MSK ULTRASOUND GUIDED INJECTIONS

INDICATIONS FOR MUSCULOSKELETAL ULTRASOUND

Clinical indications for MSUS

Current, developing and potential indications for MSUS

Tissue	Proven indication	Developing Indication	Potential Indication
Effusion	Diagnosis of joint, tendon sheath and bursal effusion. Aspiration of effusion. Differentiation of cystic from solid masses, detection of cyst rupture, sinus and fistula. Diagnosis of vascular and nerve compression syndromes by fluid collections	Role of MSUS in improving efficacy of joint and bursal injection	Differentiation of type of effusion: US microscopy of synovial Fluid
Synovium	Diagnosis of synovial proliferation and synovitis	Diagnosis of lesser degrees of synovitis. Differentiate active from inactive synovitis	US used as standardized outcome measure for synovitis in RA trials. US used to classify joint involvement(oligoarticular, polyarticular).Development of tissue specific andimmunospecific contrast agents. USsynovectomy (high-intensity focused US)
Bursa	Diagnosis of superficial and deep bursitis. Bursal aspiration and injection	Differential diagnosis of true effusive bursitis from soft tissue inflammation (greater trochanter bursitis *vs.* greater trochanter enthesitis without effusion)	Improve understanding of bursafunction and pathology
Bone	Demonstration of joint erosion	Diagnosis of fractures, bone tumors, periosteal disease	US erosion included in diagnostic criteriafor RA.US erosion used as standardizedoutcome measure in RA trials.Differentiate active vascularized erosionfrom inactive erosion
Tendon/Ligament	Diagnosis of tendon damage, rupture, tendonitis or tenosynovitis. Diagnosis of ligament injury or enthesitis. Improve assessment of indication for surgery	Monitoring of response to therapy, surgery. Role of MSUS in improving efficacy of tendon sheath and soft tissue injection	Differentiate active from inactiveenthesitis. Quantitative score of peripheralenthesitis. Improve understanding ofpathogenesis of mechanical andinflammatory enthesitis
Skin	Measure skin thickness in scleroderma. Detect subcutaneous oedema. Detect subcutaneous hypertrophy and atrophy, abscess, calcification, foreign body, nodule or tumors	Application of skin thickness as a standard measure of outcome in, scleroderma. Objective monitoring of oedema after therapy. Monitoring of subcutaneous hypertrophy and atrophy, abscess, calcification, foreign body, nodule or tumor	Diagnosis of scleroderma. Differentialdiagnosis of cellulitis, necrotizing fasciitis,subcutaneous pathology
Cartilage	Imaging of local and generalized cartilage defects and calcification	Monitoring of cartilage thickness homogeneity cartilage disease	Diagnosis of osteoarthritis and othercartilage disease

Muscle	Diagnosis of muscle trauma, tumor, abscess and calcification	MSUS guidance of muscle biopsy, aspiration	Diagnosis and monitoring of inflammatory muscle disease. Diagnosis andmonitoring of muscle dystrophy
Vasculature	Detection of inflammation with power Doppler. Imaging of location and morphology of vascular structures	Objective and reproducible quantification of inflammation with power Doppler. Correlation of MSUS with histological diagnosis of temporal arteritis and vasculitis	Imaging of 'normal 'blood flow in joints. Diagnosis of temporal arteritis without recourse to biopsy. Diagnosis of medium and large vessel vasculitis. Diagnosis and monitoring of Raynaud 's disease
Nerve	Demonstration of nerve morphology and continuity. Guidance of nerve blocks	Diagnosis of peripheral nerve tumors and pseudotumours. Diagnosis of nerve injury. Diagnosis of nerve entrapment carpal tunnel syndrome ulnar nerve compression, syndromes. MSUS demonstrates entrapment:, nerve pathology including axonal loss and common peroneal nerve at the fibular neck, posterior tibial nerve at the tarsal tunnel	MSUS as first-line diagnostic modalityfor carpal tunnel syndrome and otherentrapment syndromes. MSUS demonstratesnerve pathology including axonal loss anddemyelination
Salivary glands	Demonstration of salivary gland size and morphology	Correlation of MSUS findings with labial gland histology	Diagnosis of Sjogren's syndrome

Rheumatology 2004

Home Page

Files related to Arthrocentesis, aspiration and/or injection; major joint or bursa eg, shoulder, hip, knee joint, subacromial bursa) (20610)

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User id : 3490 Posted 4 years ago

76881 & 76882 are these to be used for upper & lower exams. And what defines limited vs complete

User id : 17865 Posted 4 years ago

76882 is used Anatomy specific, whereas 76881 is used for Complete study including multiple extremities, be it lower or upper limbs.

SuperCoder Posted 4 years ago

A complete ultrasound examination of an extremity (76881) 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.
A limited examination of an extremity (76882) that would be performed primarily for evaluation of muscles, tendons, joints, and/or soft tissues. This is a limited examination of the extremity where a specific anatomic structure such as a tendon or muscle is assessed.
Hope, it would clarify you so well.

User id : 17320 Posted 4 years ago

Do you know why the reimbursement of the limited exam is so significantly lower than the complete?

User id : 17865 Posted 4 years ago

Lower Extremity Ultrasound, CPT codes 76881 and 76882
CMS disagreed with the RUC recommendations for the two lower extremity ultrasound codes, 76881 (Ultrasound, extremity, nonvascular, real-time with image documentation; complete) and 76882 (Ultrasound, extremity, nonvascular, real-time with image documentation; limited, anatomic specific). CMS indicates that 76881will be used for evaluation of the lower extremity in the same manner as 76880 (Ultrasound, extremity, nonvascular, real time with image documentation), the code being replaced by these two codes. Based on Medicare claims data, podiatry was the dominant provider of 76880 and their specialty acknowledged that they more commonly perform a limited ultrasound examination, which will now be reported as 76882. In other words, the services that are currently reported using code 76880 will actually be reported more commonly with 76882, not 76881.
To dismiss the complete exam, 76881, as being equal to the old exam ignores the fact that

a complete exam involves greater physician work to satisfy the elements inherent to a complete exam. This difference in work was acknowledged by the RUC during extensive compelling evidence discussions. The reference service and MPC codes selected were also evaluated by the RUC as being appropriate for codes 76881 and 76882 with regards to the work RVUs. The reference service code for 76881 was 76885 with MPC codes 20610 and 11000. For code 76882, the reference service code was 76536 and MPC codes were 92083 and 11000.

Using CMS' logic, 76882 should have been the service which received the existing value of 0.59 RVU, rather than the 0.50 recommended by the RUC. Indeed, CMS' recommendation of the existing value for 76882 contradicts the concerns for survey bias discussed above. Based on CMS' concerns for bias, we would have expected CMS to recommend a lower value than 0.59. We are confused by CMS' inconsistent application of bias as an argument to invalidate the RUC's recommendations. In any case, we respectfully ask that the codes 76881 and 76882 be evaluated through the refinement process since we are concerned that the CMS-promulgated interim values create rankorder anomalies not only within the family of ultrasound procedures, but also within the entire Physician Fee Schedule.

RUC: Relative Value Scale Update Committee

About this Question

Posted by 3490, 4 years ago. There are 5 posts. The latest reply is from 17865.

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