CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One –Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 526	**Date: July 31, 2009**
	Change Request 6518

NOTE: This instruction was originally inadvertently transmitted as Pub. 100-04 Medicare Claims Processing, Transmittal 1786, dated July 31, 2009 and is rescinded and replaced by Transmittal 526, dated July 31, 2009 Pub. 100-20 One-Time Notification. All other information remains the same.

Subject: Appropriate Use of Modifier 50 and Add-On Codes for Facet Joint Injections Services

I. SUMMARY OF CHANGES: This one time notification provides clarification regarding the appropriate use of modifier 50 and add-on codes for Facet Joint Injection Services.

Clarification
Effective Date: August 31, 2009
Implementation Date: August 31, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENT:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 526	Date: July 31, 2009	Change Request: 6518

NOTE: This instruction was originally inadvertently transmitted as Pub. 100-04 Medicare Claims Processing, Transmittal 1786, dated July 31, 2009 and is rescinded and replaced by Transmittal 526, dated July 31, 2009 Pub. 100-20 One-Time Notification. All other information remains the same.

SUBJECT: Appropriate Use of Modifier 50 and Add-On Codes for Facet Joint Injection Services

Effective Date: August 31, 2009

Implementation Date: August 31, 2009

I. GENERAL INFORMATION

A. Background: Facet joints are joints in the spine that aid stability and allow the spine to bend and twist. Facet joint injections are a type of interventional pain management technique used to diagnose or treat back pain. The Current Procedural Terminology (CPT) codes used for facet joint injections are 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), 64475 (Injection; anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar/sacral, single level) and 64476 (Injection; anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar/sacral, each additional level). The two primary codes 64470 and 64475 are used for a single injection in the cervical/thoracic or lumbar/sacral areas of the spine, respectively. Each primary code has an associated add-on code, 64472 (cervical/thoracic) and 64476 (lumbar/sacral) for use when injections are provided at multiple spinal levels. Unilateral injections are performed on one side of the joint level, while bilateral injections are performed on the right and left side of the joint level. The Centers for Medicare and Medicaid Services (CMS) requires physicians to indicate a bilateral injection by using billing modifier 50.

The Office of the Inspector General (OIG) recently conducted a medical record review of facet joint injection services performed in 2006 and released a final report titled “Medicare Payments for Facet Joint Injection Services,” OEI-05-07-00200. The OIG found that physicians incorrectly billed additional add-on codes to represent bilateral facet joint injections instead of using modifier 50.

B. Policy: When facet joint injections are performed on both the right and left side of a level, physicians should use modifier 50. Physicians should use the add-on codes (64472 or 64476) to represent additional levels of the back injected, not sides. Contractors shall use the information in the background above to follow the processes and procedures already in the Claims Processing Manual concerning the appropriate use of modifier 50.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6518.1	Contractors shall be aware that physicians should use modifier 50, when facet joint injections are performed on both the right and left side of a level.	X		X	X						
6518.2	Contractors shall be aware that physicians should use the add-on codes (64472 or 64476) to represent additional levels of the back injected, not sides.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6518.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Gaysha Brooks, Gaysha.Brooks@cms.hhs.gov, (410) 786-9649

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: ***For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carries:***

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***For Medicare Administrative Contractors (MACs):***

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.