Eli's Rehab Report

You Be the Coder: Knee Injections

Test your coding knowledge. Determine how you would code this situation before looking at the box below for the answer.

Question: We are having trouble getting paid for injections to both knees and knee bursae. We now use 20610 (arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subarcomial bursa]) for the two knee joints, and then we bill 20610 again for the two knee bursae with the appropriate ICD-9 codes. Should we be using modifier -59 for this, or should we just indicate that its two units of each?

New York Subscriber

Answer: Billing for injections to both knee joints and bursae most definitely would require use of modifier -59 (distinct procedural service) to make the insurer aware that two distinct procedures were performed and that the patient has two diagnoses. You also should append the HCPCS modifiers (-RT for the right side; -LT for the left side) for the injections. So, your final claim would read as follows: 20610-LT; 20610-RT; 20610-59-LT; 20610-59-R., You should add the separate ICD-9 codes. For example, if the joint injections were for rheumatoid arthritis, you would use 714.0, and if the bursa injections were for bursitis, use 726.5.