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Part B Insider (Multispecialty) Coding Alert

CPT® 2015: Make Specifics of U/S-Guided Arthrocentesis Part of Your Permanent Record

These new codes have very specific documentation requirements.

You're aware of the new CPT® codes that went into effect Jan. 1, but do you know how to use them? We've got the lowdown on how to bill a few of these codes so you can ensure that you're coding properly.

Nail Down Arthrocentesis Changes

Three new codes joined revised codes in the family of ultrasound guided arthrocentesis of small, intermediate, and large joints. The previously existing codes, 20600, 20605 and 20610 now include the phrase "without ultrasound guidance" and each is now partnered with a new code (20604, 20606, and 20611) that read, "with ultrasound guidance, with permanent recording and reporting." The changes are as follows:

- **20600** □ Revised (Arthrocentesis, aspiration and/or injection, small joint or bursa [e.g., fingers, toes]; without ultrasound guidance)
- **20604** - Code added (...with ultrasound guidance, with permanent recording and reporting)
- **20605** □ Revised (Arthrocentesis, aspiration and/or injection, intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]; without ultrasound guidance)
- **20606** - Code added (...with ultrasound guidance, with permanent recording and reporting)
- **20610** □ Revised (Arthrocentesis, aspiration and/or injection, major joint or bursa [e.g., shoulder, hip, knee, subacromial bursa]; major joint or bursa] without ultrasound guidance)
- **20611** - Code Added (...with ultrasound guidance, with permanent recording and reporting)

Rationale: "Billing a diagnostic ultrasound code for the localization [with arthrocentesis] is a no-no; hence the new codes to include localization," said **Bernard A. Pfeifer, MD,** at the AMA's CPT® Editorial Panel Meeting in November when explaining the updates to these codes. "Accuracy is improved with guidance," Pfeifer said during the conference, so when you use the guidance, report the new codes (20604, 20606 or 20611).

To solidify this new rule, The CPT® Editorial committee has added a "do not report" cross-reference for 76942 (Ultrasonic guidance for needle placement eg, biopsy, aspiration, injection, localization device], imaging supervision and interpretation), which means that CPT® now bars you from reporting old standby 76942 with 20604, 20606 and 20611. In addition, 20600, 20605 and 20610 are bundled with 76942, Pfeifer said.

Make it permanent: When the surgeon reports the "with ultrasound guidance" codes, he should be sure to keep documentation of that. "It is important to note that codes 20604, 20606 and 20611 require that the ultrasound guidance be recorded and the report included in the patient's permanent record," the AMA says in CPT® Changes: 2015.

Get Rib Codes Straight

In addition, CPT® deleted 21800 (Closed treatment of rib fracture, uncomplicated, each), which is now billable under E/M codes, and also cut 21810 (Treatment of rib fracture requiring external fixation (flail chest) from the CPT® manual because "not a terribly big amount of these procedures were done," Pfeifer said.

If the surgeon uses internal fixation along with rib fracture open treatment, look to new codes 21811-21813, which are described as follows:

- 21811: Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when

performed, unilateral; 1-3 ribs
- 21812: ...4 to 6 ribs
- 21813: ...7 or more ribs

If these descriptors look familiar, that's because these new Category I codes used to exist under Category II codes 0245T-0248T, according to CPT® Changes: 2015.

If you perform these bilaterally, you'll append modifier 50 (Bilateral procedure), but Pfeifer noted that coding might be more difficult if the patient has an uneven number of ribs broken on the left versus the right. For example, if the physician repairs five ribs on the left side and seven on the right, you could report 21812-LT (Left side) and 21813-RT (Right side), but the payer may deny the claim, which means you may need an appeal, Pfeifer said.

As for Medicare reimbursement amounts, you'll collect $625 for 21811, $750 for 21812 and $1,020 for 21813, although those numbers may not be set in stone. The codes were placed on the "new technology" list and therefore "will be revisited in a couple years," Pfeifer added.