

Coding and Reimbursement Issues for Platelet-Rich Plasma

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As of July 1, 2010, there were new changes in the reporting of platelet-rich plasma (PRP) injections. This review summarizes what this service is and the proper coding required of PRP injections.

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As of July 1, 2010, there are new changes in the reporting of PRP injections. This review summarizes what this service is and the proper coding required of PRP injections. PRP has several different names, such as autologous conditioned plasma, Symphony II Platelet Graft Concentrate System, platelet-poor plasma, and platelet-derived growth factors (PDGF), just to name a few. The specific wording used in the supporting documentation or procedure note is critical to the coding and reimbursement process. An example of what one might include in a procedure note includes the following: "A 10 mL blood sample was drawn in a syringe from the patient utilizing an 18-gauge needle to prevent hemolysis. The syringe was preloaded with 2 mL of sodium citrate as an anticoagulant. The blood was introduced into the separation chamber utilizing aseptic technique. The blood was separated and the platelets were concentrated in a five-minute spin cycle. The separated platelets were then removed." There are 2 common situations in which PRP is most frequently used:

during a surgical procedure and a "stand-alone" office-based procedure/service.

Surgical Procedure Usage

If one is performing a PRP injection during a surgical procedure, all official sources (Center for Medicare and Medicaid Service [CMS], Current Procedural Terminology [CPT], American Academy of Orthopaedic Surgeons [AAOS], and so on) state that there would be no additional "professional" service CPT coding reported. The best reference is the April 2009 CPT Assistant where it states "The placement/injection of the cells into the operative site is an inclusive component of the operative procedure performed and not separately reported separately." This is also stated in chapter 1 of the National Correct Coding (NCCI) guidelines as well as CMS Manual Claims processing 100-04 chapter 12 section 40 where it describes what is considered inclusive in a given surgical procedure.

"Stand-Alone" Usage

When performing PRP in a stand-alone situation, such as in the office, Ambulatory Surgical Center (ASC), or outpatient facility, and this is the only procedure performed, there is now a category III code that is used to report the "professional" service being rendered. The code that should be reported is 0232T: Injection(s), Platelet Rich Plasma, any tissue, including image guidance, harvesting, and preparation when performed. There are very significant bundling issues provided for this code; CPT states the following: "Do not report 0232T in conjunction with

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The information supplied here is based on CPT and CMS current guidelines and policies. Private payers/carriers can have their own policies and procedures that you will need to check with. As with all coding, guidelines can change and it is up to the coder/physician to ensure that they have all the current and accurate information. Authors do not assume any responsibility or liability for reimbursement decisions or claims denials made by payers because of the use of this coding information.

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20550, 20551, 20926, 76942, 77002, 77012, 77021, 86965.” This is an all-inclusive code meaning no additional reporting for the harvesting, spinning, inserting, or radiologic guidance. Code 0232T covers it all. There have been references to different types of “techniques” used in providing a PRP injection. One such technique is called “peppering.” Peppering has to do with placing the needle in multiple locations, and specific language includes the following: “recommend using a peppering technique spreading in a clock-like manner to achieve a more expansive zone of delivery, needling in 5 different places at times.” This still falls under the 0232T if performed as a stand-alone procedure.

Just because there is now a code, it does not mean that payers/carriers will start to reimburse the service. Many payers/carriers still have their internal policies of noncoverage. This means that the patient may have a financial responsibility associated with the PRP injection. It is advised that the patient is provided with a waiver similar to an Advanced Beneficiary Notice (ABN), which Medicare has to alert a patient and which requires the patient’s signature to ensure that he/she understands that he/she is responsible for the bill (ABN available at: <http://www.cms.hhs.gov/transmittals/downloads/R83NCD.pdf>).

Facility Reporting

Facilities that wish to submit a claim for this procedure should reference CMS Transmittal 1984, which provides information related to facility reporting and issues pertaining to their ability to report 0232T.

Carriers/Payer Issues

Most payers/carriers have internal policies of noncoverage for PRP-type services. A few examples are provided below, but providers should reference their specific contracts with the payer/carrier.

http://www.bcidaho.com/providers/medical_policies/med/mp_20116.asp: this policy addresses the use of blood-derived growth factors, including recombinant PDGFs and PRP, as a primary treatment of wounds or other musculoskeletal conditions, including but not limited to the treatment of diabetic ulcers, ulcers related to venous stasis, lateral epicondylitis (ie, tennis elbow), planar fasciitis, or Dupuytren contracture.

PDGFs are frequently used as an adjunct to surgery, including but not limited to their use in periodontal, plastic/reconstructive, and orthopedic procedures; adjunctive use of PDGF is considered outside the scope of this policy. This policy only discusses use of blood-derived growth factors as a primary treatment. PRP is distinguished from fibrin glues or sealants, which have been used for many years as a surgical adjunct to promote local hemostasis at incision sites. Fibrin glue is created from platelet-poor plasma and consists primarily of fibrinogen. Commercial fibrin

glues are created from pooled homologous human donors; Tissel (Baxter) and Hemaseal are examples of commercially available fibrin sealants. Autologous fibrin sealants can be created from platelet-poor plasma. This policy does not address the use of fibrin sealants.

Policy: autologous blood-derived preparations (ie, PRP) are considered investigational as a primary procedure for other miscellaneous conditions, including, but not limited to, epicondylitis (ie, tennis elbow), planar fasciitis, or Dupuytren contracture. Autologous blood-derived preparations (ie, PRP) are considered investigational in the treatment of acute or chronic nonhealing wounds, including, but not limited to, Autogel and SafeBlood.

Creative Coding

“Creative coding” of PRP in which finding a code that is “close” but does not really represent the service being rendered is not encouraged and can cause difficulties should a provider audit occur. The CPT guidelines are very clear in the CPT Manual; it states the following: “Select 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. If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code.” Many may feel they can select a code and then append a modifier, such as -22 to say “it is kind of sort of like this CPT code but more difficult” or modifier -52 to say “it is kind of like this but not as hard.” Providers should technically not use this approach because CPT also states “A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.”

Words of Warning/Caution

Even though there may be a specific CPT code, it does not mean that payment will be provided by an insurance company or even Medicare. There are many procedures that are considered “noncovered,” experimental, or lacking medical necessity, which fall to the level of patient responsibility, and, thus, staff should be prepared to have the proper forms and paperwork available to alert patients before the service is rendered.

If there is no CPT code or Healthcare Common Procedure Coding System (HCPCS) code that represents any service/procedure that is being performed, it is not advisable to “create” one. It is not proper to simply “misrepresent” the service with an existing CPT code. When an existing CPT/HCPCS code is being reported, the payer/carrier infers that the described procedure is performed as per the intent of the code. There are several Federal Registers that remind providers of what might happen if this

type of coding and reporting occurs. Examples include the following:

1. Federal Register: March 16, 2000: “knowingly misrepresenting the nature or level of services provided to a Medicare beneficiary to circumvent the program’s limitation is fraudulent.”
2. Federal Register: April 26, 2000: “sanctions may only be imposed against those who act in ‘deliberate ignorance’ or with ‘reckless disregard’ of the truth or falsity of information specified on claims. A physician whose documentation fails to support the level of service submitted for a service code would not be subject to CMP liability unless he/she specifically acted in ‘deliberate ignorance’ or ‘reckless disregard’ of the truth or falsity of the claim. As a result, the Office of Inspector General (OIG) would not consider as a basis for CMP action the submitting of a claim for a service found upon review to be medically unnecessary without evidence that the issue of medical necessity was deliberately ignored or recklessly disregarded. Honest or inadvertent billing or coding mistakes will not be the basis for the imposition of CMPs. In addition, CMPs may be imposed only where a ‘pattern’ of improper claims with upcoded procedures or unnecessary services exists. Sanctions will be imposed only in appropriate cases where a ‘pattern’ of upcoding or billing for unnecessary services has been identified. The knowledge standard in the statute requires that providers assume responsibility for appropriate billing of their services. It is not our intent, however, to subject physicians to penalties for legitimate disagreements over the medical necessity of items and services or for honest mistakes or errors. The OIG intends to impose CMPs only after establishing that a provider knew that a billed item or service was not medically necessary, or that he or she deliberately ignored or recklessly disregarded such information. In response to comments, we are revising Sec. 1003.102(a)(6) by adding the words ‘knows or should know’ to read as follows: ‘An item or service that a person knows or should know is medically unnecessary, and which is part of a pattern of such claims’ (emphasis added). We are also amending the proposed Sec. 1003.102(a)(6) by deleting the words ‘or practice’ from this section in order to be consistent with language set forth in HIPAA.”

In an effort to help illustrate common examples of how PRP might be used and appropriately handled for reimbursement, the following frequently asked questions are provided:

1. As an office procedure, when I submit CPT Code 0232T, is there a 100% chance that there will be no reimbursement?

Answer: Probably yes; most payers/carriers still have non-coverage policy—patient liability. However, there recently has been some new activity with the

Food and Drug Administration regarding usage. Offices will need to check on a regular basis (quarterly) with their contracted payers to see if their policies have changed regarding PRP.

2. Can we do and bill an ultrasound-guided injection 86965 of PRP and not bill/report the PRP 0232T code?

Answer: No; because there is now a code for PRP (0232T), you cannot report something different. This code 86965 “pooling of platelets or other blood products” was never intended to be reported for PRP. That is why it states under code 0232T that you cannot report WITH 86965; it also appears to indicate you are not to use that code to represent PRP.

3. If we cannot do number 2, can we submit 0232T with a letter/paper claim and a “proxy code” as saying it is equivalent to something (ie, 86965)?

Answer: When submitting the 0232T code, which currently has no Relative Value Unit (RVU) value associated with it, you will want to report the value of the whole procedure. Remember that radiologic guidance is now included along with harvesting and preparation of PRP. That means your dollar amount assigned on the claim form should represent all service values. You may also need to justify that dollar amount to a given payer/carrier, and so finding a CPT code with work RVUs that are similar in value could be helpful. However, I would not recommend referencing 86965 because this code also has no RVU value assigned to it per CMS because they have stated this code has a statutory exclusion. These codes represent an item or service that is not in the statutory definition of “physician services” for fee schedule payment purposes. No RVUs or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule. Examples of this include ambulance and clinical diagnostic laboratory services.

4. Does Medicare have a policy that they will not cover PRP injections?

Answer: There is a national coverage determination by Medicare now for PRP—NCD 270.3 This national Medicare policy states the following:

C. Nationally Noncovered Indications:

Effective December 28, 1992, the Centers for Medicare and Medicaid Services (CMS) issued a national noncoverage determination for platelet-derived wound-healing formulas intended to treat patients with chronic, nonhealing wounds. This decision was based on a lack of sufficient published data to determine safety and efficacy and a public health service technology assessment.

Effective July 23, 2004, upon reconsideration, the clinical effectiveness of autologous PDGF products continues to not be adequately proven in scientific literature. Because the evidence is insufficient to

conclude that autologous PDGF in a platelet-poor plasma is reasonable and necessary, it remains noncovered for the treatment of chronic, nonhealing cutaneous wounds. Also, the clinical evidence does not support a benefit in the application of autologous PRP for the treatment of chronic, nonhealing, cutaneous wounds. Therefore, CMS determines it is not reasonable and necessary and is nationally non-covered.

Effective April 27, 2006, coverage for treatments using becaplermin, a nonautologous growth factor for chronic, nonhealing subcutaneous wounds, remains nationally noncovered under Part B based on section 1861 (s)² (A) and (B) of the Social Security Act because this product is usually administered by the patient.

Effective March 19, 2008, upon reconsideration, the evidence is not adequate to conclude that autologous PRP is reasonable and necessary and remains non-covered for the treatment of chronic nonhealing, cutaneous wounds. Additionally, upon reconsideration, the evidence is not adequate to conclude that autologous PRP is reasonable and necessary for the treatment of acute surgical wounds when the autologous PRP is applied directly to the closed incision, or for dehiscent wounds.

D. Other

In accordance with Section 310.1 of the National Coverage Determinations Manual, the routine costs in federally sponsored or approved clinical trials assessing the efficacy of autologous PRP in treating chronic, nonhealing cutaneous wounds are covered by Medicare.

5. What should we do if we have been billing and reporting under a different code and getting paid from Medicare?

Answer: Here is what one Medicare carrier has recently done, in an essence putting physician on notice that they better pay back if they billed PRP with inappropriate codes: "First Coast June 2010—Improper billing of blood platelet grafts. Providers have been improperly associating blood platelet grafts with CPT code 20926 (tissue grafts and others [eg, paratenon, fat, and dermis]). The CMS currently has a national coverage determination (Publication 100-03, National Coverage Determination [NCD] 270.3) supporting noncoverage of this service. Autologous blood derived products for chronic, nonhealing wounds includes both PDGF products (such as procurem) and PRP. These services are nationally noncovered under NCD 270.3 for the treatment of chronic nonhealing, cutaneous wounds (cutaneous is further defined in the national coverage analysis to include superficial and deeper wounds). Effective March 19, 2008, this service is na-

tionally noncovered for the treatment of acute surgical wounds when the autologous PRP is applied directly to the closed incision or for dehiscent wounds. Additionally, any services directly related are also noncovered. Providers are encouraged to audit their records to determine if services were incorrectly billed to the Medicare program. In situations in which providers may have inappropriately billed and were incorrectly paid for CPT code 20926 for grafting techniques using PRP, it would be expected that a voluntary reimbursement of the overpayment be sent to the First Coast Service Options Inc Medicare program to proactively take action and/or address the identified error. The appropriate form along with instructions and mailing address for submitting a voluntary refund may be found at <http://medicare.fcso.com/Forms/138379.pdf>.

6. Can we, for private insurance, not bill anything and simply charge the patient an amount?

Answer: Possibly, depending on if you are contracted or not contracted with the given payer/carrier. If you are contracted with a given payer/carrier, it is usually your responsibility to find out if the service is a noncovered service/procedure and is more of a patient liability before billing the patient directly. What is recommended is that office/facilities should determine what their contracted private insurance policies are regarding PRP and then make a copy of the "noncoverage" section and then provide a copy to the patient along with your internal form (waiver) so the patient knows they will have to pay.

7. If we do what is explained in 6, do we have to have them sign a waiver?

Answer: It would still be a good idea of getting them to sign a waiver. This protects the office/facility in cases in which patients may come back and say they did not know that their insurance would not pay for this.

8. For Medicare, do we bill them 0232T only and when we get no payment, can we charge a patient after they sign the "ABN" waiver?

Answer: Because Medicare has a national "noncoverage" policy, you would really only need to bill Medicare if the patient requests that you bill to get a denial. You would then have them sign the ABN waiver, and on your claim either append modifier GA (waiver of liability statement issued as required by payer policy, individual case) or GY (item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for Non-Medicare insurers, is not a contract benefit). When providing the waiver for Medicare patients, I would also recommend that you provide them the copy of

the national policy of noncoverage. Medicare technically does not require an ABN for “non-covered” services, but it still may be a good policy to acknowledge that the patient was aware of these facts.

9. Can we bill an injection procedure (with or without imaging) and just charge the patient for the durable goods?

Answer: Probably not now that there is a CPT category III code; you will have to use that code.