2015 CODE CHANGES FOR RHEUMATOLOGY

New 2015 CPT™ Changes for Injection Codes

As of January 1, 2015, there is a coding change to the arthrocentesis injection codes (20600 – 20611). The codes are now separated to reflect an injection/aspiration with or without ultrasound guidance. The coding corner below will demonstrate an example of this change.

CPT code 20611 is one of the new code changes in the 2015 CPT™ and there are a total of six changes to this group of codes (20600 -20611).

- 20600 Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); without ultrasound guidance
- 20604 with ultrasound guidance, with permanent recording and reporting
  (Do not report 20600, 20604 in conjunction with 73942)
- 20605 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., Temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance
- 20606 with ultrasound guidance, with permanent recording and reporting
  (Do not report 20605, 20606 in conjunction with 76942)
- 20610 Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); without ultrasound guidance
- 20611 with ultrasound guidance, with permanent recording and reporting
  (Do not report 20610, 20611 in conjunction with 27370, 76942)
  (If fluoroscopic, CT or MRI guidance is performed see 77002, 77012, 77021)

A permanent recording of the ultrasound guidance must be included in the documentation.

- indicates that this is a revised code
- shows that this is a new code
In early September 2014, The Centers for Medicare & Medicaid Services (CMS) released Transmittal 1422, CR8863 detailing new modifiers to be used in place of modifier -59 effective January 1, 2015. In its place, CMS established four new HCPCS modifiers to further define subsets of the -59 modifier, which is used to define a "Distinct Procedural Service". CMS believes that this code change will work succinctly with the National Correct Coding Initiative (NCCI) edits that are used to bundle service codes together.

The new modifiers, referred to as -X modifiers, define specific subsets of modifier 59. CMS has indicated that they will not stop recognizing modifier -59 but remind healthcare providers that the American Medical Association Current Procedural Terminology (CPT) instructs that modifier -59 should not be used when a more descriptive modifier is available.

The new HCPCS modifiers referred to collectively as -X modifiers are defined as follow:

- **XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter**
- **XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure**
- **XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner**
- **XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service**

It's vital for rheumatology practices to take time to review their coding to ensure that they use one of the more descriptive –X modifier when it is required. If it is necessary to use modifier -59, there will need to be clear and concise documentation to properly reflect modifier -59 is being used appropriately. Also, these new –X modifiers requirements are from CMS and there is no indication if they will be accepted by commercial payers.

**New Bundled Codes for DXA Services**

The American Medical Association Relative Value Update Committee identified CPT™ codes 77080 (dual-energy X-ray absorptiometry (DXA), bone density study) and code 77082 (vertebral fracture assessment) as being reported together 75% of the time or more. As a result of this data, the CPT Editorial Panel deleted CPT™ code 77082 and added a new code 77085, which bundles the bone density study and the vertebral assessment.

**Bone/Joint Studies:**

- **77080**  Dual-energy X-ray absorptiometry (DXA), bone density, 1 or more sites; axial skeleton (e.g., hips, pelvis, spine)
  - Do not report 77080 in conjunction with 77085, 77086
- **77081**  appendicular skeleton (peripheral) (e.g., radius, wrist, heel)
➢ 77082 has been deleted. To report, use 77086  
(For dual-energy X-ray absorptiometry [DXA] body composition study, use 76499)

**77085** axial skeleton (e.g., hips, pelvis, spine), including vertebral fracture assessment  
➢ Do not report 77085 in conjunction with 77080, 77086

**77086** Vertebral fracture assessment via dual-energy X-ray absorptiometry (DXA)  
➢ Do not report 77086 in conjunction with 77080, 77085

Additionally, CPT™ code 77086 was created to report a vertebral fracture assessment via DXA. Note, exclusionary language has been added in the CPT manual for instructions on how to appropriately bill for these two new codes.

Correct coding and updates is an integral part of a practice's business management and due to the increased coding and billing guidelines it is important for physicians and billing staff to be up-to-date. The ACR coding and practice management staff is here to assist with coding and billing for these new procedure codes/modifiers, contact Melesia Tillman at mtillman@rheumatology.org or (404) 633-3777, x 820 for questions or additional information.