Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 76881 Will Net You $85 More Than 76882 for Extremity Ultrasounds

Beware of overcoding tendon or muscle scan.

A remarkable rise in the number of extremity ultrasounds in the last few years brought about one deletion and two additions to CPT 2011 that you need to know. CPT 2011 replaces 76880 (Ultrasound, extremity, nonvascular, real-time with image documentation) with the following:

- 76881 -- Ultrasound, extremity, nonvascular, realtime with image documentation; complete
- 76882 -- ... limited, anatomic specific.

76882 Guidelines Point You to 'Specific Anatomic Structure'

Together with the new codes, CPT also added new guidelines for 76881 and 76882, as was noted in the presentation by **Richard Duszak, MD, FACR, FRBMA, RCC,** CPT editorial panel member, at the AMA's CPT and RBRVS 2011 Annual Symposium in Chicago.

Complete: The guidelines instruct that complete code 76881 includes real time ultrasound scans of a joint. To be complete, the documentation should reference related "muscles, tendons, joint, other soft tissue structures, and any identifiable abnormality."

Example: CPT Changes 2011: An Insider's View offers the example of a complete exam of the ankle, including all of the following:

- Lateral structures (for example, peroneus tendons; fibular ligaments)
- Medial structures (for example, posterior tibial, flexor digitorum longus, and flexor hallucis longustendons; deltoid ligament; neurovascular bundle)
- Anterior structures (for example, tibialis anterior tendon; ankle joint)
- Posterior structures (for example, Achilles tendon; retrocalcaneal and retroachilles bursa).

Limited: In contrast, limited study code 76882 applies to the examination of a specific anatomic structure, including a muscle, tendon, joint, or other soft tissue, Duszak's presentation explained. Guidelines for 76882 also explain that the code is appropriate for evaluation of a soft-tissue mass if the physician needs to learn its cystic or solid characteristics.

Example 1: CPT Changes 2011: An Insider's View offers the example of a focused exam (in multiple planes) of the Achilles tendon for an injured patient. This limited exam merits 76882.

Example 2: A diabetic patient presents with pain and swelling over the left leg. The physician performs a limited ultrasound to determine the presence of an abscess. In this case, you again should report 76882, says **Michael Granovsky, MD, CPC, FACEP**, president of MRSI, a coding and billing company in Woburn, Mass.

Expect $9 to $85 Difference in Fees Between Codes

Change rationale: Code 76880 increased in use significantly in the last several years. The AMA RUC Five-Year Review Identification Workgroup assessed the code use. Evidence suggested that limited exams made up the bulk of the increase, CPT Changes 2011 notes. Because the work and practice expense differ greatly for complete and limited exams, CPT decided two separate codes would be a more accurate way of identifying the services performed.

The difference in work is reflected in the rates for these new codes. Although the professional rates are fairly similar, the technical and global (professional plus technical) rates for these codes vary greatly.

The national rate for global complete code 76881 is roughly $115, according to the 2011 Medicare Physician Fee Schedule. Global 76882 will bring in closer to $30, which is a difference of about $85.

The professional component of 76881 should yield almost $29, and 76882 is slightly lower at about $20. So if you do the math, you see that the technical component fee for 76881 is about $86, while technical 76882 yields close to $10.

Revolutionize Your Femoral/Popliteal Coding Options

Getting yourself up to date on this year's revascularization CPT changes requires more than just swapping your old codes for new ones -- although that alone is enough to keep you busy. You also have to take a careful look at the guidelines that apply to the individual codes to be sure you're using the new codes correctly.

Start here: CPT 2011 adds new codes for lower extremity endovascular revascularization covering angioplasty, atherectomy, and stenting, noted **Stacy Gregory, CCC, CPC, RCC,** of Gregory Medical Consulting Services, in her presentation, "Peripheral Vascular Coding Tactics," at the 2011 Coding Update and Reimbursement Conference in Orlando (www.codingconferences.com).

Master the Single Code Approach for Fem/Pop Coding

The new femoral/popliteal service codes are below. Note that all of the codes include angioplasty in the same vessel when that service is performed:

Angioplasty: 37224 -- Revascularization, endovascular, open or percutaneous, femoral/popliteal artery(s), unilateral; with transluminal angioplasty

Atherectomy (and angioplasty): 37225 -- ... with atherectomy, includes angioplasty within the same vessel, when performed

Stent (and angioplasty): 37226 -- ... with transluminal stent placement(s), includes angioplasty within the same vessel, when performed

Stent and atherectomy (and angioplasty): 37227 -- ... with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed.

Remember: The general rule for 37224-37227 is that you should report the one code that represents the most intensive service performed in a single lower extremity vessel. (See "Apply This Territory Rule to Avoid Denials" below to learn what counts as a single vessel.) All lesser services are included in that one code.

For example: When the radiologist performs a stent placement, atherectomy, and angioplasty in the left popliteal vessel, you should report only 37227. That code covers stent placement, atherectomy, and angioplasty. You should not report 37224 (angioplasty), 37225 (atherectomy), or 37226 (stent placement) separately or in addition to 37227 in this scenario.

Check Out the Change From Component Coding

CPT guidelines state that -- in addition to the intervention performed -- the codes include:

- Accessing the vessel
- Selectively catheterizing the vessel
- Crossing the lesion
- Radiological supervision and interpretation for the intervention performed
- Any embolic protection used
- Closure of arteriotomy (incision in the artery)

- Imaging performed to document the intervention was completed.

For example: In 2010, you reported a superficial femoral artery angioplasty via antegrade puncture using now deleted code 35474 (Transluminal balloon angioplasty, percutaneous; femoral-popliteal), 36245 (Selective catheter placement, arterial system ...), and 75962 (2010 definition was Transluminal balloon angioplasty, peripheral artery, radiological supervision and interpretation), Gregory stated. In 2011, you should report only 37224 to cover all of the services.

Don't forget: If the physician performs mechanical thrombectomy (such as 37184-+37185, primary, or +37186, secondary), thrombolysis (such as 37201, 75896), or both, to help restore blood flow to the occluded area, CPT states you may report those services separately.

Apply This Territory Rule to Avoid Denials

The new codes (37220-+37235) apply to different "territories." Each territory has its own specific set of guidelines. Codes 37224-37227 fall under the femoral/popliteal vascular territory.

Key rule: CPT states that "the entire femoral/popliteal territory in 1 lower extremity is considered a single vessel for CPT reporting."

As a result, you should report a single code even if the radiologist performed various interventions for various lesions in the popliteal artery and in the common, deep, and superficial femoral arteries in the same leg at the same session, as noted in the presentation prepared by **Sean P. Roddy, MD, FACS,** AMA CPT advisory committee member, and **Gary R. Seabrook, MD,** AMA/specialty society relative value scale update committee member, for the AMA's CPT and RBRVS 2011 Annual Symposium in Chicago.

In these situations, you should use the code for the most complex service.

For example: If the radiologist performs angioplasty in the left popliteal artery and atherectomy in the left common femoral, you should report atherectomy code 37225 only.

Don't forget: The codes are unilateral, which means they apply to a service on a single side of the body. CPT indicates that if the physician treats the identical territory (such as femoral/popliteal) in both legs at the same session, you should use modifier 59 (Distinct procedural service) to show both legs are involved.

But watch out for payers' modifier preferences. Some may prefer you to use modifier 50 (Bilateral procedure), modifiers RT (Right side) and LT (Left side), or some combination of modifiers for procedures on both legs.