Part B Insider (Multispecialty) Coding Alert

Halt Knee-Related Injection Rejections With 3 Tips

Code 20610 might always need a modifier for Medicare pay

If denials for trigger point and joint injections are plaguing you, sticking to these guidelines will put your injections coding back on the payment track.

From California to New Jersey, injection coding dilemmas abound. "What modifier should I use for multiple muscle injections into both knees?" one reader writes. Another reader reports National Government Services (NGS), the Part B carrier for New Jersey, has recently begun denying injection code 20610, stating "required modifier is missing or inconsistent with modifier used."

Avoid these hitches with these 3 quick tips.

Report 1 TPI Code Per Muscle

CPT 2004 revised TPI codes 20552-20553 to have physicians report the codes one time per session, regardless of the number of injections given. The documentation should include the injections' location, number of injections, and muscles involved.

Here's how to assign the codes:

1. Use 20552 when the physician injects one or two muscles.

2. When the physician injects three or more muscles, you should report 20553 without units or modifiers. The location of the muscles does not matter.

Example: A runner complains of bilateral knee pain (719.46, Pain in joint; lower leg). The doctor injects the popliteus muscles in the back of the right and left knees. In this case, report one unit of 20552.

Error averted: You would not use a modifier, such as modifier 50 (Bilateral procedure), to indicate the injection was on each side of the body. Codes 20552 and 20553 are not eligible for bilateral reporting, according to the 2008 Medicare Physician Fee Schedule.

Look at Joint Size

You'll choose the correct arthrocentesis code (20600-20610, Arthrocentesis, aspiration and/or injection ...) based on the joint size. Use the table on page 263 as your guide:

Indicate Body Side(s)

Joint injection codes, unlike TPI, are billed per injection. Therefore, units and modifiers can come into play. The Medicare Physician Fee Schedule does allow bilateral reporting with codes 20600-20610.

With knee injections (20610, Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]), you might always have to indicate whether the physician performed the injection on the right (RT) side, left (LT) side, or on both knees (bilaterally, modifier 50). NGS "has an article regarding injection of hyaluronan that requires reporting either of the following modifiers (RT, LT, or 50) with the code 20610," points out **Marvel J. Hammer RN, CPC, CCS-P, PCS, ACS-PM, CHCO,** president of MJH Consulting in Denver.

NGS issued a local coverage determination (LLCD) covering 24 states. The policy states, "Effective for dates of service on or after 02/01/2008, the appropriate site modifier (RT, LT, or 50) must be appended to CPT code 20610 to indicate if the service was performed unilaterally or bilaterally. Claims without a modifier will be returned to the provider unprocessed."

Problem: Perhaps NGS has applied in their claims processing software logic the RT, LT, or 50 modifier requirement to any claim with 20610, rather than just those for hyaluronan injection, surmises Hammer. "If the line item denial indicated that the claim was 'unprocessable,' then the provider needs to resubmit the claim line item (20610) with one of the three applicable modifiers appended."

Why: "Unprocessable claims do not have appeal rights within Medicare," Hammer says.

Example: From Kentucky Medicare, you receive an unprocessable denial for no modifier on a claim containing 20610 for a joint injection of the left knee. Resubmit the claim as 20610-LT, based on the information at http://www.ngsmedicare.com/NGSMedicare/nyorkpolicya/policy/l25820_att10.htm.

If the FP had provided bilateral knee joint injections, you instead would use modifier 50 on 20610.

"If you've been using modifier 50, look at your payments to see if the insurer has been paying you unilaterally (at 100 percent) in-stead of bilaterally (at 150 percent)," says **Joanne Schade-Boyce, RDH, MS, CPC, ASC, PCS,** president of FairCode Associates LLC in Gaithersburg, Md. Audits frequently reveal documentation and coding that supports a bilateral procedure that the insurer has paid unilaterally.

The insurer may incorrectly process Medicare's preferred modifier 50 method of a one-line entry with modifier 50 (such as 20610-50). Private payers may want bilateral procedures on either two lines with modifier 50 on the second line (20610, 20610-50) or no modifier with two units on a single line item (20610 x 2).