Modifier Coding Alert

You Be the Coder: Coding Injections With Fluoroscopy

Question: Our physician recently performed multiple arthroscopic injections, and the encounter notes look kind of tricky. Documentation indicates that the physician performed injections on the patient's left finger and right elbow. Further, the notes state that the physician used fluoroscopic guidance for both of the injections. The only codes I see that specify guidance are for ultrasounds. How do I code for intra-articular injections with fluoroscopic guidance?

Nevada Subscriber

Answer: On the claim, you should report 20605 (Arthrocentesis, aspiration and/or injection, intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]; without ultrasound guidance) for the elbow injection with modifier RT (Right side) appended. Then, report 20600 (... small joint or bursa [e.g., fingers, toes]; without ultrasound guidance) for the finger injection with modifier LT (Left side) appended.

Finally, report 77002 (Fluoroscopic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device]) times two for the guidance. Ensuring that the documentation clearly show that the injection sites were two separate locations is important, as this will prove that reporting the fluoroscopy code twice was correct coding. You may also want to check with your payer to see if it wants modifier XS (Separate structure) or modifier 59 (Distinct procedural service) appended to the fluoroscopy codes to better illustrate this point. Using 59 or XS will depend on your payer.