The Many Facets of the OIG Facet Report

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The Office of Inspector General (OIG) is tasked with the protection of the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This mission is fulfilled through OIG audits, investigations and inspections. A September 2008 OIG report summarized one such investigation into Medicare payments for facet joint injection services and drew some startling conclusions.

Interventional pain management procedures – including injections, nerve blocks and spinal cord stimulation, and their reimbursement – have been increasing in volume and payment. In 2006, Medicare paid more than $2 billion for such claims. OIG found that one of these procedures, facet joint injections, an interventional technique used to diagnose or treat back pain through injections administered in the joints located between each vertebra in the spinal column, has seen dramatic increase in the number of claims and Medicare payments.

From 2003-06, the number of Medicare claims for facet joint injections increased by 76 percent, and the amount of Medicare payments (both facility and physician) increased from $141 million to $307 million. These payments account for approximately 15 percent of all 2006 Medicare payments for interventional pain management services. In an era where the government and payers are increasingly interested in value-based purchasing and skeptical of dramatic increases in popularity for a particular procedure, this news should give one pause. But more importantly, OIG found, based on its random sampling methodology analyzing 2006 claims, that 63 percent of claims allowed by Medicare in 2006 did not meet program requirements. The result? Approximately $96 million, or 47 percent of the total physician payments for facet joint injections in 2006, was improperly paid to physicians, and $33 million was improperly paid to facilities.

The primary reasons for improper payments as found by the OIG investigation (taken from Table 4 of the report) are shown in Table 1 on page 33.

Of the approximate $81 million in payments identified as documentation errors, $59 million were found to have been undocumented services in which physicians did not submit medical records to substantiate the claim, or physicians submitted a record but it did not contain documentation of the service. The remaining $22 million in payments had claims in which the records lacked a description of or details about the procedure. The coding errors identified by OIG resulted in a net overpayment of $21 million. A majority of the claims identified as overpayments resulted from instances in which physicians incorrectly billed Current Procedural Terminology (CPT®) add-on codes to represent bilateral facet joint injections instead of using modifier 50. This results in the physician receiving 200 percent of the

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Table 1	SAMPLE		PROJECTED	
Type of Error	**Services**	**Allowed Amount**	**Services**	**Allowed Amount**
Documentation	196	$35,835	38%	$81 million
Coding	173	$11,670	31%	$21 million
Medical Necessity	43	$7,394	8%	$17 million
(Overlapping Errors)	(71)	($12,247)	(14%)	($23 million)
Total	**341**	**$42,651**	**63%**	**$96 million**

base payment rather than the Medicare-allowed 150 percent. OIG did discover some underpayment issues and all involved physicians who only billed for unilateral services when they actually performed bilateral injections.

Since no National Coverage Determination exists with respect to facet joint injections, carriers may develop their own local coverage determinations (LCDs) to describe when services are reasonable and necessary and covered by Medicare. In 2006, 13 of 15 carriers had an LCD for facet joint injections, but a great deal of variation existed between each carrier, and all LCDs struggled to implement frequency limits. The reasons for a lack of frequency limits include a lack of agreement in the medical community about the appropriate frequency and the difficulty in automating edits for frequency.

Some additional interesting points illuminated by the OIG report include:

- Increased likelihood of an error if the injection was performed in an office (71 percent of services surveyed) rather than an ambulatory surgical center or hospital outpatient department (51 percent of services surveyed).

- While anesthesiology was a specialty with one of the lower error rates in terms of facet joint injection claims, the rate itself was still high at 63 percent. Other notable error rates by specialty are general practice (97 percent), internal medicine (87 percent), neurology (73 percent) and pain management (56 percent).

The data presented in the OIG report are troubling from a global perspective, but can be serious trouble for the individual physician. The OIG report specifically cites a successfully prosecuted fraud case from Ohio in which a "pain management" physician submitted more than $60 million in false claims for complex epidural and other interventional pain procedures. According to the U.S. attorney who prosecuted the case, these were actually "crude versions of trigger-point injections." While this physician was clearly operating well outside the standard of care, the OIG data demonstrating a greater than 50-percent error rate in reporting facet injections along with the rapid volume growth in these services calls into question whether best practices have been defined and are being followed.

Since 2004, at least three organizations have published guidelines that have discussed the evidence supporting facet injections.

Resnick et al. in "Guidelines for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 13: injection therapies, low-back pain, and lumbar fusion"[1] concluded that "facet injections... [are] recommended as a treatment option to provide temporary, symptomatic relief in selected patients with chronic low back pain" but cautioned that while facet injections are useful tools in predicting response to radio-frequency ablation, they are not recommended as a diagnostic tool for predicting response to lumbar fusion surgery.

The American College of Occupational and Environmental Medicine (ACOEM) has published practice guidelines[2] that called into question the efficacy of several interventional pain procedures. Many worker compensation agencies and other insurers have historically followed the ACOEM guidelines. A consortium of pain specialty societies objected strenuously to the updated low back and chronic pain chapters[3] as being flawed on several counts. In addition, Manchikanti and colleagues published an extensive review of the methodological issues associated with the guidelines.[4]

In 2007, Boswell et al.[5] published a number of evidence-based guidelines for chronic pain management. These guidelines concluded that "the evidence is strong in the diagnosis of lumbar and cervical facet joint pain" and "moderate" for thoracic facet joint pain. The authors

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determined that the evidence is moderate for lumbar and limited for cervical therapeutic joint injections, moderate for medial branch lumbar and cervical blocks and moderate for neurotomy (e.g., radiofrequency neurolysis). These guidelines addressed cost-effectiveness as part of the review; however, the data available for facet-related procedures were limited to one study of facet medial branch blocks (by one of the guideline's authors) suggesting some improvement in quality of life similar to other neural blockades and better than intrathecal morphine or lumbar laminectomy with or without instrumented fusion.

As previously mentioned, OIG stated its concern with the lack of recommendations or guidelines regarding the appropriate number of levels to be injected at a single setting for diagnostic or therapeutic procedures and the number of repeat therapeutic injections that would be clinically reasonable. These are areas strongly in need of scientific investigation and subsequent consensus recommendations. One recent study did evaluate the efficacy of bone scintigraphy with single photon emission computed tomography, or SPECT, studies in prospectively identifying patients who would most benefit from facet injections.[6] The results demonstrated improved short-term outcomes at an overall reduced cost due to reduction in injections for those not likely to benefit. While the study did not evaluate long-term results, it may point the way to further work to help answer these important clinical questions.

So what should your practice do to avoid some of the mistakes illuminated above? 2009 CPT includes four codes to describe facet joint/facet joint nerve injections.

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

2009 Physician Fee Schedule includes payment increase for anesthesiology

ASA is pleased to announce that the 2009 Physician Fee Schedule includes a nearly 5-percent increase to the national unadjusted Medicare anesthesia conversion factor. Beginning January 1, 2009, the conversion factor will be $20.92, up from $19.97 in 2008.

The increase is a result of provisions included in H.R. 6331, the Medicare Improvements for Patients and Providers Act (MIPPA), which became law on July 15, 2008. Specifically, MIPPA provided a 1.1 percent conversion factor increase and implemented a new formula for calculating budget neutrality, which accounted for approximately an additional 3 percent improvement.

To access the regulation, please visit **http://federalregister.gov/OFRUpload/OFRData/2008-26213_PI.pdf.**