Oral Surgery Coding & Reimbursement Alert

CPT® 2015 Update: Brace For New and Revised TMJ Arthrocentesis Codes For 2015 Claims

Note deletion of parotid relocation code in the upcoming year.

If you have been wondering at what new changes you will be facing with CPT® 2015, here is a first look at what you can expect. You will be seeing some new codes arthrocentesis of the temporomandibular joint (TMJ) while having to take into account some descriptor changes to old codes.

Add New Arthrocentesis Code to Your CPT® Arsenal

According to the proposed changes to CPT® codes in 2015, you'll be seeing the addition of new codes to arthrocentesis set of codes. These new codes will be based on the use of ultrasound guidance during the procedure.

As per this change, you will have a new code when your oral surgeon performs an arthrocentesis of the temporomandibular joint with ultrasound guidance. The new code that you will have to add up to your coding manual is 20606 (Arthrocentesis, aspiration and/or injection, intermediate joint or bursa [eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]; with ultrasound guidance, with permanent recording and reporting).

You will also need to incorporate some descriptor changes to the previously used code for arthrocentesis of the temporomandibular joint. According to the change, you will see the following changes to CPT® 20605 (Arthrocentesis, aspiration and/or injection, intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)without ultrasound guidance).

Coding tip: You will have now have two different codes for arthrocentesis of the TMJ depending on whether or not your clinician used ultrasound guidance for placement of the needles in the joint. So, you will have to look at documentation to ascertain the use of ultrasound guidance to arrive at the right CPT® code for the procedure performed.

"Note that the new arthrocentesis codes with imaging guidance only refer to ultrasound guidance," says **Kent Moore**, senior strategist for physician payment with the American Academy of Family Physicians. "If your physician uses some other sort of imaging guidance, that remains separately reportable, as it is now."

Eliminate 42508 From Your CPT® List

According to the list of changes to be introduced after Jan.1, 2015, you will see the deletion of the CPT® code 42508 (Parotid duct diversion, bilateral [Wilke type procedure]; with excision of 1 submandibular gland) for parotid duct diversion procedure. However, the other two CPT® codes, 42507 and 42509 (...with excision of both submandibular glands) will remain unchanged.

So, according to the new change, you will use 42507 if your oral surgeon performs parotid duct relocation or duct relocation with excision of one submandibular gland. If both the submandibular glands are excised by your surgeon during the procedure, then you will report 42509.

Embrace the Chronic Care Management Improvements

Changes to five CCM codes may make your chronic care management services coding less of a chore.

You'll find that CPT® 2015 revises the descriptor for 99487 with bulleted detail as follows: (Complex chronic care coordination management services, with the following required elements:

- multiple [two or more] chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- establishment or substantial revision of a comprehensive care plan;
- moderate or high complexity medical decision making;
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

"Adding the elements is definitely a positive; it gives the provider community a set of guidelines to follow to meet the documentation requirements of the codes," says **Suzan Berman (Hauptman), MPM, CPC, CEMC, CEDC**, director of coding operations-HIM at Allegheny Health Network in Pittsburgh, Pa. "Often we find that the providers are performing the services, but aren't necessarily illustrating them as the payer would like to see in the documentation."

In addition, you'll see that CPT® 2015 deletes 99488 (Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month).

Don't miss: For each additional 30 minutes of chronic care management your physician provides, you will still be able to report revised add-on code +99489 (Complex chronic care coordination management services. . .; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month [List separately in addition to code for primary procedure]).

Bonus: You will also have two new CCM codes to choose from:

1. 99490 □ Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,

chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,

comprehensive care plan established, implemented, revised, or monitored

2. +99498 □ ... each additional 30 minutes ....

"These changes appear to be primarily in response to the Centers for Medicare & Medicaid Services' (CMS) proposal to establish its own "G" code for chronic care management along the lines described in code 99490," Moore says. "It will be interesting to see what CMS decides to do with its proposal in light of the CPT® changes."