

Article - Billing and Coding: Pain Management (A52863)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
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

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
National Government Services, Inc.	A and B and HHH MAC	14212 - MAC B	J - K	Massachusetts
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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10/01/2015

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10/01/2023

Revision Ending Date

N/A

Retirement Date

N/A

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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.

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.

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 (\geq) 75% - 100% with the ability to perform previously painful maneuvers, and a persistent pain relief of greater than or equal to (\geq) 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.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

TRIGGER POINT INJECTIONS

Group 1 Codes: (2 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: (5 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:

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 3 Codes: (2 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

CPT/HCPCS Modifiers

N/A

ICD-10-CM 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: (21 Codes)**

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

CODE	DESCRIPTION
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: (222 Codes)

CODE	DESCRIPTION
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
M20.11	Hallux valgus (acquired), right foot
M20.12	Hallux valgus (acquired), left 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

CODE	DESCRIPTION
M25.774	Osteophyte, right foot
M25.775	Osteophyte, left foot
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

CODE	DESCRIPTION
M65.332	Trigger finger, left middle finger
M65.341	Trigger finger, right ring finger
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

CODE	DESCRIPTION
M67.331	Transient synovitis, right wrist
M67.332	Transient synovitis, left wrist
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
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

CODE	DESCRIPTION
M70.041	Crepitant synovitis (acute) (chronic), right hand
M70.042	Crepitant synovitis (acute) (chronic), left hand
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

CODE	DESCRIPTION
M71.19	Other infective bursitis, multiple sites
M71.30	Other bursal cyst, unspecified site
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

CODE	DESCRIPTION
M75.82	Other shoulder lesions, left shoulder
M75.91	Shoulder lesion, unspecified, right shoulder
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
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

CODE	DESCRIPTION
M77.21	Periarthritis, right wrist
M77.22	Periarthritis, left wrist
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-CM 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

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

N/A

ICD-10-PCS Codes

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 article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article 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 article, 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 article 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
10/01/2023	R13	Based on the annual ICD-10 code update, ICD-10 code D48.1 has been deleted from Group 2.
03/19/2023	R12	The article has been revised to remove all references to sacroiliac joint injection procedures. Please refer to Article A59233 - Billing and Coding: Sacroiliac Joint Injections and Procedures.
02/10/2022	R11	Based upon review, ICD-10 code M20.10 has been removed from Group 2 and replaced with M20.11 and M20.12 effective for dates of service on or after 10/01/2015.
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 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

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		"Sacroiliac (SI) Joint Injections" section.
01/01/2020	R7	<p>The following sentence has been added to the paragraph for CPT code 64625 in the "Indications" section of the article:</p> <p style="padding-left: 40px;">Radiofrequency ablation for denervation whether performed using traditional, cooled, or pulsed radiofrequency is considered investigational and therefore, not medically necessary.</p> <p>"Non-Covered Service" has been added to the Group 4 paragraph section.</p>
01/01/2020	R6	<p>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.</p>
10/01/2019	R5	<p>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.</p>
08/01/2019	R4	<p>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.</p>
01/01/2016	R3	<p>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 has been added to the following paragraph:</p> <p style="padding-left: 40px;">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.</p>
01/01/2016	R2	<p>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.</p>
10/01/2015	R1	<p>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.</p>

Associated Documents

Related Local Coverage Documents

LCDs

[L33622 - Pain Management](#)

Related National Coverage Documents

N/A

Statutory Requirements URLs

N/A

Rules and Regulations URLs

N/A

CMS Manual Explanations URLs

N/A

Other URLs

N/A

Public Versions

UPDATED ON	EFFECTIVE DATES	STATUS
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09/22/2023	10/01/2023 - N/A	Currently in Effect (This Version)
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Keywords

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