

New and Modified CPT Codes for 2015

It's important to keep abreast of new developments.

BY HARRY GOLDSMITH, DPM

Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

I assumed that most foot and ankle specialists were aware of the new and modified CPT codes introduced for 2015. Apparently, I was wrong. Granted, there are few changes for 2015, but at least one set does impact many podiatrists.

Modified Code

CPT 20600—Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes); without ultrasound guidance

Total non-facility RVUs: 1.35

Total facility RVUs: 1.02

This is a designated Medicare bilateral code (“-50” modifier)

New Code

CPT 20604—Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes); with ultrasound guidance, with permanent recording and reporting

Total non-facility RVUs: 2.05

Total facility RVUs: 1.32

This is a designated Medicare bilateral code (“-50” modifier)

Rationale: The use of ultrasound guidance may, in some instances, provide for a more accurate needle placement to aspirate or deliver medication to a small joint or bursa in the toe.

Reality: Regardless of the introduction of a new code that includes an allowance for ultrasound guidance,

medical necessity and standard of care for use of imaging to place a needle in the interphalangeal joint or metatarsal-phalangeal joint will determine reimbursement. Medical record documentation may be requested by the payer to validate medical necessity.

Modified Code

CPT 20605—Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance

Total non-facility RVUs: 1.41

Total facility RVUs: 1.06

This is a designated Medicare bilateral code (“-50” modifier)

New Code

CPT 20606—Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow, or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting

Total non-facility RVUs: 2.27

Total facility RVUs: 1.51

This is a designated Medicare bilateral code (“-50” modifier)

Rationale: The use of ultrasound guidance may, in some instances, pro-

vide for a more accurate needle placement to aspirate or deliver medication to the ankle or midtarsal joints.

Reality: Regardless of the introduction of a new code that includes an allowance for ultrasound guidance, medical necessity and standard of care for use of imaging to place a needle in the ankle or midtarsal joints will determine reimbursement. Medical record documentation may be requested by the payer to validate medical necessity. The medical record will need a hard copy of the image representing needle placement and a brief descrip-

The medical record will need a hard copy of the image representing needle placement and a brief description of the purpose of the injection.

tion of the purpose of the injection, clearly noting the medical necessity for the ultrasound guidance.

Comment: reimbursement probably will not be based on ‘it is the standard in my office’ or ‘I get better clinical outcomes’ [you might be challenged to produce studies validating that claim], or ‘I only have 4 more payments left on my ultrasound unit’.

Obviously, with the introduction of these new and modified codes, CPT 76942 would no longer be billed with these injection services.

Modified Codes

CPT 97605—Negative pressure wound therapy (e.g., vacuum-assist-

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ed drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters

Total non-facility RVUs: 1.23

Total facility RVUs: 0.78

This is an active wound care management [therapy] code

CPT 97606—Negative pressure wound therapy (e.g., vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters

Total non-facility RVUs: 1.46

Total facility RVUs: 0.86

This is an active wound care management [therapy] code

New Code

CPT 97607—Negative pressure wound therapy (e.g., vacuum-assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters.

Total non-facility RVUs: 0.00

Total facility RVUs: 0.00

This is an active wound care management [therapy] code; carrier price

CPT 97608—Negative pressure wound therapy (e.g., vacuum-assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters

Total non-facility RVUs: 0.00

Total facility RVUs: 0.00

This is an active wound care management [therapy] code; carrier price

Rationale: The addition of these “disposable” NPWT units allows for distinction and differentiation in their use as compared to durable medical equipment versions of negative pressure wound therapy devices.

Reality: It is critical that providers of either the DME or disposable units pre-authorize use or minimally review payer policy regarding the use and billing of these devices. Some payers may have very narrow benefits when it comes to one type of NPWT unit over another. Also, you cannot bill a DME device along with a disposable device.

What’s Next, the Elimination of the Global Periods for 10, 90 Day Procedures?

Well, yes. Medicare, in its wisdom, and apparently unilaterally, has

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decided that minor procedures now assigned a 10-day global would, in 2017, be re-assigned a 0-day global. Additionally, major procedures currently designated as having 90-day global periods would, in 2018, also be re-assigned a 0-day global period. According to Medicare, surgical procedures are being shown to be over-valued based on the estimated level and number of E/M services that have been built into the post-operative follow-up value for the procedures. For instance, CPT 28296—bunionectomy with osteotomy—valuation includes 5 E/M services and a discharge allowance expected to be performed over the current 90-day follow-up period. In an internal study, CMS revealed that some physicians performing CPT 28296 may be seeing patients less than the 5 E/M times, thus making more than they should. In fact, podiatrists may see their post-CPT 28296 patients 5 or more times post-op, but other specialists may only see their patients twice or 3 times.

I know what you are thinking: oh, my! Medicare may wrongly be depending on the common use of CPT 99024 as “the” indicator that a free post-operative encounter occurred in the global period. For those of you who don’t know what CPT 99024 is or have chosen to ignore including it on post-op claims, it represents a “post-operative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a post-operative period for a reason(s) related to the original procedure”. Since it has \$0.00 value, many surgeons do not generate a post-operative claim just to let Medicare (or other payers) know they saw a “free” (although we know the surgeon has already been paid) patient.

So, if Medicare goes through with eliminating global days, what can we expect come 2017, 2018?

- Significantly reduced procedure reimbursements (values) since the E/M allowances will be “backed out” of the overall value for the procedure;
- The ability to separately bill for each medically necessary E/M service performed, even if it is related to the

surgery just performed, while the patient is in follow-up;

- Every payer scrutinizing each billed E/M service performed while the patient is in follow-up to ensure that 1) the service is truly medically necessary and 2) the level of E/M
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service billed is accurate;

- The elimination of some existing CPT modifiers, like “-24”, “-54”, “-55”, “-56”, “-58”, “-78”, “-79”, and possibly “-62”, and probably others—that should help gut CPT; and

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- Chaos if some commercial payers decide to continue to use global periods as before.

If Medicare goes through with its plan to eliminate global periods, there will need to be a wholesale re-evaluation of the value of all CPT procedure codes (thousands)...so trust Medicare, right? Hmmm. These are people who allow CPT 28292 to be valued higher than CPT 28296 (sort of removed “relative” out of “relative value units”, doesn’t it?). Maybe this is not such a good thing, eh? Hopefully, someone at CMS will see the unintended (or are they intended?) consequences of their actions.

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**You cannot bill a DME device along
with a disposable device.**

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Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.