Codify
BY AAPC

Outpatient Facility Coding Alert

Reader Question: Avoid Use of Multiple Codes for Aspiration, Injection of Same Joint

Question: How do I code a scenario in which the provider performs a knee aspiration and then follows up with a knee injection of the same joint during the same encounter? The aspiration utilized ultrasound guidance, but the injection did not.

New York Subscriber

Answer: In circumstances where they physician treats the same joint twice, you should only apply one injection/aspiration code. This becomes slightly trickier due to the fact that the aspiration used ultrasound guidance and the injection did not.

In this situation, some coders may consider billing out for both 20610 (Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance) and 20611 (... with ultrasound guidance, with permanent recording and reporting) and applying modifier 59 (Distinct procedural service) to 20610 (column 2 code).

However, you should apply the same rules as you would if the injection and aspiration both utilized ultrasound guidance. In that scenario, you would only bill out 20611 once, and the same goes for this example.

The only question that remains is whether to bill out using 20610 or 20611. In rare circumstances such as this, you should opt for the most comprehensive code, which is typically the one reflecting the higher number of relative value units (RVUs). Obviously the higher-RVU code coincides with the ultrasound guidance, so you will bill out 20611 once for the aspiration and injection of the same knee.