Billing, Coding and Documentation for MSK US

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Disclaimer

• The following is my opinion ONLY
• I am a doctor… not an expert in billing and coding
• Even the experts in billing and coding may come to different conclusions about billing and coding practices with US
• There are state to state and sometimes carrier to carrier variability in billing and coding for MSK US
Billing and Coding 101

• 76881 - Complete Diagnostic Ultrasound
• 76882 - Limited Diagnostic Ultrasound
• 76942 – Ultrasound Guidance
• 76970 – F/U Ultrasound
76881: Complete Examination

• “A complete ultrasound of an extremity consists of real time scans of a specific joint that includes examination of the muscles, tendons, joint, other soft tissue structures, and any identifiable abnormality.”
• Requires indication, eg, “shoulder pain.”
• Requires storage of permanent images and completion of a written report.
76881: Complete Examination

– What to scan?
  • See AIUM Practice Guideline for the Performance of the Musculoskeletal Ultrasound Examination (AIUM.org).
– Should be done with measurements when clinically indicated
– Contralateral evaluation of “normal” anatomy is part of routine examination
76882: Limited Examination

• “A limited ultrasound...is performed primarily for evaluation of muscles, tendons, joints, and/or soft tissues. This is a limited examination...where a specific anatomic structure such as a tendon or muscle is assessed.”
  – the limited code would be used to evaluate a soft-tissue mass that may be present in an extremity where knowledge of its cystic or solid characteristics is needed.

• Requires indication, eg, “suspect Achilles rupture.”
• Requires storage of permanent images and completion of a written report.
• What to scan?
  – At least one “specific anatomic structure” – needs clinical justification and should impact clinical decision-making.
76942: Ultrasound Guidance

- Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation.
- Requires indication, eg, “hip osteoarthritis.”
- Requires justification for the use of image guidance, particularly in “gray areas” such as the knee joint.
- Requires a storage of permanent images and completion of a written report describing the needle localization process.
  - This code takes into account identifying all relevant anatomy prior to the injection.
76942: Cannot Use With...

- **64479-84**
  - Transforaminal injection. May use bundled Category III codes: 0228T-31T (no RVUs/payment attached)

- **64490-95**
  - Facet injection. May use bundled Category III codes: 0213T-18T (no RVUs/payment attached)

- **27096**
  - Sacroiliac joint injection.

- The above are “bundled codes” that include image guidance, and with the exception of the above-listed Category III codes, specify fluoroscopy or CT guidance.
Percutaneous Needle Tenotomy

• 24357 - "percutaneous tenotomy" performed on the medial or lateral elbow:
  1) An 18 or 20 gauge needle should be used.
  2) The tendon is "repeatedly fenestrated."
  3) Bone work is performed.
  4) Something is injected, such as anesthetic or corticosteroid
    - There is a 90 day global when this code is used so no subsequent f/u office visits can be billed
Percutaneous Tenotomy

Other tenotomy codes exist, but most include wording indicating use of a *scalpel*, not needle alone, and/or use of wording describing *transverse division* or *incision/dissection*.

Examples: 23405/6 (shoulder), 26040 (fasciotomy, palmar), 26060 (finger), 27000 (hip adductor), 27306/7 (hip adductor/hamstring), 27605 (Achilles), 28008 (fasciotomy, foot or toe), 28010/1 (toe).

Safer: Consider relevant tendon/ligament/fascia injection code instead (e.g., 20550 or 20551).
Platelet Rich Plasma

• 0232T- Cat III PRP code
  – July 1, 2010

• CPT Category III codes are a set of temporary codes that allow data collection for emerging technology, services, and procedures. These codes are intended to be used to substantiate widespread usage or to provide documentation for the Food and Drug Administration (FDA) approval process.

• This is a bundled code
  – Can not bill additional US guidance, injection codes
Billing Example

- Consult for 30 year old male with new right shoulder pain x 3 months after mishandling a bench press.
- Had immediate onset of pain and difficult lifting arm
- Still with painful limited active ROM
- Exam c/w rotator cuff pathology
- Treatment and Billing options….
Billing Options

ALL SAME VISIT

• Consult 99242-4
• 76881 for complete diagnostic ultrasound
  – Debate as to use of 25 modifier here
  – Appears radiology codes do not need modifier

SPLIT OVER 2 VISITS

• Day 1
  – Consult 99242-4
• Day 2
  – 76881 for complete diagnostic ultrasound
  – No E&M charge, no modifier
What if you also wanted to give an US-guided SA Injection?

**Same Visit**
- Consult 99242-4
- Modifier 25 for separate procedure from E&M
- 20610 - Major joint/bursa injection
- 76881 for complete diagnostic ultrasound
- 76942 – US guidance
- No additional modifier (59 or 51) unless separate/ distinct procedure done on same day
  - i.e. knee injection

**Split over 2 visits**
- **Day 1**
  - Consult 99242-4
- **Day 2**
  - 76881 for complete diagnostic ultrasound
  - 20610 - Major joint /bursa injection
  - 76942 – US guidance
## Billing Options

### SAME VISIT
- Less time for exam and for US evaluation
- Possible reimbursement conflict
- More convenient for patient

### SPLIT OVER 2 VISITS
- Some states require PA for Dx US
- More time for thorough evaluation (both clinical and US)
- Cleanest for billing
- Inconvenient for patient
- Concern for “gaming” the system
How to decide whether to bill for US evaluation?

- When do I **NOT** bill for US?:
  - If I decide to order and MRI b/c I am not sure what I am seeing
    - If I order MRI to look at labrum after eval of RTC, I would bill shoulder US
  - If I am doing the US to further my knowledge of MSK US
  - If a patient comes in for an US evaluation and then asks me to “quickly” look at another body part
  - When performing an injection, i.e. bakers’ cyst aspiration. If dx known, should only bill US guidance
    - Can not bill for planning of procedure
Bottom Line for US Billing

If the US is medically necessary and performed properly, you should bill for it
Thank You

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  - Bill Sullivan, MD