



Tricky Facet Joints

OIG FOCUSES ON OVERPAYMENT FOR FACET BLOCKS

By Jackie Miller, RHIA, CCS-P, CPC, PCS

In September of 2008, the Health and Human Services Office of Inspector General (OIG) published the results of an audit of Medicare facet-joint injection claims (<http://oig.hhs.gov/oei/reports/oei-05-07-00200.pdf>). The audit was triggered by a 76% increase in Medicare payments for facet-joint injections from 2003 to 2006. The OIG's auditors reviewed medical records and claims data for 646 injections performed in 2006.

The audit revealed that 63% of the services did not meet Medicare payment criteria due to lack of documentation,

injections are considered a *single* injection service.

The following codes are used for facet-joint injections and medial branch nerve blocks:

Code 64470 is used to report injection of a single cervical or thoracic facet joint or the medial branches that innervate it. Code 64472 is used to report each additional cervical or thoracic level that is injected. Code 64475 is used to report injection of a single lumbar or sacral facet joint or the medial branches that innervate it. Code 64476 is used to report each additional lumbar or sacral level injected.

CPT® CODE	DESCRIPTION
64470	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level
+64472	—cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64475	—lumbar or sacral, single level
+64476	—lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

incorrect coding, and/or lack of medical necessity. Of the coding errors, 82% involved overpayments by Medicare. Let's look at the coding guidelines for facet-joint injections, then revisit the OIG audit findings.

Identifying the Right Codes

Each vertebra is linked to the vertebra above it and the vertebra below it by a pair of facet joints. These joints can be a source of back, neck, or extremity pain. The pain can be treated by injection into the facet joint itself. With the patient prone, and under fluoroscopic guidance, a needle is passed through the skin of the patient's back into the facet joint. Contrast is used to visualize the anatomy and ensure correct needle placement. Then a steroid/anesthetic solution is injected into the joint.

Some patients may require a targeted medial-branch nerve block rather than a regular facet-joint block. Each facet joint is supplied by the medial branches of two different spinal nerves. For example, the facet joints at L2-3 are supplied by medial branches from the L1 and L2 spinal nerves. For this reason, the physician must actually block two median nerves for each facet joint. In the case of a medial branch nerve block at L2-3, for example, the physician would inject the medial branches of L1 and L2. For coding purposes, these two

According to the AMA (*CPT® Assistant*, September 2004), codes 64470-64476 should be reported once per level, per side, regardless of the number of needle placements that are required. Therefore, if injections are performed on both sides of one vertebral level, the base injection code (64470 or 64475) should be reported with modifier 50 (bilateral procedure). And if a second level is injected bilaterally, the add-on code (64472 or 64476) should be reported with modifier 50.

Example: Under fluoroscopic guidance, a physician inserts two needles and injects medication around both medial branch nerves supplying the left L3-4 facet joint. Report code 64475 for the unilateral injection and 77003 for the fluoro guidance.

Example: Under fluoroscopic guidance, a physician performs bilateral facet joint injections at L3-4 and L4-5. Report code 64475-50 for the bilateral injection at L3-4 and 64476-50 for the bilateral injection at L4-5, as well as 77003 for the fluoro guidance.

OIG Findings of Incorrect Claims

Now, back to the OIG findings. Nearly two-thirds of the coding errors identified by the OIG involved bilateral injections. In most cases, the physician reported a bilateral injection by listing the base code for the first side (*continued on page 27*)

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and the add-on code for the second side at the same level. For example, a bilateral single-level lumbar facet block was coded as 64475 and 64476 rather than 64475-50. National average Medicare payment for 64475-50 is \$114 (150% of the allowable for 64475). However, payment for 64475 and 64476 is \$123, since both codes are paid at 100%. The overpayment is higher in cases where multiple levels were injected during the same encounter, which is a very common occurrence.

Why did providers submit so many incorrect claims? At least part of the problem results from discrepancies between Medicare requirements and the requirements of other payors. Some payors do not follow the Medicare guidelines for bilateral claims and have instructed providers to report the second side of a bilateral injection with the add-on code instead of modifier 50. There have even been reports of Medicare contractors giving providers incorrect billing instructions for bilateral claims.

At this point the best advice is to bill bilateral facet-joint injections to Medicare following the guidelines outlined in the OIG report. And if a non-Medicare payor is unable to process bilateral claims correctly when billed according to Medicare's rules, try to get the payor's instructions in writing to protect yourself and your client.

The Documentation Dilemma

Another cause of incorrect claims is incomplete or unclear documentation. Although many pain physicians are meticulous about their record-keeping, others are not. This problem tends to be worse when the facet injections are performed in the office setting, where the physician is more likely to make do with handwritten notes rather than dictating a procedure report. In some instances the physician's documentation is so cryptic that even a knowledgeable and experienced coder will have difficulty determining what codes should be billed.

This is particularly true in the case of medial branch blocks, where the number of needle placements is not equal to the number of injections that can be coded. When poor documentation threatens to result in incorrect billing, the billing company should not hesitate to bring the problem to the physician's attention. The stakes are too high to allow the matter to slide for fear of annoying the client. ▲

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