Eli's Rehab Report

Reader Questions: Watch Out for Facet Frequency Guidelines

Question: One of our patients required facet joint injections at four levels, and our insurer paid us for the service. The patient returned to our practice five months later, and we injected the same four levels, but the insurer denied the claim, saying that we had exceeded frequency guidelines. What type of frequency guidelines did we violate?

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Answer: Many insurers restrict the maximum number of code units you can report per session or within a specified time period, experts say.

Empire Medicare Services, a Part B carrier in New York and New Jersey, for instance, instructs that claims in excess of six units of 64470-64476 (three bilateral or six unilateral) for the same patient within a 180-day period "may be subject to review."

In addition, Empire's policy states, "Facet joint nerve block injections on more than three spinal levels to a patient on the same day are not considered medically necessary."

Therefore, although your payer was more liberal than Empire when it paid you for three levels during one visit, your payer probably has similar guidelines limiting you to six units within a 180-day period -- and you billed eight units within 150 days.

Other payers publish similar guidelines. The policy of Noridian, a Medicare carrier, says, "Providing a combination of epidural block, facet joint blocks, bilateral sacroiliac joint injections, lumbar sympathetic blocks or providing more than two levels of facet joint blocks to a patient on the same day is considered not reasonable or necessary. Such therapy can lead to an improper diagnosis or unnecessary treatment." Providers would need to have supportive documentation for the medical necessity for performing more than two levels of facet joint blocks at the same session.