Eli's Rehab Report

Reader Question: Facet Joint Injection Has Global Period

Question: Our physiatrist performed a facet joint injection (64622, Destruction by neurolytic agent, paraver-tebral facet joint nerve; lumbar or sacral, single level) with fluoroscopic guidance (76005, Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural, transforaminal epidural, subarachnoid, paraver-tebral facet joint, paravertebral facet joint nerve or sacroiliac joint], including neurolytic agent destruction). The following week, we evaluated the patient for the same condition. Medicare denied the E/M service because it says it falls within the injection's 10-day global period. Is there any way we can get paid for this E/M service?

Illinois Subscriber

Answer: Although this may surprise many physiatrists who aren't accustomed to dealing with global periods, most local medical review policies (LMRPs) assign a 10-day global period to 64622 because they consider it a minor surgical procedure. This may not be the case for some private insurers, but you should contact them to determine whether they assign any global days to the injection service.

The global package includes all preoperative visits starting on the day of the injection, all procedures that are necessary parts of the injection (such as preparing the skin for injection), and all visits related to recovery during the immediate 10 days following the injection.

Because the physiatrist performed the evaluation within the 10-day postoperative period and it was related to the surgery, you cannot seek additional reimbursement for it.

If the E/M visit was unrelated to the injection, Medicare would probably reimburse you for it, provided that you appended modifier -24 (Unrelated evaluation and management service by the same physician during a postoperative period) to the appropriate E/M code (99211-99215) and included documentation indicating why the E/M visit differed from the injection (for instance, include a separate ICD-9 code).

It's a good idea to send your chart notes or operative report along with the claim if you use modifier -24, since insurers may request this information later, which would slow down the claims processing and your reimbursement.