Eli's Rehab Report

Avoid Using Trigger Point Injection Code When Billing for Prolotherapy

The benefits of prolotherapy for relieving pain and repairing ligament or tendon damage are becoming widely known, and therefore, prolotherapy is being requested by more patients and used more by **physical medicine** and rehabilitation (PM&R) practices. Despite its growing popularity, however, Medicare and most other insurers still do not cover prolotherapy (M0076). In addition, if you submit claims using **CPT 20550** (injection, tendon sheath, ligament, trigger points or ganglion cyst) for prolotherapy knowing that Medicare does not cover it, your practice could get into trouble if a file review proved that you used 20550 to get the claim paid.

A 1999 appeal by a New York physician who requested that the Health Care Financing Administration (HCFA) review its coverage policy for prolotherapy resulted in Medicares September review issues announcement maintaining its national noncoverage policy. The agency stated, Prolotherapy, joint sclerotherapy, and ligamentous injections with sclerosing agentsnot covered. The medical effectiveness of the above therapies has not been verified by scientifically controlled studies. Accordingly, reimbursement for these modalities should be denied on the ground that they are not reasonable and necessary as required by the law.

Prolotherapy Defined

Prolotherapy involves injecting solution into the trigger points to cause new tissue growth and promote healing, says **Ricardo Tan, MD,** a natural healing physician in Fort Worth, Texas. The course of treatment depends on the area size. The bigger the area, the more treatments, and we usually give the patients anywhere from one treatment to 10 treatments.

Because prolotherapy involves a series of injections into the trigger points, many practices believe that the logical way to bill for it is to charge 20550 for each area injected. For example, some coders dont charge per injection but bill for each site injected. For example, if the physician does three injections into the right trapezius area, that would be one unit of 20550, and then if he or she did three more injections on the left trapezius, that would be one more unit of 20550.

This interpretation of billing for prolotherapy, however, could get your practice into trouble if your insurer ever reviews your files. The rules for billing 20550 are outlined in each carriers local Medicare review policy (LMRP) and in private insurers guidelines, and most of these policies clearly state that 20550 cannot be billed for prolotherapy. For example, the trigger point injection LMRPs for both United Healthcare and Empire Medicare state, Prolotherapy is not covered by Medicare. Its billing under the trigger point injection code is misrepresentation of the fact.

Why 20550 Is a Misrepresentation of the Fact

Medicare says they dont cover prolotherapy, so you shouldnt bill for it, says **Grace Krycinski,** billing manager for the Long Island Pain Treatment Center in Plainview, N.Y. Why would you put yourself in danger with Medicare by billing 20550 for prolotherapy? The doctor is going to write a report saying he did prolotherapy, so youre not going to have proof in your records to support billing the 20550 for a standard trigger point injection. If you are billing this way, you have to know that if Medicare reads your doctors reports and sees that you were billing for prolotherapy when its clear that prolotherapy is not covered, you could be facing danger.

Krycinski recommends using waiver forms for Medicare patients who request prolotherapy, and operating a cash business for patients whose insurers do not cover the procedure. If the patient is happy with the prolotherapy, have the patient pay for it. Also, have the patient sign a waiver form stating he or she will pay for prolotherapy if the insurer rejects it. Write in the patients records that you did prolotherapy and send a bill to Medicare for the prolotherapy. If the patient signs the waiver, and you submit the claim to Medicare, you should bill M0076 with modifier -GA (waiver or

liability statement on file). The payment should go straight to the patient if Medicare reimburses the bill.

Other practitioners ask the patients to file insurance on their own. I always request payment for prolotherapy up front, says Ron Kennedy, MD, a provider of prolotherapy in Santa Rosa, Calif. I give my patients receipts so they can submit the claims themselves if they want to, but not many insurers cover it.

Practices that deal with insurers who will cover prolotherapy should contact those insurers to determine applicable ICD-9 codes and coverage limitations.