Outpatient Facility Coding Alert

Reader Question: Arthrocentesis, Aspiration and Injection Can Sometimes Bundle Into One Code

Question: If our physician is performing an arthrocentesis procedure and injects a steroid during the same session, can both the procedures be separately reported? If so, what codes should be used to report each procedure?

Michigan Subscriber

Answer: An arthrocentesis procedure will involve your physician inserting a needle into a joint and aspirating fluid from the joint. Sometimes, he might inject some medication during the same procedure. Depending on the type of joint on which your clinician performed the procedure, you have three options to report from:

- 20600 (Arthrocentesis, aspiration and/or injection; small joint or bursa [e.g., fingers, toes])
- 20605 (...intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa])
- 20610 (...major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa])

As you can see from the descriptors to the codes, it includes both the injection and the aspiration of the joint. So you will have to only report one code even if your clinician performed both the procedures on a given joint.

Note: However, you have not mentioned if both the procedures were performed on the same joint. If your clinician were to perform the procedures on two different joints that are covered under the same code (for example, on the fingers of the right hand and toes on the right leg), then you can report each procedure separately.

In such a case, you will have to report two units of the same CPT® code with modifier 59 (Distinct procedural service) appended to the second unit of the code. This will let the payer know that your clinician performed the procedure on two different joints and not on one single joint. Provide adequate supporting documentation or your claim, or the second unit of the code might be denied.