Tendon Injections Missing Diagnosis

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plans supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Molina Healthcare's reimbursement practices comply with state and federal guidelines. Claims must be submitted in accordance with these requirements, including adherence to the definitions provided by the Centers for Medicare & Medicaid Services (CMS).

Reimbursement Guidelines

For specific procedures - such as injections into the tendon or tendon sheath or ligament (CPT codes 20550, 20551), ganglion cyst removal (CPT code 20612), and carpal or tarsal tunnel injections (CPT code 20526) - a corresponding diagnosis code demonstrating medical necessity is required for payment. Claims missing the required diagnosis code may result in delayed payment, denial, or audit.

Supplemental Information

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services. The Centers for Medicare & Medicaid Services (CMS) is a federal entity under the United States Department of Health and Human Services (HHS). It oversees the Medicare program and collaborates with state governments to manage Medicaid, the Children's Health Insurance Program (CHIP), as well as health insurance portability regulations.
CPT Code	Current Procedural Terminology. Used by physician offices and physicians and clinicians in all settings, outpatient hospital facilities, outpatient dialysis centers, and ambulatory surgery centers. CPT codes are utilized to report the majority of procedures on claims that are submitted.

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Initial Creation Date	08/10/2023	New Policy
Revised Date	12/12/2024	Updated the template
Revised Date	08/07/2025	Updated template; added a "Policy" section, which was not in previous versions of the document.
Revised Date	08/20/2025	Added title to document

References

This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link
CMS	Article - Billing and Coding: Pain Management - injection of tendon sheaths, ligaments, ganglion cysts, carpal and tarsal tunnels (A52863) (cms.gov) Article - Billing and Coding: Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma (A57079) (cms.gov) Article - Response to Comments: Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma (A55489) (cms.gov) LCD - Pain Management - Injection of tendon sheaths, ligaments, ganglion cysts, carpal and tarsal tunnels (L33622) (cms.gov) LCD - Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma (L34218) (cms.gov)

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*