Eli's Rehab Report

Reader Question: Describe Wrist Aspiration With 20605

Question: I performed a consultation at the hospital, where I also aspirated the patient's septic wrist. Three days later I performed a follow-up visit in the hospital and reaspirated the wrist. I reported 99254-25 and 20600 for the first visit and 99261-25 and 20600-58 for the second. Is this accurate?

Colorado Subscriber

Answer: You are correct to report 99254-25 (Initial inpatient consultation for a new or established patient; Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) for the initial hospital consultation, assuming you met the requirements for a true consultation.

You should report 20605 (Arthrocentesis, aspiration and/or injection; intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]) for the first wrist aspiration instead of 20600 (... small joint or bursa [e.g., fingers, toes]) because the wrist is an intermediate joint.

Because 20605 has zero global days, you shouldn't append modifier -58 (Staged or related procedure or service by the same physician during the postoperative period) to the second wrist aspiration you performed three days later. Simply report 20605 again for the second date of service.

Don't report the follow-up consultation code for the second hospital visit. Because the physiatrist assumed the patient's wrist injury care, you should instead report a subsequent hospital care code (99231-99233) with modifier -25 appended, if you've met the criteria for reporting the EM service in addition to the injection.