Clinical Practice Guideline: **Lower Extremity Tendon, Ligament and Aponeurosis Injections**

Date of Implementation: **December 18, 2015**

Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers services consisting of CPT Codes 20550 and 20551 to be medically necessary to relieve pain or dysfunction due to inflammation or pathological changes in the tendon sheath or ligament (e.g., fasciitis, tenosynovitis) when ALL of the following are met:

- The initial injection is performed after the patient has failed conservative treatment including all of the following:
  - ≥ 6 weeks of physical therapy.
  - ≥ 3 weeks of a non-steroidal anti-inflammatory medication (unless there is intolerance or a contraindication).
  - ≥ 6 weeks of activity modification.
  - Symptoms are present for 6 weeks or more.
- For subsequent injection treatments beyond the initial injection (Second and third injections)
  - There was pain reduction ≥50 percent for at least six weeks following the previous injection.
  - Injection treatment has not exceeded 1 year since the initial injection.
  - There are not greater than 3 injections in total to treat the condition.

Imaging guidance (ultrasound [76942] or fluoroscopic [77002]) performed with tendon sheath injection and ligament injection (20550, 20551) meets the definition of medical necessity.

CPT Codes and Descriptions

CPT® Code	CPT® Code Description
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar "fascia")
20551	Injection(s); single tendon origin/insertion
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation

CPT® Code	CPT® Code Description
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)

ICD-10 Codes and Descriptions That Support Medical Necessity (if criteria are met):

ICD-10 Code	ICD-10 Code Description
D48.1	Neoplasm of uncertain behavior of connective and other soft tissue
M24.20, M24.251 - M24.276	Disorder of ligament, unspecified site, foot, ankle, or hip
M25.761 - M25.769, M25.771 - M25.776	Osteophyte of knee, ankle or foot
M65.00, M65.051 - M65.079, M65.08	Abscess of tendon sheath, ankle, foot, lower leg, thigh, unspecified site, or other site
M65.10, M65.151 - M65.179, M65.18 - M65.19	Other infective (teno)synovitis of hip, knee, ankle and foot, other site, unspecified site, and multiple sites
M65.20, M65.251 - M65.279, M65.28 - M65.29	Calcific tendinitis, ankle, foot, lower leg, thigh, unspecified site, other site, or multiple sites
M65.80, M65.851 - M65.879, M65.88 - M65.89, M65.9	Other synovitis and tenosynovitis of, ankle, foot, lower leg, thigh, unspecified site, other site, and multiple sites
M66.0, M66.10, M66.151 - M66.179, M66.18	Rupture of popliteal cyst; rupture of synovium, toe, foot, ankle, hip, unspecified site, or other site
M66.20, M66.251 - M66.279, M66.28 - M66.29	Spontaneous rupture of extensor tendons, unspecified site, ankle, foot, lower leg, thigh, other site, and multiple sites
M66.351 - M66.379, M66.38 - M66.39	Spontaneous rupture of flexor tendons, ankle, foot, lower leg, thigh, unspecified site, other site, and multiple sites
M66.80, M66.851 - M66.879, M66.88 - M66.89	Spontaneous rupture of other tendons, unspecified site, thigh, lower leg, ankle, foot, other sites, and multiple sites
M66.9	Spontaneous rupture of unspecified tendon
M67.00 - M67.02	Short Achilles tendon (acquired), ankle
M67.20, M67.251 - M67.279, M67.28 - M67.29	Synovial hypertrophy, not elsewhere classified, ankle, foot, lower leg, thigh, unspecified site, other site, or multiple sites

ICD-10 Code	ICD-10 Code Description
M67.30, M67.351 - M67.379, M67.38 - M67.39	Transient synovitis of hip, knee, ankle and foot, unspecified site, other site, and multiple sites
M67.451 - M67.479, M67.40, M67.48 - M67.49	Ganglion of hip, knee, ankle and foot, unspecified site, other site, and multiple sites
M67.50 - M67.52	Plica syndrome, knee
M67.80, M67.851 - M67.879, M67.88 - M67.89	Other specified disorders of synovium and tendon, ankle, foot, knee, hip, unspecified site, other site, and multiple sites
M67.90, M67.951 - M67.979, M67.98 - M67.99	Unspecified disorder of synovium and tendon, ankle, foot, lower leg, thigh, unspecified site, other site, or multiple sites
M70.40 - M70.42	Prepatellar bursitis, knee
M70.50 - M70.52	Other bursitis of knee
M71.00, M71.051 - M71.079, M71.08 - M71.09	Abscess of bursa, ankle, foot, knee, hip, unspecified site, other site, or multiple sites
M71.10, M71.151 - M71.179, M71.18 - M71.19, M71.50, M71.551 - M71.579, M71.58	Other bursitis not elsewhere classified - Other infective bursitis, ankle, foot, knee, hip, unspecified site, other site
M71.20 - M71.22	Synovial cyst of popliteal space [Baker], knee
M71.30, M71.351 - M71.379, M71.38 - M71.39	Other bursal cyst, ankle, foot, hip, unspecified site, other site, or multiple sites
M71.40, M71.451 - M71.479, M71.48 - M71.49	Calcium deposit in bursa, ankle, foot, knee, hip, unspecified site, other site, or multiple sites
M71.80, M71.851 - M71.879, M71.88 - M71.89	Other specified bursopathies, ankle, foot, knee, hip, unspecified site, other site, or multiple sites
M71.9	Bursopathy, unspecified
M72.1	Knuckle pads
M72.2	Plantar fascial fibromatosis
M72.4	Pseudosarcomatous fibromatosis
M72.9	Fibroblastic disorder, unspecified
M76.40 - M76.42	Tibial collateral bursitis [Pellegrini-Stieda]
M76.50 - M76.52	Patellar tendinitis
M76.60 - M76.62	Achilles tendinitis
M76.70 - M76.72	Peroneal tendinitis

ICD-10 Code	ICD-10 Code Description
M76.811 - M76.819, M76.821 - M76.829	Anterior tibial syndrome - Posterior tibial tendinitis, leg
M76.891 - M76.899, M76.9	Enthesopathies of lower extremity, excluding foot
M77.30 - M77.32	Calcaneal spur
M77.40 - M77.42	Metatarsalgia of the foot
M77.50 - M77.52	Other enthesopathy of foot and ankle
M77.8 - M77.9	Other enthesopathies, not elsewhere classified - Enthesopathy, unspecified

BACKGROUND

Injection into tendon sheaths, ligaments, or tendon origins or insertions may be indicated to relieve pain or dysfunction resulting from inflammation or other pathological changes. Proper use of this modality with local anesthetics and/or steroids should be short-term, as part of an overall management plan.

The signs or symptoms that justify these treatments should be resolved after one to two injections. Injections beyond two must be justified by the clinical record indicating the results of the first two injections and a logical rationale for further why treatment can reasonably be expected to succeed. A recurrence after a good response to injections may justify a second course of therapy.

Injection therapies for Morton's neuroma do not involve the structures described by CPT code 20550 and 20551 or direct injection into other peripheral nerves. These nerve injection therapies are not to be coded using 20550 or 20551. Rather, the provider of these therapies must bill with CPT code 64455 or 64632 injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (e.g., Morton's neuroma). Refer to ASH Clinical Practice Guideline, *Injection Treatment for Morton's Neuroma (CPG 213 - S)*, for CPT codes 64455 and 64632 injection criteria.

Injections for plantar fasciitis are addressed by 20550 and ICD-10-CM M72.2. Injections for calcaneal spurs are addressed as are other tendon origin/insertions by 20551. Injections to include both the plantar fascia and the area around a calcaneal spur are to be reported using a single CPT code 20551.

Medical necessity for injections of more than two sites at one session or for frequent or repeated injections is questionable. Such injections are likely to result in a request for medical records which must evidence justification of necessity.

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education, training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a member only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the member to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

References

Centers for Medicare and Medicaid Services (CMS). Local Coverage Article: Billing and Coding: Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma (A57201). Retrieved on November 20, 2023 from https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=57201&ver=3&LCDId=34076&bc=AAAAAAAAgAAA&

Centers for Medicare and Medicaid Services (CMS).Local Coverage Article: Billing and Coding: Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma (A57079). Retrieved on November 20, 2023 from https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57079

Centers for Medicare and Medicaid Services (CMS). Local Coverage Determinations; L34218. Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma. Retrieved on November 20, 2023 from: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34218&ver=22&bc=AAAAAAAAgAAA&

Centers for Medicare and Medicaid Services (CMS).Local Coverage Determinations; L34076. Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma. Retrieved on November 20, 2023 from: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34076&ver=20&bc=AAAAAAAAgAAA&

Cushman DM, Carefoot A, Lisenby S, Caragea M, Fogg B, Conger A. A Systematic Review of the Efficacy of Corticosteroid Injections of Tendon Sheaths, Excluding Stenosing Tenosynovitis of the Wrist and Hand. Am J Phys Med Rehabil. 2021 Jul 1;100(7):683-688. doi: 10.1097/PHM.0000000000001609. PMID: 33017344

Joint Commission International. (2020). Joint Commission International Accreditation Standards for Hospitals (7th ed.): Joint Commission Resources

Kane SF, Olewinski LH, Tamminga KS. Management of Chronic Tendon Injuries. Am Fam Physician. 2019 Aug 1;100(3):147-157. PMID: 31361101

Whittaker GA, Munteanu SE, Menz HB, Bonanno DR, Gerrard JM, Landorf KB. Corticosteroid injection for plantar heel pain: a systematic review and meta-analysis. BMC Musculoskelet Disord. 2019 Aug 17;20(1):378. doi: 10.1186/s12891-019-2749-z. PMID: 31421688; PMCID: PMC6698340