# An Open Letter to the AMA CPT Coding Panel

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This letter is addressed to the AMA CPT Coding Panel as it relates to their consideration to delete codes 93760 and 93762. I understand that code deletion is being considered due to low utilization. I would like to make two recommendations to the panel in this regard. First, this may represent an excellent opportunity to update the codes to reflect current practice and second, the data base information under consideration is not representative of actual practice.

These two codes were established well over twenty years ago. Technology has changed dramatically since then (1), and so has the methodology for this procedure (2). In addition, in recent years the medical community has become much more adept in its understanding of sympathetic pain syndromes, including, but not limited to, Chronic Regional Pain Syndrome (CRPS) and/or Reflex Sympathetic Dystrophy (RSD). There has also been a dramatic increase of awareness in all levels of society of what Thermographic Infrared Imaging is and what its capabilities are.

While the complex nature of CRPS/RSD has in itself required a medical community learning curve, over the past several years these conditions are morphing for uncommonly heard of orphan diagnostic conditions to common familiarity among the medical community. While the number of doctors who specialize in sympathetic pain syndromes remains small even among pain specialists, that too is changing.

It has become not uncommon, or even common, for CME course offerings on the topic. The AAPM&R itself frequently sponsors symposiums on CRPS/RSD and this year's course application has rather strong emphasis on the role of Medical Infrared Imaging as it relates to the same. It is anticipated that this trend will not only continue to increase, but accelerate.

The American Academy of Thermology (AAT) published internationally peer reviewed Guidelines For Neuromusculoskeletal Thermography in January of 2006 (3). Since that time there has been increased interest among several University based programs including, but not limited to, the Rusk Institute at NYU and the Rehabilitation Medicine and Anesthesia Pain departments at the University of South Florida University in Tampa, Florida.

FSU sponsored a symposium on Medical Infrared Imaging in 2007 and The Department of Physical Medicine & Rehabilitation at NYU is co-sponsoring a program with the AAT on Medical Infrared Imaging in May of 2008. The Rusk Institute currently has a book in press dedicated to Medical Infrared Imaging as well.

FLIR, a leading international corporate citizen is also taking increased interest in marketing their products to the medical community. FLIR is a major corporate player in the infrared imaging community. Every American knows that the use of this technology has increased since the Gulf war, and even more dramatically since 9/11. As a result of increased world wide demand for infrared imaging technology price has come done, computer digitalized data obtainment and storage has become the norm, and analogue based systems have become out dated.

Accounting for these developments, it makes sense to either edit the descriptions of 93760 or 93762 to reflect current study methodology and terminology, or to create new codes that have modern day descriptors (such as Computerized Infrared Medical Imaging). Other modifications might include descriptors used by the State of Colorado Workers Compensation; Thermographic Imaging: Upper Body, with Autonomic Challenge testing and Lower Body, with Autonomic Challenge Testing. It would be best if the CPT Panel obtained input from the AAT in this regard.

As it relates to the second point, it is my understanding that for Medicare, according to the RUC database, there have been zero claims on either of these codes for the last 9 years. Medicare created a policy in the mid eighties of not paying for either of these procedure codes, and in fact no one does the procedure with either liquid contact crystals anymore. A small percentage of practitioners may still use analogue, liquid cooled systems, but as noted earlier that technology is either becoming or has become obsolete in today's world. As a result, even if the procedure is performed, there is no reason to file a claim to Medicare for it.

I have been supplied with information that suggests that claim submission is low for private payers as well. According to Blue Cross Blue Shield data given to me, 93760 has been reported a total of 54 times in the last 20 months, and 93762 have been reported 85 times in the same time frame. I firmly believe that this data is in error. While my office is a regional referral center for CRPS/RSD and my claim usage may not be the norm, my own performance for 93760 over this time period is too high to make these numbers credible.

Over a decade ago the Blue Cross Blue Shield National Umbrella Organization made a policy recommendation that 93760 and 93762 be covered codes, however many local carriers followed Medicare regulation and did not follow this recommendation. In a practical sense this skews claim recognition or submission. It also reflects the need for the codes to be either replaced with new identifier numbers that reflect current methodology or to be edited to accomplish the same end.

In summary I believe that it would fall well within the goals and objectives of the AMA CPT Coding Panel to either adopt current terminology for Computerized Medical Infrared Imaging within CPT codes 93760 and 93762, or to replace the codes with new identifiers that reflect the current methodology used. I would encourage the Panel to seek input from the AAT in this regard. It would be inappropriate to delete the codes without modification or further action at this time. The data base on filed claims does not reflect actual practice and does not take into account recent developments that portend increasing utilization.

## References

1. Ammer K- Thermology 2006- a computer-assisted literature survey. Thermology international 2007, 17(1).5-31

2. Plassmann P, Ring EFJ, Jones CD. Quality Assurance of Thermal Imaging Systems in Medicine. Thermology international 2006, 16(1): 10-15

3. Practice Guideline Committee of the American Academy of Thermology. Guidelines for Neuromuscular Thermography. Thermology international 2006, 16(1): 5-8