Charges Trigger Scrutiny

Medical Billing for Spinal Injections Could Contain Costly Errors or Trickery

Many patients who suffer from accident-related cervical, thoracic, or lumbar pain and associated radiculopathies pain are treated with conventional interventions—oral medication, chiropractic, or physical therapy. Treatment often consists of range of motion, exercise, adjustments, and modalities such as heat/cold, electrical stimulation and ultrasound. Unfortunately, sometimes these interventions are not successful in achieving the patient's goals of pain relief and function restoration. When conventional treatments fail, the patient's pain management regime may shift to invasive therapeutic procedures such as trigger point, nerve block, and spinal facet injections. These injections commonly involve the use of steroids.

The spine is often the source of pain. The paravertebral facet joints, transforaminal epidural space, and sacroiliac joints are structures of a very delicate nature. The spinal cord and vascular components are intimately entwined among these vertebral areas. In the cervical region, the spinal cord has a very close proximity to the small epidural space, which can make cervical steroid injections prone to serious complications if the procedure is performed blindly. The complications of a dural puncture may include headaches, arachnoiditis, epidural abscess, epidural hematoma, and permanent spinal cord injury. Vascular structures may be injured as well from an inadvertent intravascular needle placement within the epidural space during cervical and lumbar transforaminal epidural injections. Adverse effects can lead to systemic complications, such as adverse central nervous system and cardiovascular effects. Accordingly, the American Medical Association, in designing the codes in which imaging guidance is an inclusive component, suggests that such guidance is critical.

American Medical Association CPT Codes

The Current Procedural Terminology (CPT) manual, published by the American Medical Association, indicates when imaging guidance is a component of a

CPT code. For facet injection procedures, it states "[i]maging guidance (fluoroscopy CT) and any injection of contrast are inclusive components of [CPT codes] 64490-64495." The procedures covered by the codes in this numerical sequence are for injections of therapeutic agents into the paravertebral facet joint. The codes specify whether a single vertebral level is injected, or whether additional levels are injected. The modifier "50" is required when the procedure is performed bilaterally. The CPT coding manual recognizes that some practitioners will use ultrasound guidance in lieu of fluoroscopy. Codes 0213T through 0218T are to be billed instead of 64490-64495 when ultrasound guidance is used for the needle placement. CPT code 27096 is an "injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid…27096 is to be used only with imaging confirmation of intra-articular needle positioning." CPT code 77003 should accompany 27096 when fluoroscopic guidance is used to locate the specific anatomic site for needle insertion.

Accuracy in billing is important. The provider's submission of the CPT code is its representation to the insurance company of what was performed on the patient. The code recognizes that not all providers will use radiologic guidance or other imaging in delivering injections. To that end, the CPT code also makes explicit the appropriate codes to use if no imaging is used in performing procedures 64490-64495, where imaging guidance is inclusive to the code. The CPT manual instructs, "[i]f no imaging is used, report 20552-20553 [in lieu of 64490-64495]." The CPT coding manual clearly provides the necessary codes to accurately describe the services performed for these injections.

Trigger Point or Facet Injection?

When a CPT code is billed that indicates that radiologic guidance was not used, two potential issues arise. The first issue is whether the patient was put at risk because the procedure failed to use radiologic guidance. The second issue is whether the procedure was a trigger point injection, rather than a facet injection, which would require a lesser reimbursement. Patient safety is paramount but beyond the scope of this article. For purposes of reimbursement, the second issue is considered.

Trigger points are focal, hyperirritable spots located in skeletal muscle. They produce local pain in referred patterns. A trigger point injection is the invasive delivery of an anti-inflammatory agent into the taut band of skeletal muscle. They have been shown to be an effective treatment for prompt relief of symptoms and do not require imaging guidance. Trigger points are identified by the physician's palpation of the taut area. The steroid or other therapeutic agent is injected directly into the muscle. A trigger point injection does not encroach upon the delicate structures that are involved with facet joint or epidural injections.

Radiologic guidance is used to ensure the accuracy of needle placement for facet and epidural injections and to avoid injury of the surrounding structures. Injections without guidance are commonly referred to as "blind injections." Studies conclude that facet joint injections should not be performed without radiological imaging because of the lack of accuracy, as well as the potential risk to the patient. For example, more than 50 percent of blind lumbar epidurals examined in one study actually were performed at a level other than the one intended.

Because trigger point injections are effective and performed in a blind fashion, insurers should determine whether a trigger point injection was performed when a facet procedure is billed without the use of imaging guidance. Additionally, if repeated facet injections are billed over time for the same patient, an insurer might question whether or not imaging guidance was performed. Facet joint injections are reimbursable at a level much higher than trigger point injections, and repeated injections, naturally, are far costlier.

Radiologic Capabilities

One tell-tale sign of potential fraudulent billing of codes requiring fluoroscopic or radiologic guidance is whether the provider has the ability to perform the imaging necessary to bill a code that includes such guidance. Radiologic, CT and fluoroscopic guidance involve the use of radioactive materials. Not surprisingly, this type of material is regulated by the states. For example, Pennsylvania statute 25 Pa. Code § 216.2(a)(1) indicates that "[a] person possessing a radiation-producing machine shall: (1) Register with the Department within 30 days after acquisition. Registration shall be completed on forms furnished by the Department and shall contain information required on the form and accompanying instructions." Similarly, Delaware's Title 16 Administrative Code 4000-K.2(c)(i) has a registration requirement to "possess and/or use a radiation machine (i.e. x-ray equipment) or operate a radiation facility."

Billing for imaging guidance without the required licenses may suggest that the facility does not have the apparatus necessary to perform imaging guidance. An insurer may want to inquire with the respective state department or bureau to see if the physician or facility possesses such a license or registration. This information may allow the insurer to begin a fraud inquiry. It seems that it would be fraudulent to bill for codes which

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are inclusive of imaging guidance or for separate imaging guidance codes where the provider does not possess the necessary equipment or license to substantiate use of the code.

Claims Submission

The CPT coding manual provides a standard coding convention to uniformly describe medical procedures. The instructions for use of the CPT codebook states, "[s]elect the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided." The manual goes on to indicate, "[w]hen reporting codes for services provided, it is important to insure the accuracy and quality of coding through the verification of the intent of the code by using related guidelines, parenthetical instructions, and coding resources. . ."

A quick review of the reverse side of the CMS 1500 form will offer a brief summary of the terms and conditions to which the provider has agreed. The front side of the CMS 1500 form functions as the "bill of sale" by representing to the insurance carrier which procedures were performed, the cost per unit, and the quantity of units delivered. At the bottom of Box 31 on the form is a sentence that reads, "I certify that the statements on the reverse apply to this bill and are made a part thereof." On the reverse side of the claim form, one of the statements to which the physician is attesting is: "I certify that the services shown on this form were medically indicated and necessary for the health . . . and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations." While the rules and regulations of the government payer programs, such as Medicare, generally do not apply to private payers, unless specified by state statute, an insurer has a legitimate expectation that the services claimed on the CMS 1500 form will be an accurate, truthful representation of what was performed.

To illustrate the prevalence of billing problems involving these codes, consider the following statistics from the Office of Inspector General report entitled Medicare Payments for Joint Facet Injection Services, September 2008. Sixty-three percent of facet joint injection services paid by Medicare in 2006 did not meet program requirements. In that year, Medicare improperly paid approximately $96 million for those services, and 31 percent had coding errors. Of the services with coding errors, 60 percent were overpaid because physicians failed to use the modifier "50" for bilateral services and instead billed Medicare for additional add-on codes to represent bilateral facet joint injections. Thirty-eight percent of the facet joint injection procedures billed to Medicare contained documentation errors.

Potential Legal Claims

A provider's submission of claims for services that were not delivered or were inaccurately described is, at a minimum, a misrepresentation. For private insurers, these claims may present a civil cause of action. The threshold question is whether the misrepresentation is simply billing error, or whether it rises to something greater. The provider's misrepresentations could be negligent, which may be actionable as a negligent misrepresentation claim. These fraudulent billings also could be actionable under an intentional misrepresentation claim, where the insurance carrier must demonstrate that the provider intended the misrepresentation.

In addition to the aforementioned examples of common law fraud, each state may have a statute which governs insurance fraud. For example, Title 18 of Pennsylvania's statutory code, § 4117(a)(2) defines insurance fraud as being when a person acts "[k]nowingly and with the intent to defraud any insurer or self-insured, presents or causes to be presented to any insurer or self-insured any statement forming a part of, or in support of, a claim that contains any false, incomplete or misleading information concerning any fact or thing material to the claim."

The facts and circumstances also may rise to criminal liability for the provider as well, depending on various federal and state statutes. And, of course, there are also remedies available when Medicare is fraudulently billed.

The general inaccuracy in billing for facet joint injections raise questions about the services delivered. Do the codes used indicate that imaging guidance was performed? If such guidance was not performed, what actually was delivered? Was there a trigger point injection misrepresented as a facet injection? Ultimately, the decision to use imaging guidance belongs to the provider, so too does the decision to bill using a code which is inclusive of imaging guidance. Insurers should obtain clarification from the provider with respect to which type of guidance (CT, fluoroscopic, x-ray, ultrasound) was used whenever a code indicating imaging guidance is billed. Also, where a contrast agent was involved, as in fluoroscopy, an insurer may wish to inquire as to which type was utilized. The contrast agent and imaging guidance should not be billed separately for procedure codes 64490 – 64495. Considering Medicare's reported rate of documentation and billing errors, a closer look into claim forms for these services may be indicated. The insurer should examine these types of claims to determine if further inquiry is necessary.

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