Codify by AAPC

# Internal Medicine Coding Alert

## Reader Question: Verify Anatomic Locations Before Submitting Multiple Lines of 20600

**Question:** Our physician treated a patient who has osteoarthritis in her hands by injecting 8 PIP joints with 0.1 ml of medication (methylprednisolone). I reported code 20600 with 8 units, but Medicare denied it by stating the information provided didn't support this many (or this frequency) of services. They also denied the office visit I coded as 99213-25 as a duplicate service. How should I have coded this procedure?

Connecticut Subscriber

**Answer:** When you submit 20600 (Arthrocentesis, aspiration and/or injection; small joint or bursa [e.g., fingers, toes]), each injection or aspiration must be performed at a different anatomical site. If your physician administered all injections to the same anatomic site, you should report only one item of 20600. If the injections were to different anatomic sites, list each injection on separate lines with 20600. Append modifier 59 (Distinct procedural service) to all line items except the first to indicate they were separate procedures. Also include your physician's documentation when you file the claim so the carrier will have a clear understanding of the encounter and to support that the evaluation and management service (99213) was significant and separately identifiable, as claimed. You may also want to consider reporting the appropriate J code for the methylprednisolone that was injected.

***CPT® 2023 American Medical Association. All rights reserved.***