Internal Medicine Coding Alert

Reader Question: Appropriate Use of Modifiers For Multiple Units of 20610

Question: One of our physicians administered Kenalog into right knee, left knee & right shoulder. We claimed 20610 x3. Medicare paid for two of the three 20610's. I received information from Medicare that their system does not recognize 20610 by site and will only pay for one 20610. How do I bill 20610 for three different sites if three sites are being injected?

New Jersey Subscriber

Answer: When your clinician performs arthrocentesis and performs an aspiration or injection into a major joint, you report it with 20610 (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]). If any ultrasonic guidance is used to place the needle, you will have to report it separately using 76942 (Ultrasonic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device], imaging supervision and interpretation).

You will report one unit of 20610 for one site at which your internist has performed the arthrocentesis. But, in your case, since your clinician has performed the procedure in three different sites, you are correct in reporting the procedure with 20610x3.

However, you will have to report the three units of 20610 with appropriate modifiers to enable payment for all the three sites. So, you will have to use the modifier LT (Left side [used to identify procedures performed on the left side of the body]) and the modifier RT (Right side [used to identify procedures performed on the right side of the body]) to identify that your clinician performed the procedure on the left knee and the right knee.

Since he also performed the procedure on the right shoulder, you will report this unit of 20610 with the modifier 59 (Distinct procedural service) along with the modifier RT. This will inform the payer that your clinician also performed the procedure on a separate joint on the right side. In case you do not use the modifier 59, it will be considered as duplicate by the system/software. This is probably the reason why only two of the three units that you claimed got paid out.

Finally, don't forget to report the appropriate code for the Kenalog itself. For Kenalog, the HCPCS Table of Drugs refers to triamcinolone acetonide, and for that drug, the table, in turn, refers to two codes. One is J3300 (Injection, triamcinolone acetonide, preservative free, 1 mg), and the other is J3301 (Injection, triamcinolone acetonide, not otherwise specified, 10 mg). Since the descriptor in each case specifies the number of milligrams, you might need to bill multiple units if the physician administers more than the number listed in the code descriptor. For example, you'll report J3301 with three units of the code if your physician administers 30 mg of Kenalog that is not preservative free.