Codify
BY AAPC

Internal Medicine Coding Alert

You Be the Coder: Choose Modifier Carefully for Dual Injections

Question: The internist in our office recently treated a patient with tendinitis in her right and left elbows. To treat the patient, the internist injected 10 mg of Depo-Medrol into each joint. Should I report this as 20605 twice with modifier 59 attached to the second code?

Kansas Subscriber

Answer: You are right to report 20605 (Arthrocentesis, aspiration and/or injection; intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]) for the procedures. But you should leave modifier 59 (Distinct procedural service) off this claim and choose another modifier instead.

Why? Modifier 59 is not specific enough to differentiate between injections to the right and left elbows. Contact your payer to see which modifier it wants you to file with this claim. Listed below are some of the coding options for this scenario:

Option 1: Some payers prefer you to report 20605 once with modifier 50 (Bilateral procedure) attached.

Option 2: Other payers (including many Medicare carriers) want you to use modifiers LT (Left side) and RT (Right side) instead. When coding this way, report 20605-LT and 20605-RT.

Remember: Regardless of your modifier choice, link 726.30 (Enthesopathy of elbow region, unspecified) to 20605 each time you report it to prove medical necessity for the injections. Also, include J1020 (Injection, methylprednisolone acetate, 20 mg) on the claim for the drug supply if your practice provides it.

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