Rib Fractures, Joint Injections and Aspirations, Sports Physicals, and Tuberculosis Skin Tests

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Q. What code do we use now to bill for closed treatment of a rib fracture?

A. In 2015, *Current Procedural Terminology* (CPT) deleted codes 21800, "Closed treatment of rib fracture, uncomplicated, each," and 21810, "Treatment of rib fracture requiring external fixation (flail chest)," because of lack of use. You are now to report closed treatment of an uncomplicated rib fracture using an appropriate evaluation and management (E/M) code.

Q. We perform many joint injections and aspirations. Will the 2015 code changes affect how we bill these?

A. It depends on whether you use ultrasound guidance. The phrase "without ultrasound guidance" was added to the arthrocentesis of small, intermediate, and major joint or bursa CPT codes 20600 (small), 20605 (intermediate), and 20610 (major). New codes were introduced in 2015 to represent these same procedures with 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

"Report closed treatment of an uncomplicated rib fracture using an appropriate evaluation and management (E/M) code."

If you do not use ultrasound guidance for your injections and aspirations, continue to use codes 20600 for small joints and bursa, 20605 for intermediate joints and bursa, and 20610 for major joints and bursa.

If you use guidance other than ultrasound, CPT instructs you to use codes 20600, 20605, and 20610 along with the appropriate code from the radiology section:

- **77002:** "Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)"
- **77012:** "Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation"
- **77021:** "Magnetic resonance guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation" ■

Q. What is the correct way to bill a school or sports physical? Are there specific CPT codes we can use? Our patients get upset when we bill our regular preventive medicine codes.

A. You could consider charging a flat fee for completing the examination and the school or sports physical form,

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"Another option is to make the sports or school physical part of a well visit. Perform the physical on the basis of the requirement of the activity form presented, and . . . then continue with the well-visit examination."

without billing the insurance. Of course, you would need the patient or legal guardian to agree to pay the reduced fee and not file a claim with insurance.

Another option is to make the sports or school physical part of a well visit. Perform the physical on the basis of the requirement of the activity form presented, and document your findings on the form. Then continue with the well-visit examination and document all findings in the medical record.

In both cases, you would still use the age-appropriate codes and the codes for either new or established patients in the preventive medicine section, code range 99381–99397. ■

Q. When giving a tuberculosis skin test, can we also charge for an injection?

A. This test is not a vaccine; rather, it is a screening test for the presence of an immune response, indicating the presence of the tuberculosis. This code includes the purified protein derivative (PPD). Use CPT 86580, "Skin test; tuberculosis, intradermal," for PPD testing in the office setting. This code includes the intradermal injection of the substance, so you would not bill separately for the injection.

The AMA Resource-Based Relative Value System (RBRVS) does not include the work for reading the test in calculating the reimbursement for CPT 86580. When the patient does return for a reading of test results, you may code 99211 for the reading done by a nurse. However, under incident-to regulations, a physician must be physically present in the office at the time of the reading to warrant a 99211 code.

If the test results are positive, you can code for the additional services rendered during the visit. Typically, the physician will engage in a face-to-face encounter with the patient for further evaluation and management (reviewing the diagnosis, performing a physical examination, assessing risk, determining the possibility of false positive test results, determining treatment options, etc.). You would use an appropriate E/M code (99212–99214). You should also code for any medically necessary additional testing (e.g., chest x-ray). ■