Codify
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Internal Medicine Coding Alert

Master Reporting Guidelines When You Perform Multiple Injections

Break out the modifiers if you want to collect

You can set yourself up for clean injection claims and stop expensive mistakes. The key: Know when to report modifiers 59, 50, LT or RT.

Suppose your internist sees a patient with tendinitis in both the left knee and the right shoulder. The physician administers steroids into both joints to relieve the inflammation. The practice should report 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]) two times for the two injections. However, the practice may have a tough time getting paid if the claim doesn't make it clear that it is for two separate injections.

First, you should append modifier 59 (Distinct procedural service) to the second line item of 20610, says **Susan Vogelberger, CPC, CPC-H, CMBS, CCP,** owner and president of Healthcare Consulting & Coding Education LLC in Boardman, Ohio.

Second, because the physician injected the shoulder and the knee, you should use separate ICD-9 codes for the two separate line items. As an example, your claim should appear as follows:

• 20610 linked to 726.64 (Patellar tendinitis)

• 20610-59 linked to 726.11 (Calcifying tendinitis of shoulder).

Coders should avoid reporting 726.90 (Enthesopathy of unspecified site) because it is not specific and regularly gets denied.

Tip: ICD-9 code 726.90 is listed in the index to diseases as "tendinitis." The tabular list has the more specific definition. Always check codes found in the index against the tabular list for specificity and accuracy.

Review Bilateral Options When Injecting 2 of the Same Type of Joint

Coding for two joint injections gets more complicated when both injections are performed on the same joint, but on different sides (for example, the right knee and left knee).

In that case, the ICD-9 code and modifier 59 will not be enough to differentiate the injections. Some payers prefer bilateral procedures to be submitted on one line with modifier 50 (Bilateral procedure), says **Erica D. Schwalm, CPC-GSS, CMRS,** billing and coding educator in Springfield, Mass. "They reimburse 150 percent of the allowable," she says.

Other payers, such as several Medicare carriers, prefer you to use the LT (Left side) and RT (Right side) modifiers instead.

Although insurers will generally accept 20610-50 on one line item to reflect the fact that the physician performed bilateral injections, other payers prefer that you submit your claim on two separate line items. "Your best bet is to review each of your payers' guidelines on billing bilateral procedures and bill according to their requirements," Schwalm says.

Avoid Modifier 76 in These Instances

Some coders tell us that when their physician injects two separate body parts, they report 20610, followed by 20610-76

(Repeat procedure by same physician).

You should not bill this way, however, because modifier 76 indicates that the physician performed the same exact procedure twice. For example, if he injected the left shoulder in the morning and the left shoulder again in the afternoon -- a scenario that would almost never happen for shoulder tendinitis.