

AUDITING & COMPLIANCE TIP

Reporting Arthrocentesis (Joint Injections) with Ultrasound Guidance in 2015

As many are aware, there have been substantial amendments to 2015 CPT nomenclature for codes used to report joint injections (arthrocentesis). These changes are sure to have an impact on practices from coding, compliance and reimbursement standpoints. Over the years, most of us have become familiar with CPT codes 20600 (joint injection/aspiration of small joint; e.g. finger or toe), 20605 (joint injection/aspiration of intermediate joint; e.g. wrist or ankle) and 20610 (joint injection/aspiration of large joint; e.g. shoulder, hip, knee).

Effective Jan. 1, 2015, there are three new codes specific to joint injections/aspirations performed under ultrasonic guidance requiring both documentation of the specific structures imaged **and permanent image retention**.

The new codes below have been created to include the use of the ultrasound guidance.

- **20604:** Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g. fingers, toes); with ultrasound guidance, with permanent recording and reporting
- **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
- **20611:** Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g. shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

If the procedure is done under fluoroscopic, CT, or MRI guidance, the existing codes (20600, 20605, or 20610) would be used with the code for fluoroscopic (77002), CT (77012), or MRI (77021) guidance. The most important change for the new CPT codes added in 2015 is the requirement that providers maintain all images of all structures viewed using U/S guidance. These records must be maintained by the provider/practice for the same duration as all other aspects of the medical record.

While individual states ultimately determine how long medical records are to be retained, HIPAA legislation suggests that a Medicare fee-for-service provider should maintain copies (and images) for a minimum of six years from the date of service. The Centers for Medicare and Medicaid Services (CMS) requires that patient records for Medicare beneficiaries be retained for a period of five years ([see 42CFR482.24 \(b\)](#) [PDF]). Medicaid requirements may vary by state depending on which laws are more restrictive. Unless a particular state law is more restrictive, DoctorsManagement suggests retaining records for a minimum of six years.



Today's tip provided by:



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John Burns works with NAMAS to provide training and develop educational products for our members. Mr. Burns is also a member of our Senior Auditing Team with DoctorsManagement, our parent company.

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