Codify
BY AAPC

Pain Management Coding Alert

Reader Question: Modifier 59 Might Work - But Don't Forget X{ESPU} Options

Question: Our pain management specialist frequently performs arthrocentesis with a Depo-Medrol injection and aspiration during the same encounter as a joint arthrogram. He uses fluoroscopic guidance for both procedures. We bill with 27093, 20610-59, and 73525. My physician insists this is correct for what he is doing, but some of our payers will not allow 20610. Do you have any tips for us?

Colorado Subscriber

Answer: When looking at CCI edits, 20610 (Arthrocentesis, aspiration and/or injection, major joint or bursa [e.g., shoulder, hip, knee, subacromial bursa]; without ultrasound guidance) is a Column 2 code for 27093 (Injection procedure for hip arthrography; without anesthesia). It's not appropriate to append modifier 59 (Distinct procedural service) to the Column 2 code when both procedures take place at the same anatomical site.

In addition, remember that we have more descriptive modifiers in 2015 to better define why the Column 2 code is appropriate for reporting with the Column 1 code. These new modifiers will often replace modifier 59:

- XE: Separate encounter (A service that is distinct because it occurred during a separate encounter)
- XS: Separate structure (A service that is distinct because it was performed on a separate organ/structure)
- XP: Separate practitioner (A service that is distinct because it was performed by a different practitioner)
- XU: Unusual non-overlapping service (The use of a service that is distinct because it does not overlap usual components of the main service).

In your physician's situation, modifier XS is not appropriate because of the same anatomical site. Modifier XU also is not appropriate because it is common when a physician who is not a radiologist performs this procedure. There are many times when you provider might perform a therapeutic injection or aspiration/arthrocentesis, but it cannot be separately reported.

Modifier 59 would be appropriate in your situation if the physician performed the procedures on different anatomic sites. However, you cannot report modifier 59 because he's not addressing separate sites. Therefore, you should submit 27093 and 73525. When speaking to your physician, remember that your coding is not based on your opinion or his it requires reviewing the current guidelines and following their interpretation.

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