REIMBURSEMENT POLICY STATEMENT
GEORGIA MEDICARE ADVANTAGE

Policy Name	Policy Number	Effective Date
Trigger Point Injections	PY-1270	01/01/2021

Policy Type			
Medical	Administrative	Pharmacy	REIMBURSEMENT

Reimbursement Policy Statement: Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

Reimbursement Policy Statement 1
A. Subject 2
B. Background 2
C. Definitions 2
D. Policy 2
E. Conditions of Coverage 3
F. Related Policies/Rules 3
G. Review/Revision History 3
H. References 4

A. Subject

Trigger Point Injections

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Nearly 84% of adults experience back pain during their lifetime. Long term outcomes are largely favorable for most patients, but a small percentage of patient's symptoms are categorized as chronic. Chronic pain is defined by the International Association for the Study of Pain as: "pain that persists beyond normal tissue healing time, which is assumed to be three months".

Interventional procedures for management of acute and chronic pain are part of a comprehensive pain management care plan that incorporates conservative treatment in a multimodality approach. Multidisciplinary treatments include promoting patient self-management and aim to reduce the impact of pain on a patient's daily life, even if the pain cannot be relieved completely. Interventional procedures for the management of pain unresponsive to conservative treatment should be provided only by physicians qualified to deliver these health services.

C. Definitions

- **Trigger Point Injections** - A trigger point is a hyper excitable area of the body, where the application of a stimulus will provoke pain to a greater degree than in the surrounding area. The purpose of a trigger-point injection is to treat not only the symptom but also the cause through the injection of a single substance (e.g., a local anesthetic) or a mixture of substances (e.g., a corticosteroid with a local anesthetic) directly into the affected body part in order to alleviate inflammation and pain.

D. Policy

I. Trigger Point Injections
   A. A prior authorization (PA) is required for each trigger point injection for pain management.
   B. Trigger-point injections should be repeated only if doing so is reasonable and medically necessary.

C. For trigger-point injections of a local anesthetic or a steroid, payment will be made for no more than eight dates of service per calendar year per patient.
D. Injections may be repeated only with documented positive results to prior trigger point injection of the same anatomic site. Documentation should include at least 50% improvement in pain, functioning and activity tolerance.
E. Localization techniques to image or otherwise identify trigger point anatomic locations are not indicated and will not be covered for payment when associated with trigger point injection procedures.
F. Certain trigger-point injection procedure codes specify the number of injection sites. For these codes, the unit of service is different from the number of injections given. Payment may be made for one unit of service of the appropriate procedure code reported on a claim for service rendered to a particular patient on a particular date.
G. A trigger-point injection is normally considered to be a stand-alone service. No additional payment will be made for an office visit on the same date of service unless there is an indication on the claim (e.g., in the form of a modifier appended to the evaluation and management procedure code) that a separate evaluation and management service was performed.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates**

Trigger Point Injections	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

F. Related Policies/Rules

Trigger Point Injections MM-1129

G. Review/Revision History

	DATE	ACTION
Date Issued	10/14/2021	
Date Revised		
Date Effective	01/01/2021	
Date Archived		

H. References

1. Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule. Retrieved on April 15, 2020 from cms.gov

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.