clinical presentation with symptoms, signs, and diagnostic studies of known reliability and validity that implicate the structure.
- The effect of injected corticosteroids may remain for several weeks. The benefit is attributed to a decrease of

local inflammation and perhaps some local anesthetic effect. It is usually not necessary to repeat an injection if there has been a satisfactory response to the first injection. Patients who relapse after a satisfactory response may be candidates for another trial after an appropriate interval. Consideration should be given to the cumulative dose injected and limitations made to avoid steroid complications.

- In the therapeutic phase (after the diagnostic phase is completed), the frequency should be two months or longer between each injection, provided that there is initial pain relief with diagnostic injections of greater than or equal to (>/=) 75% - 100% with the ability to perform previously painful maneuvers, and a persistent pain relief of greater than or equal to (>/=) 50% with the continued ability to perform previously painful maneuvers is maintained for at least six weeks. The therapeutic frequency must remain at least two months or longer.
- In the treatment or therapeutic phase, the injections should be repeated only as medically necessary. No more than four per patient per year are anticipated for the majority of patients.
- Only sacroiliac joints for which there has been a positive response should be injected for therapeutic reasons.

# Coding Information

**CPT/HCPCS Codes**

**Group 1 Paragraph:**

**TRIGGER POINT INJECTIONS**

**Group 1 Codes:**

| CODE | DESCRIPTION |
|---|---|
| 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 |

**Group 2 Paragraph:**

**INJECTION OF TENDON SHEATHS, LIGAMENTS, GANGLION CYSTS, CARPAL AND TARSAL TUNNELS**

**Group 2 Codes:**

| CODE | DESCRIPTION |
|---|---|
| 20526 | INJECTION, THERAPEUTIC (EG, LOCAL ANESTHETIC, CORTICOSTEROID), CARPAL TUNNEL |
| 20550 | INJECTION(S); SINGLE TENDON SHEATH, OR LIGAMENT, APONEUROSIS (EG, PLANTAR "FASCIA") |
| 20551 | INJECTION(S); SINGLE TENDON ORIGIN/INSERTION |
| 20612 | ASPIRATION AND/OR INJECTION OF GANGLION CYST(S) ANY LOCATION |
| 28899 | UNLISTED PROCEDURE, FOOT OR TOES |

**Group 3 Paragraph:**

**SACROILIAC (SI) JOINT INJECTIONS**

**Group 3 Codes:**

| CODE | DESCRIPTION |
|---|---|
| 27096 | INJECTION PROCEDURE FOR SACROILIAC JOINT, ANESTHETIC/STEROID, WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT) INCLUDING ARTHROGRAPHY WHEN PERFORMED |
| 64451 | INJECTION(S), ANESTHETIC AGENT(S) AND/OR STEROID; NERVES INNERVATING THE SACROILIAC JOINT, WITH IMAGE GUIDANCE (IE, FLUOROSCOPY OR COMPUTED TOMOGRAPHY) |
| G0260 | INJECTION PROCEDURE FOR SACROILIAC JOINT; PROVISION OF ANESTHETIC, STEROID AND/OR OTHER THERAPEUTIC AGENT, WITH OR WITHOUT ARTHROGRAPHY |

**Group 4 Paragraph:**

**Dry Needling**

For dates of service on or after 01/01/2020, dry needling should be reported using CPT codes 20560 or 20561. Effective January 21, 2020, Medicare will cover all types of acupuncture including dry needling for chronic low back pain within specific guidelines in accordance with NCD 30.3.3.

**Group 4 Codes:**

| CODE | DESCRIPTION |
|---|---|
| 20560 | NEEDLE INSERTION(S) WITHOUT INJECTION(S); 1 OR 2 MUSCLE(S) |
| 20561 | NEEDLE INSERTION(S) WITHOUT INJECTION(S); 3 OR MORE MUSCLES |

**Group 5 Paragraph:**

**Non-Covered Service**

For dates of service on or after 01/01/2020, CPT code 64625 should be used to report radiofrequency ablation whether performed using traditional or cooled radiofrequency (<80 degrees Celsius). Pulsed radiofrequency ablation should be reported using CPT code 64999.

**Group 5 Codes:**

| CODE | DESCRIPTION |
|---|---|
| 64625 | RADIOFREQUENCY ABLATION, NERVES INNERVATING THE SACROILIAC JOINT, WITH IMAGE GUIDANCE (IE, FLUOROSCOPY OR COMPUTED TOMOGRAPHY) |
| 64999 | UNLISTED PROCEDURE, NERVOUS SYSTEM |

**CPT/HCPCS Modifiers**

N/A

**ICD-10 Codes that Support Medical Necessity**

**Group 1 Paragraph:**

The use of an ICD-10-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in the attached determination.

**TRIGGER POINT INJECTIONS (CPT codes 20552 and 20553)**

**Group 1 Codes:**

| ICD-10 CODE | DESCRIPTION |
|---|---|
| M60.811 | Other myositis, right shoulder |
| M60.812 | Other myositis, left shoulder |
| M60.821 | Other myositis, right upper arm |
| M60.822 | Other myositis, left upper arm |
| M60.831 | Other myositis, right forearm |
| M60.832 | Other myositis, left forearm |
| M60.841 | Other myositis, right hand |
| M60.842 | Other myositis, left hand |
| M60.851 | Other myositis, right thigh |
| M60.852 | Other myositis, left thigh |
| M60.861 | Other myositis, right lower leg |
| M60.862 | Other myositis, left lower leg |
| M60.871 | Other myositis, right ankle and foot |
| M60.872 | Other myositis, left ankle and foot |
| M60.88 | Other myositis, other site |
| M60.89 | Other myositis, multiple sites |
| M60.9 | Myositis, unspecified |
| M79.11 | Myalgia of mastication muscle |
| M79.12 | Myalgia of auxiliary muscles, head and neck |
| M79.18 | Myalgia, other site |
| M79.7 | Fibromyalgia |

**Group 2 Paragraph:**

**INJECTION OF TENDON SHEATHS, LIGAMENTS, GANGLION CYSTS, CARPAL AND TARSAL TUNNELS (CPT codes 20526, 20550, 20551, 20612, 28899 [use for tarsal tunnel injections])**

**Group 2 Codes:**

| ICD-10 CODE | DESCRIPTION |
|---|---|
| D48.1 | Neoplasm of uncertain behavior of connective and other soft tissue |
| G56.01 | Carpal tunnel syndrome, right upper limb |
| G56.02 | Carpal tunnel syndrome, left upper limb |
| G56.03 | Carpal tunnel syndrome, bilateral upper limbs |
| G57.51 | Tarsal tunnel syndrome, right lower limb |
| G57.52 | Tarsal tunnel syndrome, left lower limb |
| G57.53 | Tarsal tunnel syndrome, bilateral lower limbs |
| M20.10 | Hallux valgus (acquired), unspecified foot |
| M25.711 | Osteophyte, right shoulder |
| M25.712 | Osteophyte, left shoulder |
| M25.721 | Osteophyte, right elbow |
| M25.722 | Osteophyte, left elbow |
| M25.731 | Osteophyte, right wrist |
| M25.732 | Osteophyte, left wrist |
| M25.741 | Osteophyte, right hand |
| M25.742 | Osteophyte, left hand |
| M25.751 | Osteophyte, right hip |
| M25.752 | Osteophyte, left hip |
| M25.761 | Osteophyte, right knee |
| M25.762 | Osteophyte, left knee |
| M25.771 | Osteophyte, right ankle |
| M25.772 | Osteophyte, left ankle |
| M25.774 | Osteophyte, right foot |
| M25.775 | Osteophyte, left foot |

| ICD-10 CODE | DESCRIPTION |
|---|---|
| M46.01 | Spinal enthesopathy, occipito-atlanto-axial region |
| M46.02 | Spinal enthesopathy, cervical region |
| M46.03 | Spinal enthesopathy, cervicothoracic region |
| M46.04 | Spinal enthesopathy, thoracic region |
| M46.05 | Spinal enthesopathy, thoracolumbar region |
| M46.06 | Spinal enthesopathy, lumbar region |
| M46.07 | Spinal enthesopathy, lumbosacral region |
| M46.08 | Spinal enthesopathy, sacral and sacrococcygeal region |
| M46.09 | Spinal enthesopathy, multiple sites in spine |
| M65.111 | Other infective (teno)synovitis, right shoulder |
| M65.112 | Other infective (teno)synovitis, left shoulder |
| M65.121 | Other infective (teno)synovitis, right elbow |
| M65.122 | Other infective (teno)synovitis, left elbow |
| M65.131 | Other infective (teno)synovitis, right wrist |
| M65.132 | Other infective (teno)synovitis, left wrist |
| M65.141 | Other infective (teno)synovitis, right hand |
| M65.142 | Other infective (teno)synovitis, left hand |
| M65.151 | Other infective (teno)synovitis, right hip |
| M65.152 | Other infective (teno)synovitis, left hip |
| M65.161 | Other infective (teno)synovitis, right knee |
| M65.162 | Other infective (teno)synovitis, left knee |
| M65.171 | Other infective (teno)synovitis, right ankle and foot |
| M65.172 | Other infective (teno)synovitis, left ankle and foot |
| M65.18 | Other infective (teno)synovitis, other site |
| M65.19 | Other infective (teno)synovitis, multiple sites |
| M65.311 | Trigger thumb, right thumb |
| M65.312 | Trigger thumb, left thumb |
| M65.321 | Trigger finger, right index finger |
| M65.322 | Trigger finger, left index finger |
| M65.331 | Trigger finger, right middle finger |
| M65.332 | Trigger finger, left middle finger |
| M65.341 | Trigger finger, right ring finger |

| ICD-10 CODE | DESCRIPTION |
|---|---|
| M65.342 | Trigger finger, left ring finger |
| M65.351 | Trigger finger, right little finger |
| M65.352 | Trigger finger, left little finger |
| M65.4 | Radial styloid tenosynovitis [de Quervain] |
| M65.80 | Other synovitis and tenosynovitis, unspecified site |
| M65.811 | Other synovitis and tenosynovitis, right shoulder |
| M65.812 | Other synovitis and tenosynovitis, left shoulder |
| M65.821 | Other synovitis and tenosynovitis, right upper arm |
| M65.822 | Other synovitis and tenosynovitis, left upper arm |
| M65.831 | Other synovitis and tenosynovitis, right forearm |
| M65.832 | Other synovitis and tenosynovitis, left forearm |
| M65.841 | Other synovitis and tenosynovitis, right hand |
| M65.842 | Other synovitis and tenosynovitis, left hand |
| M65.851 | Other synovitis and tenosynovitis, right thigh |
| M65.852 | Other synovitis and tenosynovitis, left thigh |
| M65.861 | Other synovitis and tenosynovitis, right lower leg |
| M65.862 | Other synovitis and tenosynovitis, left lower leg |
| M65.871 | Other synovitis and tenosynovitis, right ankle and foot |
| M65.872 | Other synovitis and tenosynovitis, left ankle and foot |
| M65.88 | Other synovitis and tenosynovitis, other site |
| M65.89 | Other synovitis and tenosynovitis, multiple sites |
| M65.9 | Synovitis and tenosynovitis, unspecified |
| M66.211 | Spontaneous rupture of extensor tendons, right shoulder |
| M66.212 | Spontaneous rupture of extensor tendons, left shoulder |
| M66.811 | Spontaneous rupture of other tendons, right shoulder |
| M66.812 | Spontaneous rupture of other tendons, left shoulder |
| M67.311 | Transient synovitis, right shoulder |
| M67.312 | Transient synovitis, left shoulder |
| M67.321 | Transient synovitis, right elbow |
| M67.322 | Transient synovitis, left elbow |
| M67.331 | Transient synovitis, right wrist |
| M67.332 | Transient synovitis, left wrist |

| ICD-10 CODE | DESCRIPTION |
|---|---|
| M67.341 | Transient synovitis, right hand |
| M67.342 | Transient synovitis, left hand |
| M67.351 | Transient synovitis, right hip |
| M67.352 | Transient synovitis, left hip |
| M67.361 | Transient synovitis, right knee |
| M67.362 | Transient synovitis, left knee |
| M67.371 | Transient synovitis, right ankle and foot |
| M67.372 | Transient synovitis, left ankle and foot |
| M67.38 | Transient synovitis, other site |
| M67.39 | Transient synovitis, multiple sites |
| M67.40 | Ganglion, unspecified site |
| M67.411 | Ganglion, right shoulder |
| M67.412 | Ganglion, left shoulder |
| ICD-10 CODE | DESCRIPTION |
| M67.421 | Ganglion, right elbow |
| M67.422 | Ganglion, left elbow |
| M67.431 | Ganglion, right wrist |
| M67.432 | Ganglion, left wrist |
| M67.441 | Ganglion, right hand |
| M67.442 | Ganglion, left hand |
| M67.451 | Ganglion, right hip |
| M67.452 | Ganglion, left hip |
| M67.461 | Ganglion, right knee |
| M67.462 | Ganglion, left knee |
| M67.471 | Ganglion, right ankle and foot |
| M67.472 | Ganglion, left ankle and foot |
| M67.48 | Ganglion, other site |
| M67.49 | Ganglion, multiple sites |
| M70.031 | Crepitant synovitis (acute) (chronic), right wrist |
| M70.032 | Crepitant synovitis (acute) (chronic), left wrist |
| M70.041 | Crepitant synovitis (acute) (chronic), right hand |
| M70.042 | Crepitant synovitis (acute) (chronic), left hand |

| ICD-10 CODE | DESCRIPTION |
|---|---|
| M70.10 | Bursitis, unspecified hand |
| M70.11 | Bursitis, right hand |
| M70.12 | Bursitis, left hand |
| M70.21 | Olecranon bursitis, right elbow |
| M70.22 | Olecranon bursitis, left elbow |
| M70.31 | Other bursitis of elbow, right elbow |
| M70.32 | Other bursitis of elbow, left elbow |
| M70.41 | Prepatellar bursitis, right knee |
| M70.42 | Prepatellar bursitis, left knee |
| M70.51 | Other bursitis of knee, right knee |
| M70.52 | Other bursitis of knee, left knee |
| M70.61 | Trochanteric bursitis, right hip |
| M70.62 | Trochanteric bursitis, left hip |
| M70.71 | Other bursitis of hip, right hip |
| M70.72 | Other bursitis of hip, left hip |
| M71.111 | Other infective bursitis, right shoulder |
| M71.112 | Other infective bursitis, left shoulder |
| M71.121 | Other infective bursitis, right elbow |
| M71.122 | Other infective bursitis, left elbow |
| M71.131 | Other infective bursitis, right wrist |
| M71.132 | Other infective bursitis, left wrist |
| M71.141 | Other infective bursitis, right hand |
| M71.142 | Other infective bursitis, left hand |
| M71.151 | Other infective bursitis, right hip |
| M71.152 | Other infective bursitis, left hip |
| M71.161 | Other infective bursitis, right knee |
| M71.162 | Other infective bursitis, left knee |
| M71.171 | Other infective bursitis, right ankle and foot |
| M71.172 | Other infective bursitis, left ankle and foot |
| M71.18 | Other infective bursitis, other site |
| M71.19 | Other infective bursitis, multiple sites |
| M71.30 | Other bursal cyst, unspecified site |

| ICD-10 CODE | DESCRIPTION |
|---|---|
| M71.521 | Other bursitis, not elsewhere classified, right elbow |
| M71.522 | Other bursitis, not elsewhere classified, left elbow |
| M71.531 | Other bursitis, not elsewhere classified, right wrist |
| M71.532 | Other bursitis, not elsewhere classified, left wrist |
| M71.541 | Other bursitis, not elsewhere classified, right hand |
| M71.542 | Other bursitis, not elsewhere classified, left hand |
| M71.551 | Other bursitis, not elsewhere classified, right hip |
| M71.552 | Other bursitis, not elsewhere classified, left hip |
| M71.561 | Other bursitis, not elsewhere classified, right knee |
| M71.562 | Other bursitis, not elsewhere classified, left knee |
| M71.571 | Other bursitis, not elsewhere classified, right ankle and foot |
| M71.572 | Other bursitis, not elsewhere classified, left ankle and foot |
| M71.58* | Other bursitis, not elsewhere classified, other site |
| M72.0 | Palmar fascial fibromatosis [Dupuytren] |
| M72.2 | Plantar fascial fibromatosis |
| M72.9 | Fibroblastic disorder, unspecified |
| M75.01 | Adhesive capsulitis of right shoulder |
| M75.02 | Adhesive capsulitis of left shoulder |
| M75.101 | Unspecified rotator cuff tear or rupture of right shoulder, not specified as traumatic |
| M75.102 | Unspecified rotator cuff tear or rupture of left shoulder, not specified as traumatic |
| M75.21 | Bicipital tendinitis, right shoulder |
| M75.22 | Bicipital tendinitis, left shoulder |
| M75.30 | Calcific tendinitis of unspecified shoulder |
| M75.31 | Calcific tendinitis of right shoulder |
| M75.32 | Calcific tendinitis of left shoulder |
| M75.41 | Impingement syndrome of right shoulder |
| M75.42 | Impingement syndrome of left shoulder |
| M75.51 | Bursitis of right shoulder |
| M75.52 | Bursitis of left shoulder |
| M75.81 | Other shoulder lesions, right shoulder |
| M75.82 | Other shoulder lesions, left shoulder |
| M75.91 | Shoulder lesion, unspecified, right shoulder |

| ICD-10 CODE | DESCRIPTION |
|---|---|
| M75.92 | Shoulder lesion, unspecified, left shoulder |
| M76.01 | Gluteal tendinitis, right hip |
| M76.02 | Gluteal tendinitis, left hip |
| M76.11 | Psoas tendinitis, right hip |
| M76.12 | Psoas tendinitis, left hip |
| M76.21 | Iliac crest spur, right hip |
| M76.22 | Iliac crest spur, left hip |
| M76.31 | Iliotibial band syndrome, right leg |
| M76.32 | Iliotibial band syndrome, left leg |
| M76.41 | Tibial collateral bursitis [Pellegrini-Stieda], right leg |
| M76.42 | Tibial collateral bursitis [Pellegrini-Stieda], left leg |
| M76.51 | Patellar tendinitis, right knee |
| M76.52 | Patellar tendinitis, left knee |
| M76.61 | Achilles tendinitis, right leg |
| M76.62 | Achilles tendinitis, left leg |
| M76.71 | Peroneal tendinitis, right leg |
| M76.72 | Peroneal tendinitis, left leg |
| M76.811 | Anterior tibial syndrome, right leg |
| ICD-10 CODE | DESCRIPTION |
| M76.812 | Anterior tibial syndrome, left leg |
| M76.821 | Posterior tibial tendinitis, right leg |
| M76.822 | Posterior tibial tendinitis, left leg |
| M76.891 | Other specified enthesopathies of right lower limb, excluding foot |
| M76.892 | Other specified enthesopathies of left lower limb, excluding foot |
| M76.899 | Other specified enthesopathies of unspecified lower limb, excluding foot |
| M76.9 | Unspecified enthesopathy, lower limb, excluding foot |
| M77.01 | Medial epicondylitis, right elbow |
| M77.02 | Medial epicondylitis, left elbow |
| M77.11 | Lateral epicondylitis, right elbow |
| M77.12 | Lateral epicondylitis, left elbow |
| M77.21 | Periarthritis, right wrist |
| M77.22 | Periarthritis, left wrist |

| ICD-10 CODE | DESCRIPTION |
|---|---|
| M77.30 | Calcaneal spur, unspecified foot |
| M77.31* | Calcaneal spur, right foot |
| M77.32* | Calcaneal spur, left foot |
| M77.41 | Metatarsalgia, right foot |
| M77.42 | Metatarsalgia, left foot |
| M77.51* | Other enthesopathy of right foot and ankle |
| M77.52* | Other enthesopathy of left foot and ankle |
| M77.8 | Other enthesopathies, not elsewhere classified |

**Group 2 Medical Necessity ICD-10 Codes Asterisk Explanation:**

*Use ICD-10-CM code M71.58 for bursitis in the foot

*Use ICD-10-CM code M77.31-M77.32 for heel pain syndrome

*Use ICD-10-CM code M77.51-M77.52 for calcaneal bursitis

**Group 3 Paragraph:**

**SACROILIAC (SI) JOINT INJECTIONS (CPT codes 27096, 64451, G0260)**

**Group 3 Codes:**

| ICD-10 CODE | DESCRIPTION |
|---|---|
| M12.9 | Arthropathy, unspecified |
| M43.27 | Fusion of spine, lumbosacral region |
| M43.28 | Fusion of spine, sacral and sacrococcygeal region |
| M46.1 | Sacroiliitis, not elsewhere classified |
| M53.2X7 | Spinal instabilities, lumbosacral region |
| M53.2X8 | Spinal instabilities, sacral and sacrococcygeal region |
| M53.3 | Sacrococcygeal disorders, not elsewhere classified |
| M53.87 | Other specified dorsopathies, lumbosacral region |
| M53.88 | Other specified dorsopathies, sacral and sacrococcygeal region |
| Z79.01* | Long term (current) use of anticoagulants |

**Group 3 Medical Necessity ICD-10 Codes Asterisk Explanation:**

*Use Z79.01 only as a supplemental code in addition to primary diagnosis, when anticoagulant therapy has been discontinued to facilitate therapeutic injections for pain management.

**ICD-10 Codes that DO NOT Support Medical Necessity**

N/A

**Additional ICD-10 Information**

N/A

**Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type.Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

**Revenue Codes:**

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

N/A

**Other Coding Information**

N/A

# Revision History Information

| REVISION HISTORY DATE | REVISION HISTORY NUMBER | REVISION HISTORY EXPLANATION |
|---|---|---|
| 06/24/2020 | R10 | Based on Transmittal 10128, (CR 11755 - National Coverage Determination (NCD30.3.3): Acupuncture for Chronic Low Back Pain (cLBP)), the article has been revised to add: Effective January 21, 2020, Medicare will cover all types of acupuncture including dry needling for chronic low back pain within specific guidelines in accordance |

| REVISION HISTORY DATE | REVISION HISTORY NUMBER | REVISION HISTORY EXPLANATION |
|---|---|---|
| | | with NCD 30.3.3. CPT codes 64625 and 64999 have been moved to Group 5 in the CPT/HCPC Code Group section. |
| 01/01/2020 | R9 | The guideline for pulsed radiofrequency has been revised to indicate that CPT code 64999 should be used. For dates of service on or after 01/01/2020, CPT code 64625 should be used to report radiofrequency ablation whether performed using traditional or cooled radiofrequency (<80 degrees Celsius). CPT code 64999 has been added to CPT/HCPC Codes Group 4. |
| 01/01/2020 | R8 | CPT code 64451 has been added to the bilateral surgery guidelines under the "Sacroiliac (SI) Joint Injections" section. |
| 01/01/2020 | R7 | The following sentence has been added to the paragraph for CPT code 64625 in the "Indications" section of the article:<br><br>Radiofrequency ablation for denervation whether performed using traditional, cooled, or pulsed radiofrequency is considered investigational and therefore, not medically necessary.<br><br>"Non-Covered Service" has been added to the Group 4 paragraph section. |
| 01/01/2020 | R6 | Based on the annual CPT/HCPCS update, CPT codes 20560 and 20561 have been added to the article to report dry needling. CPT code 64625 has been added to the article to report radiofrequency ablation, nerves innervating the sacroiliac joint. CPT codes 20560, 20561 and 64625 have been added to a new CPT/HCPCS Codes section (Group 4). CPT code 64451 has been added to the CPT/HCPCS Codes section Group 3 and ICD-10 Codes that Support Medical Necessity Group 3 for sacroiliac joint injections. CPT code 64451 has been added to the "Coding Information" section for sacroiliac joint injections. |
| 10/01/2019 | R5 | The article has been revised for annual ICD-10-CM code updates. The descriptor for ICD-10-CM codes M77.51 and M77.52 was changed in Group 2. Bill types and Revenue codes have been removed from this article. Guidance on these codes is available in the Bill type and Revenue code sections. This article was converted to the new Billing and Coding Article type. |
| 08/01/2019 | R4 | The title of the article has been revised to add Billing and Coding. The Coding Information section has been revised to add a guideline for CPT code 72275. Documentation, Utilization and ICD-10-CM coding sections have been added. |
| 01/01/2016 | R3 | The first paragraph under "HCPCS DRUG CODES" has been revised to add off campus-outpatient hospital (19) and ICD-10-CM codes M77.11 and M77.12. Place of service 19 |

| REVISION HISTORY DATE | REVISION HISTORY NUMBER | REVISION HISTORY EXPLANATION |
|---|---|---|
| | | has been added to the following paragraph:<br><br>When services are rendered in places of services 19, 21, 22, 23, 61, and 62 there should be no claim for the HCPCS drug code. In addition, drugs packaged in ASC payments should not be separately reported. |
| 01/01/2016 | R2 | Based on the annual 2016 HCPCS update, the description for CPT code 20553 has changed. Minor template changes were made to reflect current template language. |
| 10/01/2015 | R1 | The article has been revised to coincide with the ICD-9 version. The place of service guidelines for the Part B MAC have been removed. |

# Associated Documents

**Related Local Coverage Document(s)**

LCD(s)
L33622 - Pain Management

**Related National Coverage Document(s)**

N/A

**Statutory Requirements URL(s)**

N/A

**Rules and Regulations URL(s)**

N/A

**CMS Manual Explanations URL(s)**

N/A

**Other URL(s)**

N/A

**Public Version(s)**

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# Keywords

N/A