Internal Medicine Coding Alert

Modifiers -59 and -50 Key: Get Paid for Two Joint Injections on the Same Day

When reporting two joint injections on the same day, internal medicine coders must remember to use the appropriate CPT and HCPCS modifiers on the CPT code 20610* (see section below for explanation of starred procedures), and the appropriate ICD-9 diagnosis code to get reimbursed for both services.

For example, **Catherine Brink, CMM, CPC,** president of Healthcare Resource Management, a physician practice management consulting firm in Spring Lake, NJ, gives the following example: An internist sees a patient with tendinitis in both the left knee and right shoulder; the physician administers steroids into both joints to relieve the inflammation. The practice should report code 20610* (introduction or removal, 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 codes reported dont make it clear that it is for two separate injections.

In this situation, with the injection into a shoulder and a knee joint, using a specific diagnosis code should get the procedure paid, says Brink. You should report code 20610* twice, and the ICD-9 code should be specific and indicate either a tendinitis of the knee (patellar tendinitis, 726.64) or tendinitis of the shoulder (i.e., 726.11, calcifying tendinitis of the 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.

Injections for Two of the Same Type of Joint

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

In that case, notes Brink, the ICD-9 code will not be enough to differentiate the injections. For Medicare patients, coders should report the 20610* code with the HCPCS modifiers -LT (left) and -RT (right), she explains.

Medicare carriers recognize the -LT and -RT modifiers in situations where you have injected the right shoulder and left shoulder or right knee and left knee, she explains. You should still report the specific ICD-9 code (e.g., 726.64, patellar tendinitis) to indicate the medical necessity of the procedure. However, for non-Medicare payers, a CPT modifier is necessary.

I would use a -59 modifier (distinct procedural service) to indicate the procedures are not usually performed on the same day, but which are, under certain circumstances, performed on the same day, Brink adds.

Garnet Dunston, CPC, MPC, past national secretary of the American Academy of Professional Coders and president of AZ-based Dunston Enterprises, a healthcare consulting firm, agrees, but adds that she would also attach the -50 modifier (bilateral procedures) to both codes.

I would use the -50 modifier first to indicate that it is bilateral and then use the -59 to indicate that they are separate procedures, she explains.

Note: Payers may have claims-processing systems that will read codes with modifiers differently, so coders should check with their payer if claims with -50 and -59 modifiers are not paid correctly.

Caution! Starred vs. Minor Procedure

Getting paid correctly for two injections for Medicare patients is particularly important because carriers consider the evaluation and management (E/M) service related to the injections to be included in the code for the procedure. CPT lists 20610* as a starred procedure, indicating that the code is for the surgical procedure only and all related E/M services are separately reportable (with a -25 modifier attached to the E/M code). Medicare, however, divides surgical procedures only into major and minor procedures and does not consider related E/M services to be separately reportable for either category. Therefore, the physician will only get paid for the 20610* codes. Accordingly, it is more important than ever to code correctly with modifiers, because if one code is not paid because the carrier does not recognize that injections were performed on two separate joints, it can mean a significant loss in reimbursement over time.

Note: For more information on getting paid for joint injections, see Optimal Billing for Joint Injections: Get Paid for the E/M Service, Administration, and Medication, on page 9 in the February 99 issue of ICA.