Internal Medicine Coding Alert

Procedure Coding: Think You Know Arthrocentesis, Steroid Administration Coding?

You will when you follow this step-by-step guide for accurate osteoarthritis procedure reporting.

Osteoarthritis is a condition that affects many of the older patients in your practice. To help relieve the condition, physicians often turn to two procedures arthocentesis and steroid injections.

You're probably familiar with coding both, but let this scenario help you brush up on your knowledge and stay sharp the next time you document a similar encounter.

The Scenario:

A patient reports to your office with osteoarthritis in both knees, and your provider decides to perform arthocentesis and administer steroid injections to help alleviate the pain.

Arthrocentesis, also known as joint aspiration, is the process of removing synovial fluid from a joint for testing or to relieve joint pain by relieving pressure. When you document this procedure, you need to be careful that you choose the code most appropriate to the kind of joint your provider is attending to and that you know whether the procedure was performed with or without ultrasound guidance.

Know Joint Size and Procedure Type to Begin

The relevant CPT® codes distinguish between three sizes of joint large, intermediate, and small providing examples in each of the descriptors for precise anatomical identification. So, 20604 (Arthrocentesis, aspiration and/or injection, small joint or bursa [eg, fingers, toes]; with ultrasound guidance, with permanent recording and reporting), as the descriptor clearly points out, would not be applicable in this scenario. Neither would 20606 (... intermediate joint or bursa [eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa] ...). Instead, you would choose 20611 (...major joint or bursa [eg, shoulder, hip, knee, subacromial bursa] ...), as long as the provider performed the procedure with ultrasound guidance.

But if your provider performed the arthrocentesis without ultrasound guidance, you would document 20610 (Arthrocentesis, aspiration and/or injection, major joint or bursa [eg, shoulder, hip, knee, subacromial bursa]; without ultrasound guidance), which is one of three codes that are parallel to the ultrasound guidance codes.

Proceed with Modifier 59 when Needed

Regardless of whether you report 20610 or 20611, you will not be able to report the procedure with 27370 (Injection of contrast for knee arthrography) or 76942 (Ultrasonic guidance for needle placement [eg, biopsy, aspiration, injection, localization device], imaging supervision and interpretation). As **Mary I. Falbo**, **MBA, CPC** CEO of Millennium Healthcare Consulting Inc., Lansdale, Pennsylvania notes, this is because "the intent of these codes is different ... 27370 specifies a contrast agentinjection into the knee for the purpose of arthrography and excludes other injection types."

Coding 76942 is also not reportable as, according to **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians, "reporting 76942 in addition to 20611 would be redundant, since 20611 already includes ultrasound guidance." But, Moore goes on to note, it is possible to code 20610 or 20611 with 27370 or 76942 with an appropriate modifier, according to Correct Coding Initiative (CCI) edits.

So, for example, if "27370 is done on one knee and 20610/20611 is done on the other on the same date" or "if 76942 is

used in conjunction with a biopsy elsewhere on the body on the same date as a joint injection involving 20610/20611," you could use modifier 59 (Distinct Procedural Service) with 27370 or 76942 to document the services. You would append the modifier to 27370 or 76942, because each is the Column 2 code in the CCI edits with 20610/20611.

Inject J Code, Dx and Encounter into Your Documentation to Finish

As for the steroid injection, Falbo notes that like all medications, "you must report the correct strength dosage." One commonly used steroid, methylprednisolone acetate, can be coded using J1020 (Injection, methylprednisolone acetate, 20 mg), J1030 (... 40 mg), or J1040 (... 80 mg) depending on the strength your provider administers, so it is vital that you pay attention to the dosages specified in the descriptors to choose the correct code. The administration of the steroid is included in 20610/20611, since the descriptor says "Arthrocentesis, aspiration and/or [Emphasis added] injection. ..."

Finally, Moore adds a reminder to code the diagnosis with two ICD-10-CM codes: M17.0 (Bilateral primary osteoarthritis of knee) and Z79.52 (Long term [current] use of systemic steroids) if, per ICD-10-CM guidelines, "the patient is receiving a medication for an extended period ... as treatment for a chronic condition (such as arthritis)."