Contractor Name	Contract Type	Contract Number	Jurisdiction	States
Novitas Solutions, Inc.	A and B MAC	12901 - MAC A	J - L	Delaware District of Columbia Maryland New Jersey Pennsylvania

Article Information

General Information

Article ID
A57751

Article Title
Billing and Coding: Trigger Point Injections

Article Type
Billing and Coding

Original Effective Date
11/21/2019

Revision Effective Date
09/06/2026

Revision Ending Date
N/A

Retirement Date
N/A

CPT codes, descriptions, and other data only are copyright 2025 American Medical Association. All Rights Reserved. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. CPT is a registered trademark of the American Medical Association.

Current Dental Terminology © 2025 American Dental Association. All rights reserved.

Copyright © 2026, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution, or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at ub04@aha.org or 312-422-3366.

Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. The American Hospital Association (the "AHA") has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.

CMS National Coverage Policy

Social Security Act References:

- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

CMS Internet-Only Manual (IOM) Citations:

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*,
  - Chapter 23, Section 20.9 National Correct Coding Initiative (NCCI)

Article Guidance

Article Text

This Billing and Coding Article provides billing and coding guidance for Local Coverage Determination (LCD) L35010, Trigger Point Injections. Please refer to the LCD for reasonable and necessary requirements.

Coding Guidance

It is not appropriate to bill Medicare for services that are not covered (as described by the entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Pursuant to the provisions of the applicable LCD, CPT code 76942 is not eligible for separate payment and will be denied when billed on the same date of service with CPT codes 20552 or 20553.

When a beneficiary receives four (4) TPI sessions within the same rolling 12-month period, the claim for the fourth session must include the KX modifier to attest that the service complies with all coverage requirements outlined in the LCD and all other applicable Medicare regulations.

Utilization Parameters

Per the LCD, no more than 3 TPI sessions are expected within a rolling 12-month period. However, in select circumstances, there may be a therapeutic benefit to an additional session. Consistent with the LCD, reporting 4 TPI sessions in a rolling 12-month period will require attestation; however, 5 or more sessions will be denied.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
4. For the treatment of established trigger points, the patient’s medical record must have:
    a. The evaluation/process of arriving at the diagnosis of the trigger point in an individual muscle or muscle group must be clearly documented in the patient’s medical record.
    b. The reason for the trigger point injection, and whether it is being used as an initial or subsequent treatment for myofascial pain, as well as the appropriate diagnosis code, must be clearly documented in the patient's medical records.
5. Attestation for extended services (e.g., above 3 TPI sessions per rolling 12 months) must be supported by documentation that validates the therapeutic benefit of additional TPIs beyond what is typically expected, including:
    a. Clinical indications for continued treatment,
    b. Documentation of adherence to multi-modal therapy,
    c. Evidence of prior response and ongoing medical necessity,
    d. Compliance with frequency and duration limits,
    e. All required elements specified in the LCD.

Coding Information

CPT/HCPCS Codes

Group 1 (2 Codes)

Group 1 Paragraph

Trigger Point Injections

Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.

Group 1 Codes

Code	Description
20552	Njx 1/mlt trigger point 1/2
20553	Njx 1/mlt trigger points 3/>

Group 2 (13 Codes)

Group 2 Paragraph

Injectates that will be Denied

Note: Providers are reminded to refer to the long descriptors of the HCPCS codes in their HCPCS book.

In accordance with the LCD, the following HCPCS codes will be **denied** when billed with CPT codes **20552** and **20553**:

Group 2 Codes

Code	Description
J0585	Injection,onabotulinumtoxina

Code	Description
J0586	Abobotulinumtoxina
J0587	Inj, rimabotulinumtoxinb
J0588	Incobotulinumtoxin a
J0589	Inj daxibotulinumtoxina-lanm
J0702	Betamethasone acet&sod phosp
J1010	Inj, methylpred acetate 1 mg
J1100	Dexamethasone sodium phos
J2919	Inj, methylpred sod succ 5mg
J3121	Inj testostero enanthate 1mg
J3300	Triamcinolone a inj prs-free
J3301	Triamcinolone acet inj nos
J7040	Normal saline solution infus

CPT/HCPCS Modifiers

Group 1 (1 Code)

Group 1 Paragraph

It is the provider's responsibility to assess the applicability of modifiers and to select the appropriate modifier in accordance with the medical record. Any modifier submitted on a claim must be valid and effective for the date of service reported. Identified payment modifiers, those that directly affect reimbursement, must be listed first. Informational or statistical modifiers must be listed after the payment modifiers, in any order, if there are multiple modifiers applicable.

Note: The modifier table is not an exhaustive list of coding related modifiers. Providers must append any additional modifiers necessary to accurately reflect the services rendered.

Group 1 Codes

Code	Description
KX	REQUIREMENTS SPECIFIED IN THE MEDICAL POLICY HAVE BEEN MET

ICD-10-CM Codes that Support Medical Necessity

Group 1 (2 Codes)

Group 1 Paragraph

Trigger Point Injections and Appropriate Diagnoses

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

The following ICD-10 CM codes support medical necessity and provide coverage for **CPT codes 20552 and 20553:**

Group 1 Codes

Code	Description
M79.12	Myalgia of auxiliary muscles, head and neck

Code	Description
M79.18	Myalgia, other site

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

Group 1 (1 Code)

Group 1 Paragraph

All those not listed under the “ICD-10-CM Codes that Support Medical Necessity” section of this article.

Group 1 Codes

Code	Description
XX000	Not Applicable

ICD-10-PCS Codes

Group 1

Group 1 Paragraph

N/A

Group 1 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.

Code	Description
999x	Not Applicable

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