UB ORTHOPAEDICS & SPORTS MEDICINE

Knee Injection with Ultrasound Guidance Billing Policy

Purpose: To establish uniform criteria for billing viscosupplementation injections of the knee with and without ultrasound guidance.

Applies To: CPT© Procedure Codes 20610 Arthrocentesis, aspiration and/or injections; major joint or bursa **76942** Ultrasonic guidance for needle placement, imaging supervision and interpretation, and applicable HCPCS Code J7325.

Policy: Knee injections will be performed at the physician's discretion in accordance with medical necessity standards supporting osteoarthritis of the affected joint under the following conditions:

- *There is radiological evidence to support the diagnosis of osteoarthritis; and*
- *There is adequate documentation that simple pharmacologic therapy (e.g. aspirin), or exercise and physical therapy have been tried and the patient failed to respond satisfactorily*

Ultrasound guidance for knee injections can only be billed separately when at least one of the following medical necessity requirements has been met and thoroughly documented:

- *History of severe trauma which would derange the normal architecture of the joint*
- *Erosive systemic arthritis (rheumatoid disease) or other systemic disease (lupus, gout, etc.).*
- *Failure of the initial attempt of a knee joint injection*
- *Size of the knee due to morbid obesity (BMI ≥ 30) or disease process*
- *Aspiration of a Baker's cyst*

Additional repeat treatments are considered medically necessary and can be billed for patients being treated for osteoarthritis of the knee, who meet **both** of the following criteria:

- *Significant improvement in knee pain and known improvement in functional capacity resulted from previous series of injections which has been documented in the record; and*
- *At least six (6) months have lapsed since the prior series of injections.*

Billing points:

- *If aspiration and injection performed in same session, bill only one unit 20610.*
- *Append appropriate site modifier to code 20610 (RT or LT) if unilateral and modifier (50) if bilaterally.*
- *Drug codes must be reported on separate line for each site being injected with a modifier (RT or LT).*
- *Evaluation and management codes may be billed, when criteria has been met, with modifier 25*

Reference: Article for Hyaluronans (e.g. Hyalgan®, Supratz®, Euflexxa™, Synvisc®, Synvisc-One™, Orthovisc®, Gel-One®), Intra-articular Injections of – Related to LCD L25820 (A46100). Please refer to www.NGSMedicare.com for full publication. While these are Medicare guidelines, they will be applied across all payers in the absence of a more specific policy.