

October 3, 2005

Grace M. Kotowicz, Director
CPT Editorial Research and Development
American Medical Association
515 North State Street
Chicago, IL 60610

RE: Appropriate use of CPT 76003 and 76005

Dear Ms. Kotowicz:

Many of the members of the American Society of Interventional Physicians have brought to the attention of the Board of Directors the fact that the above codes are being billed by some radiologists who are not present in the room and whose services have not been requested. This does not meet the criteria as described by the AMA code description, rationale or vignettes. Further, they also do not meet the criteria of reasonable and medically necessary and their services have not been requested in such cases. If a radiologist is performing the procedures, it is appropriate for them to use the codes as the physician providing the primary service.

Recently, it has become a major problem and the New Jersey Medicare Carrier has determined that the radiologist is the appropriate physician to bill for these services and the services of interventional pain physicians performing these procedures have been denied and refunds are being requested.

I am enclosing a recent letter sent to a Medicare Director.

We would like to request the opinion of the AMA CPT Committee with regards to the appropriateness of this code to be used by a physician who is not performing the service. If you need any further information, please feel free to contact us at 2831 Lone Oak Road, Paducah, KY 42003, phone: 270.554.8373 ext. 107, fax: 270.554.8987 or e-mail at drm@apex.net

Thank you in advance for your assistance.

Sincerely,

Laxmaiah Manchikanti, MD

Enclosure

December 7, 2005

Marie L. Mindeman
Director – CPT Editorial Research and Development
515 N. State Street
Chicago IL 60610
Marie.Mindeman@ama-assn.org

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Dear Ms. Mindeman:

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Thank you in advance for your assistance.

Sincerely,

Laxmaiah Manchikanti, MD

Enclosure

RE: Denial of CPT Code 76003 and 76005, fluoroscopic guidance for needle placement and localization of needle or catheter tip

Dear Dr. []:

We were puzzled by a recent barrage of refusals of the above services for CPT code 76005 and 76003, along with requests for refunds. We have been notified that the billings were incorrect and we were paid incorrectly. However, it is our strong belief that we have billed correctly for the services and were paid appropriately. We also have demonstrated medical necessity.

To understand the issues related to these procedures, we would like to describe the CPT definition of these codes, rationale, and medical necessity guidelines.

Description:

CPT 76003 – Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device)

CPT 76005 –Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction

CPT 76005 is considered a component code of CPT 76003.

Thus, both code definitions clearly demonstrate that it is fluoroscopy guidance for needle placement and localization. Nowhere in the description of the codes are they identified as diagnostic or therapeutic radiologic procedures.

Rationale:

CPT described the rationale and provided vignettes for these codes. Use of CPT 76005 is specifically for spinal and paraspinal procedures, whereas, CPT 76003 is for non-spinal procedures.

Spinal and Paraspinal Procedures:

CPT 76005 identifies the fluoroscopic “guidance” to assist in accurately localizing specific spinal anatomy for placement of a needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint) including neurolytic agent destruction.

CPT 76005 should be reported in conjunction with CPT codes 62270-62273, 62280-62282, and 62310-62319, when fluoroscopic guidance is required in the performance of these injection procedures. Since fluoroscopic guidance is required to perform paravertebral facet joint and facet joint nerve injections, paravertebral facet joint nerve destruction by neurolytic agent, transforaminal epidural and sacroiliac joint injections, CPT 76005 should be additionally reported in conjunction with CPT codes 27096, 64470-64476, 64479-64484, and 64622-64627.

CPT 76005 does not represent a formal contrast study. Examples of a formal contrast study are myelography, epidurography, and sacroiliac joint arthrography. These codes include the use of fluoroscopy. Therefore, CPT 76005 is considered an included component of CPT codes 72240, 72255, 72265, 72270, 72275, and 73542.

Several revisions were made to the series of cross-references following CPT 76005 for fluoroscopic guidance, including the addition of CPT codes 62263, 62264, and 0027T to the “injection of contrast” cross-reference, to indicate that contrast injection for fluoroscopic guidance is an inclusive component of the listed procedures and not separately reported. A cross-reference was added following CPT 76005 to also indicate that, since fluoroscopic guidance is included in CPT codes 62263, 62264, and 0027T, 76005 is not separately reportable when performed in addition to these procedures

Vignette

CPT 76005 ----- A 45-year-old man has severe pain (rated at 8 on a scale of 0-10, where 10 is the worst pain imaginable) involving both legs and the lower back after multiple back operations during a 10-year period. Various systemic medications (oral narcotic and nonnarcotic) and physical therapy have all failed to provide significant long-term pain relief. There are no further operations on his spine that are felt likely to provide further relief.

Non-Spinal Procedures

CPT 76003 identifies fluoroscopic guidance for non-spinal interventional techniques.

CPT 76003 may be used to report fluoroscopic guidance with the following procedures:

- ◆ Sympathetic blocks
- ◆ Discography without interpretation
- ◆ Intercostal nerve blocks
- ◆ Peripheral nerve blocks
- ◆ Trigger point injections, etc.

MEDICAL NECESSITY

As per the guidelines established by the Centers for Medicare and Medicaid Services (CMS) we understand the following:

- ◆ It is essential to establish medical necessity for each encounter and each service has to stand on its own.
- ◆ Reasonable and necessary:
 - Medicare will only pay for services that meet the Medicare definition of reasonable and necessary. Further, Medicare may deny payment for a service that is not reasonable and necessary according to the Medicare reimbursement rules.
- ◆ For a service to be reasonable and necessary, it must be:
 - Safe and effective
 - Not experimental or investigational
 - Appropriate, including the duration or frequency that is considered appropriate for the service, in terms of whether it is:
 - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient’s condition or to improve the function
 - Furnished in a setting appropriate to the patient’s medical needs and condition
 - Ordered and/or furnished by qualified personnel
 - One that meets, but does not exceed, the patient’s medical need.
 - At least as beneficial as an existing and available medically appropriate.
- ◆ It is essential to document medical necessity
 - The physician’s practice should be able to provide documentation, such as patient’s medical records and physician’s orders, to support the appropriateness of a service that the physician has provided.

- The physician's should only bill those services that meet the Medicare standard of being reasonable and necessary for the diagnosis and treatment of a patient.

DISCUSSION

Based on the above 3 issues, only a physician who is performing the procedure is eligible to bill for these codes. Further, a radiologist could never establish medical necessity. The following are the flaws in the argument about a radiologist's capacity to supersede an interventional pain physician performing the procedure.

- 1) CPT code clearly describes that it is a fluoroscopy guidance for needle placement
- 2) Rationale, along with its vignette clearly describes that the needle placement is controlled, along with the fluoroscopy with injection by the interventional pain physician.
- 3) A radiologist will not be able to prove that it is reasonable and necessary for a radiologist to bill for this service for the following reasons:
 - ◆ The radiologist is not furnishing this service with accepted standards of medical practice (accepted standard is for an interventionalist to determine the position of the needle) for the diagnosis or treatment of the patient's condition or to improve the patient's function.
 - ◆ The radiologist is not providing the service in any type of setting as Medicare requires that it should be furnished in a setting appropriate to the patient's medical needs and condition (at no time during these procedures, a radiologist was present in the operating room suite).
 - ◆ A radiologist was not interpreting the position of the needle during the procedures. Obviously the radiologist is doing this after the fact with no benefit to the patient or the physician performing the procedure.
 - ◆ The service must be ordered and/or furnished by qualified personnel (the service was never ordered or requested and the patient is not the radiologist's patient. He or she is a patient of the interventional pain physician).
 - ◆ This should meet the patient's medical need. There was no medical need for the radiologist to provide this service.
 - ◆ The radiologist has no necessity to provide the service as it exceeds the service provided by the physician and the patient is not benefiting from this service.
 - ◆ Generally during these procedures, an interventionalist directs the placement of the fluoroscopy unit prior to each of the procedures in question, and obtains an initial film that is used for directing needle insertion.
 - Subsequent films are also obtained based on the needle placement. Additional measures may be required if contrast is injected.
 - The post-contrast images document the spread of the injected medications.
 - ◆ As the physician performing the procedures, the interventionalist is the only person in the room trained and/or qualified to determine the appropriateness of the needle placement based on an interpretation of the films obtained. A radiologist's interpretation is retrospective or retroactive which is absolutely useless. Further, as stated earlier, the radiologists that are separately billing for similar services have never been requested to provide such services.

In summary, we believe that we have provided overwhelming evidence that these codes have to be used for appropriate positioning of the needle, have to be interpreted immediately during the procedures, not retrospectively, and an interventional pain physician is the only person who is present and responsible for this activity (unless a radiologist is the interventionalist). Consequently, we request that you continue to reimburse us appropriately.