Part B Insider (Multispecialty) Coding Alert

Compliance: OIG Finds 63-Percent Error Rate on Facet Joint Injections -- Here's How to Avoid Problems

Hint: Bilateral injection errors accounted for scores of issues

According to a Sept. 17 OIG report, practices billing facet joint injections should be double-checking their claims.

The OIG report, entitled Medi-care Payments for Facet Joint In-jection Services, states, "Sixty-three percent of facet joint injection services allowed by Medicare in 2006 did not meet Medicare program requirements, resulting in approximately $96 million in improper payments for physician services."

Office-based errors: The report indicates that 71 percent of facet joint injections performed in physicians' offices contained errors, while only 51 percent of facility-based facet joint injections showed errors.

If you don't want to become an OIG statistic, follow these quick tips to ensure that you're reporting facet joint injections properly.

Add-Ons Apply to Extra Levels

When reporting facet joint injections, you should choose either 64470 (Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level) or 64475 (... lumbar or sacral, single level), depending on the spinal area your physician treats.

For each additional level the physician injects in the cervical or thoracic area, report +64472 (... cervical or thoracic, each additional level). For each additional level he injects in the lumbar or sacral area, turn instead to +64476 (... lumbar or sacral, each addition- al level).

Clarify terminology: Although the descriptors for 64470-64476 specify spinal "levels," your doctor actually targets facet joint injections at the space between vertebrae (in other words, the interspace), not at the vertebrae themselves, says **Alexandra Cortina** with **Pain Billing Pros** in Clearwater, Fla.

If the physician documents, for instance, "Facet joint injection at C4-C5," this represents a single injection to the interspace between the fourth and fifth cervical vertebrae, not two separate injections at the fourth and fifth cervical vertebrae.

Keep Modifier 50 at Hand

You should report only a single unit of service for multiple injections at the same spinal level -- unless your physician provides the injections bilaterally. Simply append modifier 50 (Bilateral procedure) for bilateral injections, but be careful to not exceed your carrier's utilization guidelines, says **Heather Corcoran** with **CGH Billing**.

OIG note: The OIG report indicated that over 60 percent of the errors it found were "Instances in which the physician billed incorrectly for bilateral facet joint injections."

For example: Physicians reported add-on codes to indicate that a second side of a spinal level was injected, although they should have simply appended modifier 50 to the primary injection code.

Other side of the coin: The OIG also indicated that it discovered 29 underpaid services during the audit, and that 100 percent of the undercoded services were instances when the physician billed for unilateral services when he actually performed bilateral injections, "resulting in a 50 percent underpayment," the report said.

These examples of the OIG's findings underscore the importance of thorough documentation and correct coding when it comes to bilateral injections.

For instance: Your physician injects intra-articularly or directly into the joint at the right and left C4-C5 and C5-C6 facet joints. You should report 64470-50 (for the initial bilateral injection at C4-C5) and 64472-50 (for the additional bilateral injection at C5-C6).

To read the complete OIG report, visit http://www.oig.hhs.gov/oei/reports/oei-05-07-00200.pdf.