

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



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## **Inappropriate Medicare Payments for Transforaminal Epidural Injection Services**

**Note:** This article was updated on August 14, 2012, to reflect current Web addresses. All other content remains the same.

### **Provider Types Affected**

Physicians who bill Medicare contractors (carriers or Medicare Administrative Contractors (A/B MAC)) for providing transforaminal epidural injection services to Medicare beneficiaries are affected.

### **What You Need to Know**

This Special Edition article is based on the August 2010 Department of Health and Human Services Office of the Inspector General report entitled "Inappropriate Medicare Payments For Transforaminal Epidural Injection Services."

It summarizes the study's objectives which were: 1) To determine the extent to which Medicare Part B physician payments for transforaminal epidural injections met Medicare requirements, and 2) To determine the safeguards that existed to ensure Medicare Part

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B payments for transforaminal epidural injections met Medicare requirements. The report also describes the study's identified problems with transforaminal epidural injections; and its findings and recommendations. This article is intended to remind physicians of the importance of properly documenting the services for which they bill and to assure the documentation meets Medicare's requirements. In addition, the documentation must show such services meet Medicare's medical necessity requirements.

## Background

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Chronic pain affects many adults in the United States. One type of interventional pain management technique used to diagnose or treat pain is transforaminal epidural injection; in which the injection is given through a spinal column foramen (or foramina) enabling the physician to inject the medication as close to the source of pain as possible, reducing inflammation and relieving the patient's pain.

In order to determine the extent to which Medicare Part B payments for transforaminal epidural injections met Medicare requirements and to evaluate the safeguards that existed to ensure Medicare Part B payments for these injections met Medicare requirements, the Office of the Inspector General (OIG) performed a study focused on the procedure performed in 2007. The OIG did this by: 1) conducting a medical record review of a sample of Medicare claims from 2007; 2) reviewing CMS and Medicare contractor policies related to safeguarding transforaminal epidural injection services, and 3) conducting structured telephone interviews with Medicare contractor staff.

### *Study Methodology*

For the medical record review component of the study, a random sample of 433 Medicare physician line item claims were selected from approximately 800,000 claims (amounting to \$141 million in allowed physicians payments) consisting of all 2007 allowed physician services for transforaminal epidural injection CPT codes 64479 (Injection; anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, single level), 64480, (Injection; anesthetic agent and/or steroid, transforaminal epidural; cervical or thoracic, each additional level), 64483 (Injection; anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level), and 64484 (Injection; anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, each additional level) for services billed in offices, Ambulatory Surgical Centers (ASCs), or hospital outpatient departments. The reviewers determined whether the service was adequately documented and medically necessary and whether the appropriate CPT code and modifier(s) were used.

### *Findings*

The study found that in 2007:

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1. Thirty-four percent of transforaminal epidural injection services that Medicare allowed did not meet Medicare requirements.
2. Nineteen percent of transforaminal epidural injection services had a documentation error with ten percent of transforaminal epidural injection services undocumented and nine percent were insufficiently documented.
3. Further, the study found that thirteen percent of injection services had a medical necessity error and eight percent had a coding error resulting in overpayments for services that were miscoded –primarily using add-on codes and bilateral modifiers improperly, and in some instances, actually performing less intensive procedures, but billing for transforaminal epidural injections.

**Note:** The documentation errors were found more often to occur in office settings (forty one percent of all errors occurring in physicians' offices, compared to twenty-eight percent occurring from care provided in facilities).

The Centers of Medicare & Medicaid Services concurred with all of the study's findings and reminds physicians to comply with Medicare's documentation requirements, as well as with all medical necessity requirements. Based on Chapter 3, Section 11 of the "Medicare Program Integrity Manual" for Medicare to consider coverage and payment for any item or service, the information submitted by the supplier or provider (e.g., claims) must be corroborated by the documentation in the patient's medical record that Medicare coverage criteria have been met. The patient's medical record includes: physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and/or test reports. This documentation must be maintained by the physician and/or provider and available to the contractor upon request.

This supporting information may be requested by CMS and its agents on a routine basis in instances where diagnoses on the claims do not clearly indicate medical necessity. The "Medicare Program Integrity Manual" is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html> on the CMS website.

Section 1833(e) of the Social Security Act states that "No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period."

Also, consider any Local Coverage Determinations (LCDs) that may have been made by your Medicare contractor. These LCDs are documented in the CMS Medicare Coverage Database available at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx> on the CMS website. For example, LCD number L30481 requires, among other requirements, the following:

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- Documentation in the medical record must contain the initial evaluation including history and physical examination, diagnosis, pain and disability of moderate to severe degree, site of injection with name and dosage of drug instilled, and the patient's response to the prior injections.
- Documentation of conservative therapies that were tried and failed except in acute situations such as acute disc herniation with disabling and debilitating pain, herpes zoster and post herpetic neuralgia, reflex sympathetic dystrophy, post operative and obstetric pain and intractable pain secondary to carcinoma.
- Pre and post procedure evaluation documenting patient's response to the injection, including pain level and ability to perform previously painful maneuvers must be included in the medical record.

**LCD number L27512 requires the following specific documentation requirements for Transforaminal Epidural and Paravertebral Facet Joint Injections:**

- The patient's medical record must indicate the medical necessity of services for each date of service billed and the frequency. This must include the patient's history (complete pain history and inclusion of failed conservative measures), physical examination and adequate follow-up documentation specific to patient response to the nerve blocks.
- The pre-procedure evaluation leading to suspicion of the presence of the facet joint pathology must be explicitly documented in the patient's medical record along with the post procedure conclusions or the reasoning behind the need for a transforaminal epidural injection must be explicitly documented in the patient's medical record along with post procedure conclusions. All documentation must be available to Medicare upon request.
- The primary codes *64479*, *64483*, *64490* and *64493* are used for a single injection in the cervical/thoracic or lumbar/sacral areas of the spine, respectively. Each primary code has an associated add-on code, *64480*, *64491*, *64492* (cervical/thoracic) and *64484*, *64494* and *64495* (lumbar/sacral) for use when injections are provided at multiple spinal levels. Unilateral injections are performed on one side of the joint level, while bilateral injections are performed on the right and left side of the joint level. The Centers for Medicare and Medicaid Services (CMS) requires physicians to indicate a bilateral injection by using billing modifier 50. Unilateral injections must be identified by an appropriate RT or LT.

**In addition, LCD number 27512 discusses the following general documentation requirements:**

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- All documentation must be maintained in the patient's medical record and available to the contractor upon request.
- Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.
- The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code should describe the service performed.
- The patient's record should document an appropriate history and physical examination by the anesthesiologist/anesthetist specifying the medical indications requiring his/her presence when applicable. The indications should be recorded by both the anesthesiologist/anesthetist and the provider performing the injection in their respective notes.

## Additional Information

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If you are unsure of, or have questions about, documentation requirements, contact your Medicare contractor at their toll-free number which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

You can find the entire OIG report on inappropriate Medicare payments or transformational epidural injection services at <http://oig.hhs.gov/oei/reports/oei-05-09-00030.pdf> on the OIG website.

**News Flash - It's Not Too Late to Give and Get the Flu Vaccine.** Take advantage of each office visit and continue to protect your patients against the seasonal flu. Medicare will continue to pay for the seasonal flu vaccine and its administration for all Medicare beneficiaries through the entire flu season. The Centers for Disease Control and Prevention (CDC) recommends that patients, health care workers, and caregivers be vaccinated against the seasonal flu. Protect your patients. **Protect your family. Protect yourself. Get Your Flu Vaccine - Not the Flu.**

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