Oral Surgery Coding & Reimbursement Alert

CPT® Coding Strategies: Here's How to Upgrade Your TMJ Arthrocentesis Reporting Accuracy

Ensure you can support criteria for medical necessity.

If your oral surgeon is planning on performing an arthrocentesis of the temporomandibular joint (TMJ), don't forget to check whether you need prior authorization for the procedure or you could forfeit reimbursement. You should also pay attention to bundling edits when you are planning on reporting other TMJ procedural codes or E/M service codes with the code for arthrocentesis.

Check Medical Necessity of Performing Arthrocentesis

When your oral surgeon performs an arthrocentesis of the temporomandibular joint, you report the procedure with the CPT® code, 20605 (Arthrocentesis, aspiration and/or injection; intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]).

As you can see from the descriptor to the code, you use the code when your clinician inserts hypodermic needles (under local anesthesia) and injects a saline solution and aspirates the same. You use just one code for the entire procedure and not separate codes for the injection and the aspiration of the fluid.

Caveat: Be aware that not all payers cover TMJ procedures, so prior authorization will be necessary.

Best bet: Payers will consider the arthrocentesis procedure medically necessary if the conservative management procedures such as avoiding chewing hard foods, pharmacological management and physical therapy have failed to remove symptoms and this is documented specifically. Despite this conservative management for more than two weeks, your clinician should note symptoms such as pain, difficulty in chewing, and there is restricted range of motion in either jaw opening, lateral movements of the jaw or if there is continued deviation of opening of the jaw present. "The evaluation and management of the patient should indicate pain and other symptoms that indicate the need for TMJ arthrocentesis," says **Barry Shipman, DMD**, clinical professor, University of Florida School of Dentistry, Hialeah Dental Center.

Example: Your oral surgeon reviews 35-year-old male patient who has been complaining of severe pain in the right TMJ area, along with increasing difficulty in chewing for the past four weeks or so. The patient had been earlier advised to go on a soft diet and avoid hard chewing for about two weeks. The patient had also been advised to take pain killing medication for the same period of time but it had failed to produce any relief in the pain.

Your clinician orders x-rays and ultrasonography of the TMJ that enables your clinician to diagnose the patient with internal derangement. Your clinician then plans to perform an arthrocentesis to help stretch the joint capsule and allow the disc to move freely.

What to report: You report the procedure with 20605. You report the diagnosis with the ICD-9 code, 524.60 (Temporomandibular joint disorders, unspecified) or use M26.60 (Temporomandibular joint disorder, unspecified) if you are using ICD-10 codes.

Observe Caution Reporting 20605 With Other Procedure Codes

Sometimes when performing an arthrocentesis, your oral surgeon might want to probe further and use other TMJ procedures such as an arthroscopy or might even decide to perform an open surgical procedure such as an arthrotomy. "The decision to perform an additional procedure might depend on the possible diagnosis and the symptoms present,"

reminds Shipman.

If your clinician decides to perform additional procedures apart from arthrocentesis in the same session, you might want to check for Correct Coding Initiative (CCI) edits as many of these procedures are bundled with 20605.

While you will not face edits if your clinician performs an arthrotomy (21010, Arthrotomy, temporomandibular joint), you will face edits if your oral surgeon performs same session arthroscopy. So, you will face edits when you are planning on reporting one of the following codes with 20605:

- 29800 (Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy [separate procedure])
- 29804 (Arthroscopy, temporomandibular joint, surgical)

Reminder: The modifier indicator for these above mentioned edit bundles with 20605 is '1.' This modifier indicator denotes that you can use a modifier to help undo the edit so that you can get separate reimbursement for both the codes. You will have to append the modifier with 20605 as this forms the column 2 code for the edits. The modifier that you have to append to 20605 is 59 (Distinct procedural service).

Understand When to Report an E/M Code

When your clinician performs an arthrocentesis procedure, he will undertake a preoperative evaluation of the patient. This being part of the preoperative management of the patient prior to the procedure does not allow you to report a separate E/M code for the same. Also, CCI edits are in place that prohibit you from using an E/M code for evaluation of the patient prior to the procedure.

However, there are instances when you are allowed to report a separate E/M code for an evaluation done prior to the procedure. This can be done only if a separate and significantly identifiable E/M service was provided to the patient that is not a direct evaluation of the patient for the persisting problem for which the procedure has been planned.

Also, the modifier indicator for the bundling of E/M codes with 20605 carry the modifier indicator '1,' which indicates that you can unbundle and report both the codes if a suitable modifier is used. Since the E/M codes form the column 2 codes in the edits with 20605, you will have to append the modifier to it. The appropriate modifier that you will have to use with the E/M code is 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service).

Example: A 41-year-old male patient turns up to your oral surgeon's office for his scheduled arthrocentesis procedure. During the visit, the patient complains of some pain in the retromolar area. The pain is present on the right side while the TMJ problem is present on the left side. Your clinician examines the patient and notes some amount of pericoronal inflammation surrounding a vertically impacted third molar tooth.

Your surgeon then evaluates the patient for signs of infection of the tooth and checks for lymph node involvement. Since he does not see any signs of involvement of the lymph nodes or severe infection of the pericoronal area around the impacted tooth, your clinician proceeds with the arthrocentesis procedure.

What to report: You report the arthrocentesis with 20605. You report the E/M service with an appropriate E/M (such as 99212, Office or other outpatient visit for the evaluation and management of an established patient...) with the modifier 25 appended to the code.