Priority Health	BILLING POLICY No. 048
ARTHROCENTESIS, ASPIRATION, INJECTION	
Effective date: Dec. 23, 2024 **Date of origin: Oct. 14, 2024**	**Review dates: 2/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise state

DEFINITION

Trigger point injections (TPI) are given to relieve pain for patients by injecting an anesthetic, saline and possibly a steroid into a muscle to help relax muscles that are causing knots and/or irritation to the nerves around the muscles.

Arthrodesis, Aspiration, Injections uses a needle to relieve discomfort, drain off infected fluid or instill medication.

POLICY SPECIFIC INFORMATION

Trigger point injections

Trigger point injections are reported with CPT codes 20552 and 20553.

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

- CPT 20552 is reported when 1 or 2 muscle groups are injected.
- CPT 20553 is reported when 3 or more muscle groups are injected.
- One reimbursement will be made per site regardless of the number of trigger point injections.
- It isn't appropriate to report each muscle injection separately based on CPT description.
- Modifier 50 for bilateral services is not coded for these services.
- E/M services performed for assessment prior to procedure are considered inclusive as defined by correct coding guidelines. Documentation must support a significant, separately identifiable service when modifier 25 is used.
- Trigger point injection documentation must be specific to anatomical location of trigger points treated including muscles injected. Failure to document this detail will result in a claim denial.

Utilization

- Trigger point injections are limited to 4 sessions per rolling year.

Drugs/medications

- Drugs or medications utilized for trigger point injections must be reported on the same claim.
- Drugs or medication should be reported with the appropriate drug code, NDC and unit dosage.
- Drugs or medications reported with an unlisted drug code must the drug name, NDC and unit dosage; C3999 is only payable in the ASC setting.
- For facility billing, the appropriate revenue code should be reported (HCPCS should be reported if applicable).

- Biologicals and non-FDA approved drugs or substances are not payable. This is based on the FDA not currently defining any FDA approved biologicals as injectables for trigger point services.

Failure to accurately report medications or drugs with appropriate detail and in alignment with coding guidelines will result in a denial.

Anesthesia services aren't separately payable with trigger point injections.

Arthrocentesis, Aspiration, Injection

Arthrocentesis, aspiration or injections performed in a major joint or bursa are reported with CPT codes 20610 or 20611. Major joints include shoulder, hip, knee, subacromial bursa.

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

- Codes are selected based on whether or ultrasound guidance is utilized in performing service.
- If both an aspiration and injection service are performed during the same session, only one unit is reported.
- The appropriate anatomical modifiers are required when performed unilaterally or bilateral modifier when performed bilaterally.
- The appropriate modifier for distinct services is required when different major site sites are injected, and documentation must support separate sites for modifier use.
- When administering multiple substances into a single site, only one unit is billable per site.
- If a denial is applied to the drug or substance injected, the associated injection services will also be denied.
- E/M services performed for assessment prior to procedure are considered inclusive as defined by correct coding guidelines. Documentation must support a significant, separately identifiable service when modifier 25 is utilized.

Drugs / medications

Refer to the Medical Benefit drug list for coverage

- Drugs or medications utilized for injections must be reported on the same claim.
- Drugs or medication should be reported with the appropriate drug code, NDC and unit dosage
- Drugs or substances dosage and units should align to HCPCS code descriptions and align with a per dose descriptor or milligram (mg) descriptor.
- Drug waste must be documented in the medical record with appropriate waste detail.
- Drugs or medications reported with an unlisted drug code must the drug name, NDC and unit dosage; C3999 is only payable in the ASC setting.
- For facility billing, the appropriate revenue code should be reported (HCPCS should be reported if applicable).

For intraarticular knee injections with Hyaluronan, dosage and frequency should align as detailed below based on FDA approved dosing.

Code	Drug name	Dosing per series / knee	Dose per knee	Units
J7321	**Hyalgan**	**3 to 5 weekly injections**	**20 mg once weekly**	**1 unit**
J7321	Supartz	3 to 5 weekly injections	25 mg once weekly	1 unit
J7321	Visco-3	3 weekly injections	25 mg once weekly	1 unit
J7323	Euflexxa	3 weekly injections	20 mg once weekly	1 unit
J7324	Orthovisc	3 to 4 weekly injections	30 mg once weekly	1 unit
J7326	Gel-One	Single injection	30 mg x 1 dose	1 unit
J7327	Monovisc	Single injection	88 mg x 1 dose	1 unit

Per milligram (mg) doses:

Code	Mg	Drug name	Dosing per series / knee	Dose per knee	Units
J7328	per 0.1 mg	Gelsyn-3	3 weekly injections	16.8 mg once weekly	168 units
J7329	per 1 mg	TriVisc	3 weekly injections	25 mg once weekly	25 units
J7318	per 1 mg	Durolane	Single injection	60 mg x 1 dose	60 units
J7320	per 1 mg	Genvisc 850	3 to 5 weekly inj	25 mg once weekly	25 units
J7325	per 1 mg	Synvisc3	Weekly injections	16 mg once weekly	16 units
J7325	per 1 mg	Synvisc-One	Single injection	48 mg x 1 dose	48 units
J7322	per 1 mg	Hymovis	2 weekly injections	24 mg once weekly	24 units
J7331	per 1 mg	Synojoynt	3 weekly injections	20 mg once weekly	20 units
J7332	per 1 mg	Triluron	3 weekly injections	20 mg once weekly	20 units

The EJ modifier must be used when reporting subsequent injections within a series. The series of injection consists of each set of joint injections specific to an anatomical site and treatment plan. Reporting this modifier with the first injections of a series or failure to report for subsequent injections will result in a claim denial.

The JW or JZ modifiers must be reported when applicable. Refer to our modifier guidelines.

Documentation requirements

- The medical record must accurately describe the services rendered and support the CPT/HCPCS code reported on the claim.
- The medical record procedural detail should clearly detail indications for performing the service, describe medical necessity for the services, detail the anatomical site or location including laterality when applicable, and any pre and/or post services associated with the procedure
- The medical record should detail the name and units of any drug or medication supplied or injected. The associated NDC should also be detailed.
- At a minimum, the medical record should include the following:
    - Assessment as it related to the chief complaint or conditions reported by the member
    - Appropriate or relevant medical history
    - Any pertinent tests and/or procedural details
    - Post procedural plan should be outlined
    - Signature and date that meets valid signature requirements (Add signature page link). Failure to sign and date the medical record will result in a claim denial.

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding

accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section
July 11, 2025	Updated the policy name to "Arthrocentesis, Aspiration, Injection"