Clinical Practice Guideline: **Ultrasound and Fluoroscopic (Non-Spinal) Guidance for Needle Placement and Fluoroscopy (Separate Procedure)**

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Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers CPT code 76000 to be medically necessary in limited situations within an office-based setting that will be identified on a case-by-case basis. This code is most often bundled with a surgical procedure and not separately billable.

CPT code 76000 - Fluoroscopy (up to 1 hour physician time) is intended for use as stand-alone code when fluoroscopy is the only imaging performed. The most common scenarios include imaging that is not described by a separate supervision and interpretation (S&I) code and when a radiologist assists another physician in the performance of a procedure.

The following clinical examples illustrate when fluoroscopy is used as a stand-alone code:

1. A patient presents to the radiology department with a prior joint X-ray series, which demonstrates a calcified body near the joint. The radiologist uses fluoroscopy with the joint flexed, extended and rotated to determine if the calcification is indeed loose within the joint. Again, since fluoroscopy is the only imaging performed, CPT code 76000 would be used. In this example, there is both physician work and technical expense in providing the fluoroscopic service. Fluoroscopy requires personal supervision, i.e., the physician must be in attendance in the room during the performance of the procedure. If the radiologist is not present in the room during a fluoroscopic imaging procedure, CPT code 76000 should not be coded.
2. Another example is when there is no other fluoroscopy code that more accurately describes the imaging performed (i.e., code 77001, 77002, or 77003). For example, a patient steps on a needle and fluoroscopy (C-arm) is used to assist the physician to locate and remove this foreign body from the skin wound. In this instance, if C-arm fluoroscopic imaging is being provided without a diagnostic radiologic examination (i.e., no hard copy record of the images is produced), then code 76000 should be used to identify the imaging procedure provided.

ASH considers CPT Code 76942 - Ultrasound guidance for needle injections to be medically necessary in limited situations. The codes 20604, 20606, and 20611 include the

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descriptor, "with ultrasound guidance, with permanent recording and reporting." These codes specifically address ultrasound guidance and require that the report be included in the patient's permanent record. These are the codes that should be used for specific joint and soft tissue injection, etc. rather than CPT code 76942. Refer to the *Joint and Soft Tissue Arthrocentesis, Aspiration, and Injection (CPG 196 – S)* clinical practice guideline for more detailed guidelines governing the use of CPT codes 20604, 20606, and 20611.

Other considerations:

A. According to clinical literature and practicing physician input, ultrasound guidance may not be reasonable and necessary and is not the established standard of care for all needle placement procedures.
B. Ultrasound guidance for viscosupplement injections is considered experimental and investigational because it has not been established that this approach will improve health outcomes.
C. Ultrasound guidance for needle procedures of the foot by podiatry or other specialists is not medically necessary as most of these are standard office-based needle procedures and not special procedures performed in a radiology suite.
D. Ultrasound guidance for trigger point or peripheral nerve block injections is not medically necessary.
E. It is not expected that a non-physician practitioner (NPP) would perform procedures utilizing 76942 as they are not qualified to "interpret" diagnostic ultrasounds. Note that this code includes "imaging supervision and interpretation." An interpretation of the ultrasound guidance must be documented in the patient's medical record in order to separately bill this procedure code.
F. CPT 76942 is an imaging code that lets you visualize what you are injecting. It is important to document why the imaging was necessary for this type of injection. Typically, a plantar fascia injection does not require ultrasound guidance.
G. CPT code 76942 has both professional and technical components, meaning that a separate radiology report (not part of the procedure note) is required to meet the code's radiology requirements. The specific documentation requirements for ultrasound guidance include the following:
    - A final, written report should be issued for inclusion in the patient's medical record.
    - Ultrasound guidance procedures also require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized.
    - Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation, and final, written report, is not separately reportable.

ASH considers CPT Code 77002 - Fluoroscopic guidance for needle placement to be medically necessary in limited situations where ultrasound guidance is not possible or

appropriate, despite improved safety profile (i.e., no radiation with ultrasound) and medically necessary because palpation is not possible for accurate placement.

Additionally, ASH considers CPT Code 77002 - Fluoroscopic guidance for knee injections only to be medically necessary and allowed if documentation supports that the presentation of the patient's affected knee on the day of the procedure makes needle insertion problematic. No other imaging modality for the purpose of needle guidance and placement will be covered.

Ultrasound or fluoroscopic guidance for needle placement is not indicated, reasonable or medically necessary when used to penetrate an easily palpable joint.

CPT codes 76942 and 77002 describe radiologic guidance for needle placement by different modalities. Only one unit of service for either of these codes is allowed at a single patient encounter regardless of the number of needle placements performed. The unit of service for these codes is the patient encounter, not number of lesions, number of aspirations, number of biopsies, number of injections, or number of localizations.

CPT Code	Description
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time
76942	Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation
77002	Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)

BACKGROUND

Fluoroscopy

Fluoroscopy is a type of medical imaging that shows a continuous x-ray image on a monitor. During a fluoroscopy procedure, an x-ray beam is passed through the body. The image is transmitted to a monitor so the movement of a body part or of an instrument or contrast agent ("x-ray dye") through the body can be seen in detail. Fluoroscopy, as an imaging tool, enables physicians to look at many body systems, including the skeletal, digestive, urinary, respiratory, and reproductive systems. Fluoroscopy may be performed to evaluate specific areas of the body, including the bones, muscles, and joints, as well as solid organs, such as the heart, lung, or kidneys. Fluoroscopy is used in many types of examinations and procedures, such as barium X-rays, cardiac catheterization, arthrography (visualization of a joint or joints), lumbar puncture, placement of intravenous (IV) catheters (hollow tubes inserted into veins or arteries), and biopsies.

Other uses of fluoroscopy include but are not limited to locating foreign bodies; image-guided anesthetic injections into joints or the spine; and percutaneous vertebroplasty (a minimally invasive procedure used to treat compression fractures of the vertebrae of the spine.

Fluoroscopy carries some risks, as do other imaging procedures. The radiation dose the patient receives varies depending on the individual procedure. Fluoroscopy can result in relatively high radiation doses, especially for complex interventional procedures (such as placing stents or other devices inside the body) which require fluoroscopy be administered for a long period of time. Radiation-related risks associated with fluoroscopy include:

- Radiation-induced injuries to the skin and underlying tissues ("burns"), which occur shortly after the exposure
- Radiation-induced cancers, which may occur later in life

However, the likelihood that these effects will be experienced from a fluoroscopic procedure is very small. Typically, the radiation risk is outweighed by the benefit to the patient. To minimize the radiation risk, fluoroscopy should always be performed with the lowest acceptable exposure for the shortest time necessary.

Imaging Guidance for Needle Insertion

The use of ultrasound to evaluate musculoskeletal structures has become increasing popular over the recent years, particularly in the office setting. Ultrasound allows physicians to visualize soft-tissue structures including muscle, tendons, ligaments, arteries, and nerves, as well as identify any pathologic changes within these structures. Ultrasound has also been used as an imaging guide for intra-articular or soft-tissue injections to help improve accuracy. Using ultrasound guidance, a physician can directly visualize an injection needle's path and the immediate structures around it, thereby minimizing risk of injury to adjacent nerves or blood vessels. There are two approaches to ultrasound injections: in-plane (IP) and out-of-plane (OOP). With the IP or long-axis approach, the needle is lined up with and parallel to the ultrasound transducer, enabling the physician to see the length of the needle as it approaches the target site. The in-plane technique is often preferred during ultrasound-guided procedures because the needle tip and shaft are visualized throughout the entire procedure. With the OOP or short-axis approach, the needle is placed perpendicular to the transducer and a transverse section of the needle is visualized at the target site so that only the tip of the needle is visualized. The out-of-plane approach is typically used for superficial injections with minimal surrounding soft tissues.

Fluoroscopy has significantly contributed to the increase of image-guided interventions across all areas of clinical medicine. While these procedures allow for the execution of often complex internal manipulations through a small skin opening rather than a surgical

incision, they are not without risk, including the risks of ionizing radiation, as mentioned previously. When fluoroscopy is simply used for image guidance, other real time modalities should be considered that do not use ionizing radiation, like ultrasound. Thus, unlike fluoroscopy, ultrasound has no radiation exposure.

While the studies show that image guidance during injection improves accuracy compared to blind injection and landmark-based injections for the shoulder, more high quality studies are required to determine whether the outcomes improve with imaging guidance. Based on outcomes in two moderate-sized shoulder injection studies, researchers concluded that patients who had undergone ultrasound-guided injections demonstrated greater improvement in both pain and shoulder function at 6 weeks than those who received landmark-guided injections. The hip joint is another large joint that can be technically challenging to inject due to its depth and the femoral neurovascular bundle that lies in close proximity. Fluoroscopy, which has been shown to be relatively safe and accurate, requires significant resource allocation and introduces the risk associated with exposure to ionizing radiation. Also, fluoroscopy does not visualize soft tissue or neurovascular structures. As a result, the ultrasound-guided technique for hip joint injections has been widely accepted as a safe and effective alternative by physicians.

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education, training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a member only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the member to the more expert practitioner.

Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to

their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies in a Health Care Facility (CPG 159 – S)* clinical practice guideline for information.

References

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