Injection, Tendon Sheath, Ligament, Ganglion Cyst, Carpal and Tarsal Tunnel – Supplemental Instructions Article (A47720)

Contractor Information

Contractor Name

National Government Services, Inc.

Contractor Number

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Contractor Type

MAC – Part A
MAC - Part B

Article Information

Article ID Number

A47720

Article Type

Article

Key Article
Yes

Article Title

Injection, Tendon Sheath, Ligament, Ganglion Cyst, Carpal and Tarsal Tunnel – Supplemental Instructions Article

Primary Geographic Jurisdiction

<table>
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Original Article Effective Date

07/18/2008

Article Revision Effective Date

Not applicable

Article Text

The information in this Supplemental Instructions Article (SIA) contains coding or other guidelines that complement the Local Coverage Determination (LCD) for Injection, Tendon Sheath, Ligament, Ganglion Cyst, Carpal and Tarsal Tunnel. The LCD can be accessed on our contractor Web site at www.NGSMedicare.com. It can also be found on the Medicare Coverage Database at www.cms.hhs.gov/mcd.

Coding Guidelines:

General Guidelines for claims submitted to Carriers or Intermediaries:

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-9-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.

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 CPT 20526, 20550, 20551 or 20612.

The exceptions to this guideline are:

- When services are rendered in places of services 21, 22 and 23 where there should be no claim for the HCPCS drug code since the reimbursement for the drug is a Part A responsibility

- When a physician bills for the injection in the office (11) or independent clinic (49)* and does not charge for the injectable

- When CPT 20612 is reported for aspiration and not for injection

- When the ICD-9-CM code reported is 726.32

  Paper claims must include the drug and dosage in item 19 of the CMS-1500 claim form, and electronic claims must include the same information in the narrative note.

A claim for services rendered in the inpatient hospital (21), outpatient hospital (22) or emergency room, hospital (23) must indicate the name of the drug and dosage in item 19 or in the narrative note. The HCPCS drug code is not required when CPT 20612 is reported for aspiration and not for injection or when the ICD-9-CM code reported is 726.32.

A claim for services rendered in the office or independent clinic, when the physician does not bill for the injectable, must include the name of the drug and dosage in item 19 or in the narrative. The name of the drug and dosage is not required when CPT 20612 is reported for aspiration and not for injection or when the ICD-9-CM code reported is 726.32.

An office visit must not be reported unless there has been a separate,
identifiable and medically necessary service rendered and documented. If these circumstances are met, the appropriate modifier (modifier 25) must be appended to the E&M code.

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

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. The modifier 50 should not be reported with CPT codes 20550, 20551 or 20612, but it may be reported, when appropriate, with CPT code 20526.

CPT code 20550 should be billed for the treatment of tarsal tunnel syndrome.

In the treatment of Morton’s Neuroma, the injection is into the surrounding tissue and not the nerve complex. Therefore, CPT code 20550 must be reported and NOT CPT codes for injections of anesthetic agents (nerve blocks) or destruction by neurolytic agents.

Do not use CPT codes 20526, 20550, 20551, or 20612 when the actual service being performed is acupuncture.

Prolotherapy (HCPCS code M0076) is not covered by Medicare and will be denied as not medically necessary. Its billing under CPT codes 20526, 20550, 20551 or 20612 is a misrepresentation of the procedure performed.

Advance Beneficiary Notice of Noncoverage (ABN) Modifier Guidelines (for outpatient services):

An ABN may be used for services which are likely to be non-covered, whether for medical necessity or for other reasons.

Services not meeting medical necessity guidelines should be billed with modifier -GA or -GZ.

The -GA modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a specific service as not reasonable and necessary and they do have an ABN signed by the beneficiary on file. An ABN, Form CMS-R-131, should be signed by the beneficiary to indicate that he/she accepts responsibility for payment. The -GA modifier may also be used on assigned claims when a patient refuses to sign the ABN and the latter is properly witnessed. For claims submitted to the Fiscal Intermediary, occurrence code 32 and the date of the ABN is required.
The -GZ modifier should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they have not had an ABN signed by the beneficiary.

If the service is statutorily non-covered, or without a benefit category, submit the appropriate CPT/HCPCS code with the -GY modifier.

**For claims submitted to the carrier:**

Claims for injection, tendon sheath, ligament, ganglion cyst, carpal and tarsal tunnel services are payable under Medicare Part B in the following places of service:

Injections, tendon sheath, ligament, ganglion cyst are payable in the following places of service: office (11), home (12), assisted living facility (13), group home foster care setting (14), urgent care facility (20), inpatient hospital (21), outpatient hospital (22), emergency room (23), (ASC) ambulatory surgical center (24), skilled nursing facility (31), nursing facility (32), custodial care facility (33), independent clinic (49), comp inpatient rehab facility (61), comp outpatient rehab facility (62), end stage renal disease treatment facility (65) and state or local public health clinic (71).

The HCPCS drug code is payable in the following places of service: office (11), home (12), assisted living facility (13), group home foster care setting (14), urgent care facility (20), nursing facility (32), custodial care facility (33), independent clinic (49), comp outpatient rehab facility (62), end stage renal disease treatment facility (65) and state or local public health clinic (71).

**For claims submitted to the fiscal intermediary:**

**Hospital Inpatient Claims:**

- The hospital should report the patient's principal diagnosis in Form Locator (FL) 67 of the UB-04. The principal diagnosis is the condition established after study to be chiefly responsible for this admission.
- The hospital enters ICD-9-CM codes for up to eight additional conditions in FLs 67A-67Q if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay. It may not duplicate the principal diagnosis listed in FL 67.
- For inpatient hospital claims, the admitting diagnosis is required and should be recorded in FL 69. (See CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 25, Section 75 for additional instructions.)
Hospital Outpatient Claims:

- The hospital should report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in FL 67. If no definitive diagnosis is made during the outpatient evaluation, the patient’s symptom is reported. If the patient arrives without a referring diagnosis, symptom or complaint, the provider should report an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82).
- The hospital enters the full ICD-9-CM codes in FLs 67A-67Q for up to eight other diagnoses that co-existed in addition to the diagnosis reported in FL 67.

Bill Type Guidelines

CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 100(B) states that no type of technical services, such as...a technical component of a diagnostic or screening service, is ever billed on TOBs 71x or 73x...Technical services/components associated with professional services/components performed by independent RHCs or FQHCs are billed to Medicare carriers...Technical services/components associated with professional services/components performed by provider-based RHCs or FQHCs are billed by the base-provider on the TOB for the base-provider and submitted to the FI.

Per CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 100(B), only four types of services are billed on TOBs 71X and 73X: Professional or primary services not subject to the Medicare outpatient mental health treatment limitation are bundled into line item(s) using revenue code 052X; services subject to the Medicare outpatient mental health treatment limitation are billed under revenue code 0900 (previously 0910); ...telehealth originating site facility fees under revenue code 0780 [and] FQHC supplemental payments are billed under revenue code 0519, effective for dates of service on or after 01/01/2006.

For dates of service on or after July 1, 2006, the following revenue codes should be used when billing for RHC or FQHC services, other than those services subject to the Medicare outpatient mental health treatment limitation or for the FQHC supplement payment...: 0521, 0522, 0524, 0525, 0527 and 0528 (See CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 9, Section 100[B].)

Hospitals have been instructed to provide Hospital-Issued Notices of Noncoverage (HINNs) to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is:

8/29/2008
• Not medically necessary;
• Not delivered in the most appropriate setting; or
• Is custodial in nature.

Coverage Topic

Surgical Services

Coding Information

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.

13x Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
71x Clinic-rural health
73x Clinic-independent provider based FQHC (eff 10/91)
85x Special facility or ASC surgery-rural primary care hospital (eff 10/94)

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.

Revenue codes only apply to providers who bill these services to the fiscal intermediary. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier.
Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

0510  Clinic-general classification
0517  Clinic-family practice clinic (eff 10/96)
0519  Clinic-other
0520  Free-standing clinic-general classification
0521  Free-standing clinic-rural health clinic
0523  Free-standing clinic-family practice
0529  Free-standing clinic-other

**CPT/HCPCS Codes**

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

**ICD-9 Codes that are Covered**

Please see LCD

**ICD-9 Codes that are Not Covered**

Not applicable

Other Information

**Other Comments**

When CPT code 20612 is used for the purpose of aspiration and not for injection, the HCPCS drug code and the ICD-9-CM codes listed in this policy
will not be required.

**Revision History Explanation**
This Supplemental Instructions Article (SIA) is effective for Downstate New York – Part B on July 18, 2008; for Connecticut – Part B on August 1, 2008; for Upstate New York – Part B on September 1, 2008; for New York and Connecticut – Part A on November 14, 2008.

**Article published June, 2008**

These supplemental instructions apply within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

**Related Documents**

**LCD(s)**

L28161 - Injection, Tendon Sheath, Ligament, Ganglion Cyst, Carpal and Tarsal Tunnel