Part B Insider (Multispecialty) Coding Alert

FACET JOINT COMPLIANCE: Physicians Overbilled Facet Joint Injections by $96 Million, OIG Says

CMS warns MACs to be on the lookout for improperly billed injections.

Making a $50 error might not seem like a big deal -- but add all of those errors together and you could put a giant dent in Medicare's injection payment structure.

That's the word from CMS transmittal 440, issued Feb. 6. The OIG examined facet joint injections that practices performed in 2006 in their offices, and discovered an outrageous 63 percent error rate, which racked up $96 million in improper payments for these services. Due to the OIG's findings, CMS advises its carriers to strengthen safeguards to prevent improper facet joint injection billing.

Follow our experts' tips to ensure that you stay out of the OIG's crosshairs when you bill these procedures.

The challenge: One potential snag in facet joint injection coding is whether to report multiple units of a code when the doctor performs more than one injection.

For example: If a physician administers a 3-level lumbar injection, such as right L3-L4, L4-L5 and L5-S1, does the practice report three codes with a modifier appended to them? Should they use an add-on code (e.g, 64475 followed by 2 units of +64476)? Or should they use a different method?

"From a CPT coding perspective the add-on codes (+64472, +64476,+64623, +64627) do not require a modifier when the procedure is unilateral," says consultant J**oanne Mehmert, CPC, CCCPM, ACS-PM** of Joanne Mehmert & Associates, LLC.

You can, however, append the appropriate RT (Right side) or LT (Left side) modifier for these unilateral injections for informational purposes only, says **Marvel J Hammer, RN, CPC, CCS-P, PCS, ACS-PM ,CHCO,** with MJH Consulting. In the above example, the unilateral injections would be reported as follows, she advises:

1. 64475 x 1 for first level L3-L4
2. 64476 x 2 for the two additional levels -- L4-L5 and L5-S1

Or with the informational right side (RT) modifier:

3. 64475-RT x 1 for first level L3-L4
4. 64475-RT x 2 for the two additional levels -- L4-L5 and L5-S1

"The problem lies in the thirdparty payer processing of the claims and use of modifiers," Mehmert says. "Facet procedures are especially complicated in this regard -- even Medicare carriers vary in claim processing. It is especially complicated for Medicare when the procedures are bilateral. There is no one answer to this question because there are as many layers as there are insurers."

Snafu repair: "Some payers' claims processing software have 'difficulty' processing multiple units of 'add-on' codes such as +64476," Hammer says. "In that case, a provider may need to report the last add-on code as a separate line item.

"To prevent the payers' claims processing software from denying the last line item as a duplicate, in most cases providers would need to append a modifier to indicate the second line item of the add-on code was not a charge entry

error but rather a separate and distinct injection procedure at a different level, Hammer advises. She offers the following example:

5. 64475 x 1 for first level L3-L4
6. 64476 x 1 for the first additional level L4-L5
7. 64476-59 x 1 OR 64476-76 x 1 for the second additional level L5-S1.

Remember: You'd only use this method if a payer has difficulty correctly processing multiple units of service of the add-on codes,Hammer says.

Stay tuned next week when we show you how to avoid the errors the OIG found regarding bilateral facet joint injections.

To read CMS's transmittal on facet joint injection billing, visit www.cms.hhs.gov/transmittals/downloads/R440OTN.pdf.