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Medicare Improperly Paid Physicians an Estimated $15.2 Million for Sacroiliac Joint Injections

REPORT HIGHLIGHTS

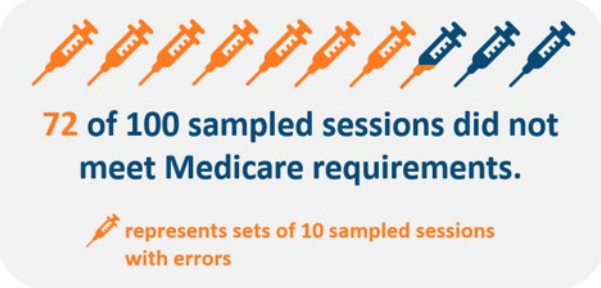
August 2026 | OAS-25-09-021

Medicare Improperly Paid Physicians an Estimated $15.2 Million for Sacroiliac Joint Injections

Why OIG Did This Audit

- Sacroiliac joint injections (a type of spinal pain management service) are covered under Medicare Part B when medically reasonable and necessary.
- In two prior audits of facet-joint interventions (another type of spinal pain management service), we found that Medicare paid for more than 50 percent of the sampled services that did not comply with one or more Medicare requirements.
- Because we identified a high risk of noncompliance with facet-joint interventions, we conducted this nationwide audit to determine whether Medicare paid physicians for sacroiliac joint injections in accordance with Medicare requirements and guidance.

What OIG Found



- Of the 100 sampled sessions, 72 did not comply with Medicare requirements. In addition, of the 100 sampled sessions, physicians' billing of 25 sessions did not meet Medicare guidance.
- On the basis of our sample results, we estimated that Medicare improperly paid $15.2 million for 134,526 of 186,842 total sessions from October 1, 2023, through September 30, 2024. We also estimated that physicians incorrectly billed 46,711 sessions as therapeutic injections when they should have been billed as diagnostic injections.
- Oversight provided by CMS and the Medicare Administrative Contractors (MACs) was not sufficient to ensure compliance with Medicare requirements and guidance.

What OIG Recommends

We made three recommendations to CMS, including that it work with the MACs to develop education that is specific to the Medicare requirements, guidance for sacroiliac joint injections to prevent improper Medicare payments, and solutions to prevent the incorrect billing of diagnostic injections as therapeutic injections. The full recommendations are in the report.

CMS concurred with our first and second recommendations, but did not concur with our third recommendation.

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INTRODUCTION

WHY WE DID THIS AUDIT

Sacroiliac joint injections are used to improve spinal motion and provide pain relief. Medicare Part B covers spinal pain management services, such as sacroiliac joint injections, when they are medically reasonable and necessary. Prior Office of Inspector General (OIG) audits found that Medicare improperly paid physicians for spinal pain management services. (See Appendix B for related OIG reports.) In two audits, we found that Medicare improperly paid physicians for facet-joint interventions for more than 50 percent of the sampled services that did not comply with one or more of the Medicare requirements.[1] We conducted this audit of sacroiliac joint injections because we identified a high risk of noncompliance with Medicare requirements for facet-joint interventions.

OBJECTIVE

The objective of our audit was to determine whether Medicare paid physicians for sacroiliac joint injections in accordance with Medicare requirements and guidance.

BACKGROUND

Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Medicare Part B provides supplementary medical insurance for medical and other health services. CMS contracts with seven Medicare Administrative Contractors (MACs) to, among other things, determine reimbursement amounts and pay claims, safeguard against fraud and abuse, and establish local coverage determinations (LCDs).[2, 3] The MACs are responsible for processing claims submitted by physicians within 12 designated geographic areas, or jurisdictions, of the United States and its territories.

MACs also provide education to providers and suppliers about Medicare billing requirements and new LCDs. MACs have discretion to determine the educational topics that are most relevant to their provider populations.

[1] Facet-joint interventions treat neck or back pain resulting from arthritis in or injury to the spinal facet joints.

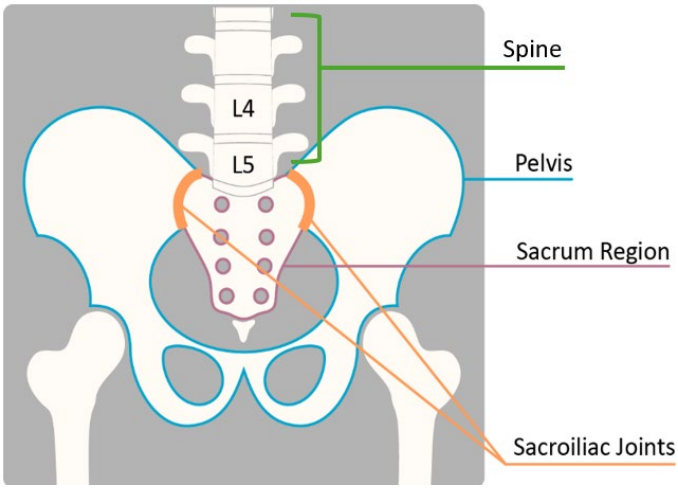
[2] An LCD is a determination by a MAC on whether to cover a particular item or service on a contractor wide basis in accordance with section 1862(a)(1)(A) of the Act.

[3] Congress delegated to MACs the function of developing LCDs, as defined in section 1869(f)(2)(B) of the Act. MACs have the authority to determine when an LCD should be developed. The statute does not mandate LCDs to be uniform across all jurisdictions.

Sacroiliac Joint Injections

Sacroiliac joints are the joints that connect the lower spine to the pelvis. (See Figure 1.) These joints provide a range of functions, including supporting upper-body weight, walking, and changes in posture or position (e.g., changing from a standing position to a sitting position). The sacroiliac joints can become painful because of various conditions, including sacroiliac joint dysfunction, which is a condition caused by excessive or insufficient movement of the sacroiliac joint, usually from injury, pregnancy, or osteoarthritis.

Figure 1: Pelvis and Sacroiliac Joints



To improve spine movement and provide pain relief, a physician can administer a sacroiliac joint injection.[4] First, a diagnostic injection is administered to confirm whether the sacroiliac joint is the source of lower back pain. If a person experiences significant pain relief immediately after the injection, it strongly indicates that the sacroiliac joint is the source of the pain. Then, a therapeutic injection is administered after the sacroiliac joint is determined to be the source of pain, with pain relief expected to last up to 6 months.

Medicare Coverage of Sacroiliac Joint Injections

Medicare Part B covers sacroiliac joint injections when they are medically reasonable and necessary. Of the seven MACs, five MACs issued LCDs that list Medicare requirements for sacroiliac joint injections related to: (1) indications of pain, (2) imaging and pain assessment, (3) limitation of coverage, and (4) diagnostic and therapeutic injections.[5] In addition to these requirements, the LCDs limit coverage to a maximum of two sessions of diagnostic sacroiliac joint injections and a maximum of four sessions of therapeutic sacroiliac joint injections within a rolling 12-month period, whether performed unilaterally or bilaterally. Furthermore, each of the five MACs issued a related billing and coding LCD Reference Article for sacroiliac joint injections, providing billing and coding guidance needed to implement the LCD requirements. According to the LCD Reference Articles for sacroiliac joint injections, if a diagnostic injection

[4] Physicians who administer sacroiliac joint injections include those who specialize in interventional pain management, anesthesiology, and radiology.

[5] The five MACs that established LCDs for sacroiliac joint injections are CGS Administrators, LLC; National Government Services, Inc.; Noridian Healthcare Solutions, LLC; Palmetto GBA; and Wisconsin Physicians Service Insurance Corporation.

was administered, the physician must add to each claim line the modifier "KX" to distinguish the injection from a therapeutic injection.[6]

These LCD requirements and LCD Reference Article billing guidance are for sacroiliac joint injections performed on or after March 19, 2023. Appendix C shows the MAC and geographic composition for each jurisdiction, along with the corresponding LCDs and LCD Reference Articles that were in effect during our audit period.

Physician Submission of Claims for Sacroiliac Joint Injections and the Use of Procedure Codes

Federal law prohibits Medicare payment to a physician unless the physician has furnished information necessary to determine the amounts due.[7] Each submitted Medicare Part B claim must contain specific detail regarding each provided service.

To receive Medicare payment for a sacroiliac joint injection, the physician must indicate on the claim—using Current Procedural Terminology (CPT®)[8, 9] codes—whether the injection was administered directly into the sacroiliac joint or to the nerves that innervate the joint.[10]

- CPT code 27096 is used for injections made directly into the sacroiliac joint.
- CPT code 64451 is used for injections targeting the nerves that innervate the sacroiliac joint.

[6] A modifier is a two-character code that can be reported with a Current Procedural Terminology (CPT) code to give Medicare additional information needed to process a claim. CMS, *Medicare National Correct Coding Initiative Manual*, chapter I, § E, Jan. 1, 2024. Accessed Jan. 14, 2026.

[7] The Act § 1833(e).

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[10] Nerves that innervate the sacroiliac joints transmit sensory information and control movement.

HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicare Part B payments for 186,970 claim lines for sacroiliac joint injections, which we grouped into 186,842 sessions, with dates of service from October 1, 2023, through September 30, 2024 (audit period) for which Medicare paid $22 million.[11] Payments for these claim lines were made by five MACs that issued an LCD (i.e., Medicare requirements) and an LCD Reference Article (i.e., Medicare billing guidance) for sacroiliac joint injections. We selected for review a random sample of 100 sessions. Medicare paid a total of $11,243 for these sessions.

For each session, we reviewed the physician's supporting documentation to determine whether the session met Medicare requirements (i.e., LCD) and billing guidance (i.e., LCD Reference Article). In addition, we shared our findings with the five MACs that issued LCDs and LCD Reference Articles for sacroiliac joint injections and obtained their agreement with our determinations of the sessions that did not comply with Medicare requirements and sessions that did not comply with Medicare billing guidance. We did not perform medical review of the sampled sessions to determine whether sacroiliac joint injections were medically reasonable and necessary. Our determinations were limited to whether documentation met the applicable LCD coverage and billing requirements.

We also totaled the amounts paid for sacroiliac joint injections by the two MACs without an LCD or an LCD Reference Article. We determined what percentage this amount made up of the total payment for all sacroiliac joint injections nationwide during our audit period. The percentages of the total amounts paid by the two MACs without an LCD or an LCD Reference Article show potential risk of improper payments made for these injections that were not covered in our audit. [12]

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology, Appendix D describes our statistical sampling methodology, and Appendix E contains our sample results and estimates.

[11] A session refers to one or more claim lines for sacroiliac joint injections performed on the same date of service for the same enrollee. We grouped the claim lines into sessions in which the payment was $50 or greater by MAC, Health Insurance Claim (HIC) number, and date of service. Of the 186,842 sessions, 128 included 2 claim lines.

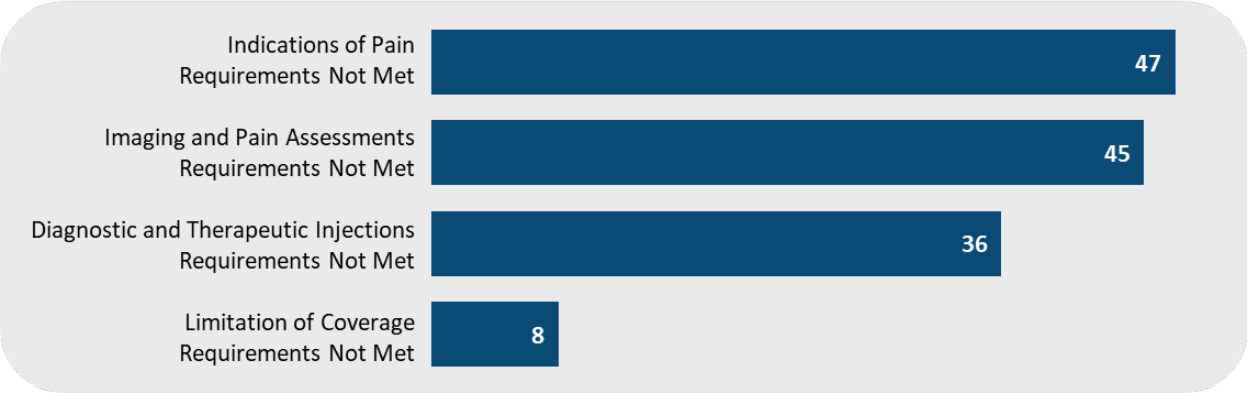
[12] We did not determine whether payments for these sacroiliac joint injections were reasonable or necessary.

FINDINGS

Medicare did not pay physicians for sacroiliac joint injections in accordance with Medicare requirements and guidance. Of the 100 sampled sessions, 28 complied with Medicare requirements and 75 complied with Medicare billing guidance. However, the remaining 72 sessions did not comply with Medicare requirements and 25 did not comply with Medicare billing guidance.

Seventy-two sampled sessions did not comply with one or more of the requirements. Figure 2 shows the number of noncompliant sessions by the type of noncompliance.

Figure 2: Noncompliant Sessions by Type*



* The total exceeds 72 sessions because 41 sessions had more than 1 deficiency.

On the basis of our sample results, we estimated that Medicare made $15.2 million, for 134,526 of 186,842 total sessions, in improper payments to physicians for sacroiliac joint injections for our audit period.[13]

In addition, 25 sampled sessions did not meet Medicare billing guidance. Specifically, the sessions were incorrectly billed as therapeutic sacroiliac joint injections when they should have been billed as diagnostic sacroiliac joint injections, with the appropriate use of modifier "KX."[14] On the basis of our sample results, we estimated that 46,711 of 186,842 total sessions during our audit period were incorrectly billed as therapeutic sacroiliac joint injections when they should have been billed as diagnostic sacroiliac joint injections. Although billing for a therapeutic injection instead of a diagnostic injection does not affect the payment amount that a physician receives, incorrectly classifying the type of injection that was administered could result in the enrollee not receiving the maximum allowable number of medically necessary sacroiliac joint injections sessions during a rolling 12-month period, which may affect the

[13] The estimated improper Medicare payment amount was $15,156,922.

[14] In addition, of the 25 sampled sessions, 19 did not comply with 1 or more of the Medicare requirements.

enrollee's quality of care. The LCDs limit reimbursement to no more than four therapeutic injection sessions per enrollee during a rolling 12-month period.

These deficiencies occurred because CMS and MAC oversight was not sufficient to prevent improper payments made to physicians for sacroiliac joint injections. Although CMS had oversight mechanisms to identify certain billing errors, it did not conduct additional oversight activities, such as providing education to physicians, to ensure that Medicare pays physicians only for the injections that met Medicare requirements and billing guidance. CMS relied on the MACs to provide education to physicians. However, the education that MACs provided was not sufficient and may have contributed to physicians not fully understanding Medicare requirements and billing guidance. Some physicians whose claims had errors stated that more consistent and additional training would have helped them better understand Medicare requirements and billing guidance, which could prevent future errors.

Furthermore, during the audit period, two of the seven MACs that did not issue LCDs paid physicians $12.3 million for sacroiliac joint injection sessions, accounting for approximately 36 percent of total Medicare payments for sacroiliac joint injections nationwide that may include improper payments.

SACROILIAC JOINT INJECTIONS DID NOT COMPLY WITH CERTAIN MEDICARE REQUIREMENTS

Of the 100 sampled sessions, 72 did not comply with 1 or more Medicare requirements related to: (1) indications of pain, (2) imaging and pain assessments, (3) diagnostic and therapeutic sacroiliac joint injections, and (4) limitation of coverage.

Indications of Pain Requirements Not Met

Related to indications of the enrollee's pain, the LCDs stated that enrollees must have: (1) at least three positive findings with provocative maneuvers,[15] (2) low back pain below the L5 vertebra without radiculopathy,[16] (3) low back pain that persists despite a minimum of 4 weeks of conservative therapies,[17] (4) clinical findings and imaging studies that do not suggest any other diagnosed or obvious cause of the lumbosacral pain such as tumor and fracture,[18] (5) low back pain for at least 3 months, and (6) moderate to severe low back pain primarily experienced

[15] Provocative maneuvers are physical examination tests used to help determine whether the sacroiliac joint is the likely source of a patient's low back pain.

[16] Radiculopathy is commonly referred to as a pinched nerve.

[17] Conservative therapies consist of therapeutic-dose medications (e.g., NSAIDs, analgesics) administered to assess effectiveness, along with physical therapy, a home exercise program, or other interventions based on the individual's physical findings and imaging results.

[18] The lumbosacral region is the lower part of a patient's back, where the lumbar spine (the lower back bones) connects to the sacrum.

over the anatomical location of the sacroiliac joints between the upper level of the iliac crests and the gluteal fold.[19]

For 47 sampled sessions, sacroiliac joint injections did not comply with Medicare requirements related to indications of pain.[20]

- Enrollees did not have at least 3 positive provocative maneuvers (26 sessions).
- Enrollees did not have low back pain with the absence of radiculopathy (21 sessions).
- Enrollees did not have a minimum of 4 weeks of conservative therapy prior to the injection (18 sessions).
- Enrollees had clinical findings or imaging studies that suggested other diagnoses or causes of pain (10 sessions).
- Enrollees did not have chronic low back pain lasting at least 3 months (10 sessions).
- Enrollees did not have moderate to severe low back pain over the area of the sacroiliac joints (four sessions).

Imaging and Pain Assessments Requirements Not Met

Related to imaging guidance and the enrollee's pain assessments, the LCDs stated that: (1) the sacroiliac joint primary pain level must be measured prior to the injection at the beginning of the session, (2) the post procedure pain level must be measured at the end of the session, (3) the injections must be performed under Computed Tomography (CT) or fluoroscopy image guidance with contrast unless the patient has a documented contrast allergy so that ultrasound guidance without contrast may be considered.[21]

For 45 sampled sessions, sacroiliac joint injections did not comply with imaging and pain assessment requirements.[22]

[19] The iliac crest is the top curved edge of the hip bone, and the gluteal fold is the crease under the buttocks.

[20] The total number of sample items that did not comply with Medicare requirements related to indications of pain is more than 47 because 26 sample items had more than 1 deficiency.

[21] CT is a medical test that uses x-rays and a computer to take detailed pictures of the inside of the body. Fluoroscopy image guidance helps with accurate needle placement and proper delivery of the injection, and contrast dye helps visualize the joint space during the procedure. Ultrasound guidance helps with accurate needle placement but has a lower accuracy than fluoroscopy guidance for sacroiliac joint injection procedures.

[22] The total number of sample items that did not comply with Medicare requirements related to imaging and pain assessments is more than 45 because 17 sample items had more than 1 deficiency.

- Physicians did not document the pain level at the end of the session (31 sessions).

- Physicians administered the injection with fluoroscopy image guidance without contrast or used ultrasound guidance without documenting a contrast allergy, which is required when CT guidance or fluoroscopy is not used (17 sessions).

- Physicians did not document the primary pain level at the beginning of the session (16 sessions).

Diagnostic or Therapeutic Sacroiliac Joint Injections Requirements Not Met

Related to diagnostic sacroiliac joint injections, the LCDs stated that a subsequent diagnostic sacroiliac joint injection is not reasonable and necessary when the initial diagnostic injection does not produce a positive response of greater than or equal to 75 percent pain relief. Related to therapeutic sacroiliac joint injections, the LCDs stated that: (1) a diagnostic injection must have provided a minimum of 75 percent relief of primary pain before a therapeutic injection is administered and (2) a subsequent therapeutic injection is not reasonable and necessary when the prior therapeutic injection did not result in at least 50 percent consistent pain relief or functional improvement for at least 3 months.

For 36 sampled sessions, sacroiliac joint injections did not comply with requirements related to diagnostic or therapeutic sacroiliac joint injections.

- Physicians administered a therapeutic injection when a diagnostic injection was not performed or did not provide at least 75 percent pain relief (29 sessions).

- Physicians administered a therapeutic injection after the prior therapeutic injection did not result in at least 50 percent consistent pain relief or functional improvement for at least 3 months (six sessions).

- The physician administered a second diagnostic injection when the initial diagnostic injection did not result in at least 75 percent pain relief (one session).

Limitation of Coverage Requirements Not Met

Related to limitation of coverage for sacroiliac joint injections, the LCDs stated that it is not considered medically reasonable and necessary to: (1) administer other musculoskeletal injections in the lumbosacral spine during the same session as sacroiliac joint injections;[23] or (2) perform multiple injections (e.g., epidural steroid injections, facet-joint injections, and

[23] A musculoskeletal injection is the administration of medication directly into a muscle, joint, tendon sheath, bursa, or ligament to relieve pain, reduce inflammation, or improve mobility in patients with musculoskeletal disorders.

trigger point injections)[24] during the same session as sacroiliac joint injections and during the period when the physician is evaluating whether the injection reduced pain (i.e., efficacy assessment period).

For eight sampled sessions, sacroiliac joint injections did not comply with Medicare requirements related to the limitation of coverage.

- The physician administered other musculoskeletal injections in the lumbosacral spine during the same session as sacroiliac joint injections (six sessions).

- The physician performed multiple blocks during the same session as sacroiliac joint injection (two session).

Medicare Improperly Paid Physicians an Estimated $15.2 Million for Sacroiliac Joint Injections That Did Not Meet Medicare Requirements

Medicare made improper payments to physicians for 72 of 100 sampled sessions, totaling $8,112. On the basis of our sample results, we estimated that physicians improperly billed 134,526 of 186,842 total sessions for sacroiliac joint injections totaling $15.2 million that did not meet Medicare requirements during our audit period.

PHYSICIANS' BILLING OF THERAPEUTIC INSTEAD OF DIAGNOSTIC SACROILIAC JOINT INJECTIONS DID NOT MEET MEDICARE BILLING GUIDANCE

The LCD Reference Articles' billing guidance stated that if a diagnostic sacroiliac joint injection is administered, the physician should append modifier "KX" to each claim line to distinguish it from a therapeutic sacroiliac joint injection. Physicians should not use this modifier for therapeutic-related claim lines. The LCDs limit reimbursement to no more than two diagnostic sacroiliac joint injection sessions and then no more than four therapeutic injection sessions per enrollee during a rolling 12-month period.

Of the 100 sampled sessions, 25 were incorrectly billed as therapeutic sacroiliac joint injections. The physicians should have billed these sessions as diagnostic with the appropriate use of modifier "KX." On the basis of our sample results, we estimated that physicians incorrectly billed for 46,711 of 186,842 total sessions as therapeutic injections instead of diagnostic injections.

Although billing for a therapeutic injection instead of a diagnostic injection does not affect the payment amount that a physician receives, incorrectly classifying the type of injection that was administered could result in the enrollee not receiving the maximum allowable number of

[24] A nerve block is a medication injection close to a targeted nerve or group of nerves to provide temporary pain relief. It may also help diagnose the source of pain or be used to manage pain.

therapeutic injection sessions (four) during a rolling 12-month period.[25] Not following the billing guidance may also result in enrollees having to pay for sessions out of pocket because the LCDs limit reimbursement to no more than four therapeutic injection sessions per enrollee during a rolling 12-month period.

CMS AND MAC OVERSIGHT WAS NOT SUFFICIENT TO PREVENT IMPROPER PAYMENTS

Although CMS had oversight mechanisms to identify certain billing errors, it did not conduct additional oversight activities, such as providing education to physicians to ensure that Medicare pays physicians for the injections that met Medicare requirements and billing guidance. For example, the last education material (i.e., the Medicare Learning Network Connects newsletter) that CMS issued for sacroiliac joint injections was dated January 16, 2004.[26, 27]

Although CMS also relied on the MACs to provide education to physicians, it did not direct the MACs to conduct any additional educational efforts on Medicare requirements and billing guidance for sacroiliac joint injections. During our audit period, of the five MACs that had the LCDs and LCD Reference Articles, three MACs did not provide education specific to sacroiliac joint injections.[28] Another MAC's training was limited to postings of the LCDs and the LCD Reference Articles on its website. The remaining MAC hosted a webinar that reviewed the new LCD requirements with a question-and-answer session in February 2023, which was a month prior to the LCD's effective date, but did not provide any follow up training during our audit period. The limited education provided by the MACs to physicians was not sufficient and may have contributed to physicians not fully understanding Medicare requirements and billing guidance for sacroiliac joint injections.

In addition, some physicians whose sessions had errors stated that the LCD requirements and the LCD Reference Article billing guidance are complex and that more consistent and additional training would have helped them better understand Medicare requirements and billing guidance, which could prevent future errors. Without additional educational efforts from CMS and the MACs, physicians may continue to misunderstand the MACs' LCDs and LCD Reference Articles for sacroiliac joint injections, increasing the risk of improper payments.

[25] Medicare pays the same amount for diagnostic and therapeutic sacroiliac joint injections.

[26] The *Medicare Learning Network Connects* newsletter is a weekly publication for national fee-for-service news for health care providers, suppliers, billers, and coders.

[27] CMS, MLN Matters (number: MM2979), "Payment to ambulatory surgical centers (ASCs) for G0260 and to physicians for 27096 when 27096 is performed in an ASC," Jan. 16, 2004.

[28] One of the three MACs provided training covering an LCD for multiple pain management procedures, including sacroiliac joint injections, in September and December 2022, prior to our audit period.

TWO MACS WITHOUT LOCAL COVERAGE DETERMINATIONS FOR SACROILIAC JOINT INJECTION PROCEDURES ACCOUNTED FOR OVER ONE-THIRD OF PAID SESSIONS

During our audit period, two of the seven MACs (First Coast and Novitas) paid physicians $12.3 million for sacroiliac joint injections, accounting for approximately 36 percent of total Medicare payments for sacroiliac joint injections nationwide. These two MACs did not issue an LCD for sacroiliac joint injection sessions for our audit period, which poses a potential risk of improper payments made for these injections.

CONCLUSION

Medicare improperly paid physicians for 72 of the 100 sampled sacroiliac joint injection sessions. Also, for 25 of the 100 sessions, physicians incorrectly billed for therapeutic injections instead of diagnostic injections. These deficiencies occurred because CMS and MAC oversight was not sufficient to prevent improper payments made to physicians for sacroiliac joint injections. Although physicians are responsible for complying with current Medicare requirements and for staying informed of any updates, they did not fully understand Medicare requirements and billing guidance as evidenced by the findings of the report and information provided by the physicians.

In addition, if physicians do not follow LCD Reference Article guidance for billing diagnostic injections with modifier "KX," Medicare enrollees may not receive all the injections they need, which may impact their quality of care. Incorrectly classifying the diagnostic injection as a therapeutic injection that was administered could result in the enrollee not receiving the allowable number of therapeutic injection sessions (four) during a rolling 12-month period or having to pay out of pocket.

Although the MACs have discretion to determine educational topics that are most relevant to their provider population, CMS and the MACs could reduce billing errors by collaborating to develop and implement consistent, targeted training programs across all jurisdictions. Strengthening oversight and standardizing educational efforts could help reduce improper payments for sacroiliac joint injections.

RECOMMENDATIONS

- We recommend that CMS work with the five MACs with LCDs and LCD Reference Articles to develop education specific to the Medicare requirements and billing guidance for sacroiliac joint injections to be used for all of the five MACs, which could have saved an estimated $15,156,922 during our audit period.

- We recommend that CMS work with the five MACs with LCDs and LCD Reference Articles to develop solutions to prevent the incorrect billing of diagnostic sacroiliac joint injections as therapeutic sacroiliac joint injections, such as developing additional education specific to billing injections with modifier "KX."

- We recommend that CMS use the results of this audit and other pertinent information to either adopt a national coverage determination (NCD) for sacroiliac joint injections or work with the two MACs without an LCD and LCD Reference Article for sacroiliac joint injections to develop them, thereby promoting greater consistency and reducing duplication of effort.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our first and second recommendations and provided information on actions that it had taken and planned to take to address them. However, CMS did not concur with our third recommendation. After reviewing CMS's comments, we maintain that this recommendation is valid.

CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix E.

CMS COMMENTS

Regarding our first and second recommendations, CMS concurred and stated that it has provided technical assistance as needed for the MACs to collaborate on their LCDs and will notify the MACs of our audit so that they may determine whether additional education on proper billing and Medicare requirements for sacroiliac joint injections is necessary. CMS also stated that its current funding and resources allow for provider education only for national coverage requirements. Without a national coverage requirement on this topic, the MACs would be responsible for any provider education.

Regarding our third recommendation, CMS did not concur and stated that Congress delegated the development of LCDs to MACs under section 1869(f)(2)(B) of the Act and this statute does not mandate that LCDs be uniform across all jurisdictions. CMS also stated that "an NCD would not resolve the issues with MAC's adjudicating claims that are inconsistent with coverage criteria. Implementation of LCDs and NCDs are carried out in the same manner by the same adjudication systems, so the criteria adherence issues that are occurring with the LCDs would likely continue if an NCD were in place." In addition, CMS stated that the education mechanisms in the first and second recommendations more precisely address the root of the issue.

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding CMS's comments on our third recommendation, we continue to believe that greater consistency across all MAC jurisdictions would help to reduce improper payments and promote uniform application of Medicare coverage criteria. Although statutory authority grants MACs discretion in developing LCDs, the lack of LCDs at the two MACs could result in those MACs having a different adjudication system than the five MACs that have implemented LCDs and LCD Reference Articles. This inconsistency among MACs' adjudication systems would

undermine uniform application of Medicare coverage criteria across all MAC jurisdictions. As CMS noted in its response, "the coverage limitations [in LCDs and LCD Reference Articles] are intended to address inappropriate billing for pain management tied to overuse of spinal sacroiliac joint injections." Therefore, we maintain that our recommendation for CMS to either adopt an NCD for sacroiliac joint injections or work with the two MACs without an LCD and LCD Reference Article for sacroiliac joint injections to develop them is valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Medicare Part B payments of $22 million for 186,970 claims lines for sacroiliac joint injections. Payments for these claim lines were made by five MACs that issued an LCD (i.e., Medicare requirements) and an LCD Reference Article (i.e., Medicare billing guidance) for sacroiliac joint injections and had dates of service from October 1, 2023, through September 30, 2024. We grouped these claim lines into 186,842 sessions.[29] We selected for review a random sample of 100 of these sessions, for which Medicare paid $11,243. For each session, we reviewed the physician's supporting documentation to determine whether the session met Medicare requirements and billing guidance. We shared our findings with the five MACs and obtained their agreement with our determinations of sessions that did not comply with Medicare requirements and billing guidance. We did not perform medical review to determine whether sacroiliac joint injections were medically reasonable and necessary. Our determinations were limited to whether documentation met the applicable LCD coverage and billing requirements.

In addition, we totaled the amounts paid for sacroiliac joint injections by the two MACs without an LCD or an LCD Reference Article. We then calculated the percentage that this amount comprised of the total payment nationwide for all sacroiliac joint injections nationwide during our audit period to show the potential risk of improper payments made for these injections that were not covered in our audit.[30]

We did not perform an overall assessment of the internal control structures of CMS and the MACs. Rather, we limited our review to those controls that were significant to our objective. Specifically, we obtained an understanding of CMS's and the MACs' oversight activities to identify and prevent improper payments made to physicians for sacroiliac joint injections.

Our audit procedures enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's Integrated Data Repository (IDR).

We conducted our audit from November 2024 through May 2026.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal laws, regulations, and guidance, and the five MACs' LCDs and LCD Reference Articles related to sacroiliac joint injections

[29] See footnote 11.

[30] We did not determine whether payments for these sacroiliac joint injections were reasonable or necessary.

- Obtained written responses from staff at CMS and the MACs regarding the types of provider education they have provided specific to sacroiliac joint injections and the types of oversight mechanisms they have implemented to prevent payments for services that exceed coverage limitations for sacroiliac joint injection sessions

- Used data from CMS's IDR to identify claim lines for sacroiliac joint injections (billed using CPT codes 27096 and 64451) with dates of service during our audit period

- Grouped the claim lines into sessions by MAC, HIC number, and date of service

- For the five MACs that had LCD and LCD Reference Article related to sacroiliac joint injections during our audit period:

    - Constructed a sampling frame of 186,842 sessions valued at $22 million

    - Selected a simple random sample of 100 sessions and:

        - Obtained from physicians supporting documentation for each sampled session and reviewed them

        - Determined whether the payment for each sampled session complied with Medicare requirements and billing guidance

        - Shared our determinations of sessions that did not comply with Medicare requirements and billing guidance with the five MACs to obtain their agreement with our determinations of the sessions that did not comply with Medicare requirements and billing guidance

        - Determined the improper payment for each sampled session that did not comply with Medicare requirements

        - Obtained responses from physicians regarding deficiencies in understanding and applying LCDs and LCD Reference Articles

        - Estimated: (1) the improper payments made to physicians for sacroiliac joint injection sessions that did not comply with Medicare requirements, (2) the number of improperly paid sacroiliac joint injection sessions, and (3) the number of incorrectly billed therapeutic sacroiliac joint injection sessions that should have been billed as diagnostic injection sessions

- Totaled the amounts paid for sacroiliac joint injections for the two MACs that did not issue an LCD or LCD Reference Article related to sacroiliac joint injections and then calculated the percentage that this amount comprised of the total payment nationwide for all sacroiliac joint injections nationwide during our audit period to show the

potential risk of improper payments made for these injections that were not covered in our audit

- Discussed the results of our audit with CMS officials

See Appendix D for our statistical sampling methodology and Appendix E for our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Could Have Saved an Estimated $17.7 Million if CMS's Oversight Had Prevented At-Risk Payments for Anesthesia Administered During Spinal Pain Management Procedures	A-09-23-03013	07/29/2025
Medicare Improperly Paid Physicians an Estimated $30 Million for Spinal Facet-Joint Interventions	A-09-22-03006	3/22/2023
Medicare Improperly Paid Physicians for Epidural Steroid Injection Sessions	A-07-21-00618	3/10/2023
Medicare Improperly Paid Physicians for Spinal Facet-Joint Denervation Sessions	A-09-21-03002	12/3/2021
Noridian Healthcare Solutions, LLC, Made Improper Medicare Payments of $4 Million to Physicians in Jurisdiction E for Spinal Facet-Joint Injections	A-09-20-03010	2/19/2021
Medicare Improperly Paid Physicians for More Than Five Spinal Facet-Joint Injection Sessions During a Rolling 12-Month Period	A-09-20-03003	10/9/2020

APPENDIX C: MEDICARE ADMINISTRATIVE CONTRACTORS AND GEOGRAPHIC COMPOSITION FOR EACH JURISDICTION*

Jurisdiction	MAC	States and Territories	LCD	LCD Reference Article
5	WPS	Iowa, Kansas, Missouri, Nebraska	L39475	A59257
6	NGS	Illinois, Minnesota, Wisconsin	L39455	A59233
8	WPS	Indiana, Michigan	L39475	A59257
15	CGS	Kentucky, Ohio	L39383	A59154
E	Noridian	American Samoa, California, Guam, Hawaii, Nevada, Northern Mariana Islands	L39462	A59244
F	Noridian	Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming	L39464	A59246
H	Novitas	Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas	N/A	N/A
J	Palmetto	Alabama, Georgia, Tennessee	L39402	A59192
K	NGS	Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont	L39455	A59233
L	Novitas	Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania	N/A	N/A
M	Palmetto	North Carolina, South Carolina, Virginia, West Virginia	L39402	A59192
N	First Coast	Florida, Puerto Rico, U.S. Virgin Islands	N/A	N/A

* The five MACs that established LCDs and LCD Reference Articles for sacroiliac joint injections are CGS Administrators, LLC (CGS), National Government Services, Inc. (NGS), Noridian Healthcare Solutions, LLC (Noridian), Palmetto GBA (Palmetto), Wisconsin Physicians Service Insurance Corporation (WPS). The remaining two MACs—First Coast Service Options Inc. (First Coast) and Novitas Solutions, Inc. (Novitas)—did not establish an LCD or an LCD Reference Article for sacroiliac joint injections. The jurisdiction designation, MAC, and geographic composition for each jurisdiction are accurate as of January 2026. The LCDs and LCD Reference Articles identified in this table were effective as of March 19, 2023, and during our audit period.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 186,970 Medicare Part B paid claim lines for sacroiliac joint injections. Payments for these claim lines were made by five MACs that issued an LCD (i.e., Medicare requirements) and an LCD Reference Article (i.e., Medicare guidance) for sacroiliac joint injections and had dates of service from October 1, 2023, through September 30, 2024. We grouped the claim lines into sacroiliac joint injection sessions in which the payment was $50 or greater by MAC, HIC number, and date of service. The resulting sampling frame consisted of 186,842 sessions with a total paid amount of $22,044,999.[31] The frame includes sessions where payment was $50 or greater paid by the Medicare Trust Fund.[32]

SAMPLE UNIT

The sample unit was a sacroiliac joint injection session.

SAMPLE DESIGN AND SAMPLE SIZE

We used a simple random sample. We selected 100 sample items.

SOURCE OF RANDOM NUMBERS

The source of the random numbers was the Office of Audit Services' (OAS's) statistical software.

METHOD OF SELECTING SAMPLE UNITS

We sorted the items by HIC number and the date of service. We consecutively numbered the items in the sampling frame. We generated the random numbers for our sample according to our sample design, and we then selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the: (1) total amount of any payments made by the MACs to physicians for sacroiliac joint injection sessions that did not comply with Medicare, (2) number of any sacroiliac joint injection sessions billed by physicians that did not comply with Medicare requirements, and (3) number of sacroiliac joint injection sessions that physicians incorrectly billed as therapeutic sacroiliac joint injection sessions when they should have billed as diagnostic injection sessions. We used this software to calculate the point

[31] See footnote 11.

[32] We included claim lines with a provider specialty code not equal to "49," which applies to the ambulatory surgical centers' facility expenses.

estimate and the corresponding lower and upper limits of the two-sided 90-percent confidence interval.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results for Sacroiliac Joint Injection Sessions That Did Not Comply With Medicare Requirements

Frame Size (No. of Sessions)	Value of Frame	Sample Size	Value of Sample	No. of Sessions in Sample That Did Not Comply With Requirements	Total Improper Payments in Sample
186,842	$22,044,999	100	$11,243	72	$8,112

Table 2: Estimated Improper Payments in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)

Point estimate	$15,156,922
Lower limit	13,181,722
Upper limit	17,132,122

Table 3: Estimated Number of Improperly Paid Sacroiliac Joint Injection Sessions in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)

Point estimate	134,526
Lower limit	118,987
Upper limit	148,184

Table 4: Sample Results for Incorrectly Billed Therapeutic Sacroiliac Joint Injection Sessions That Should Have Been Billed as Diagnostic Injection Sessions in the Sampling Frame

Frame Size (No. of Sessions)	Sample Size	No. of Sessions in Sample That Were Incorrectly Billed Therapeutic Sacroiliac Joint Injection That Were Diagnostic
186,842	100	25

Table 5: Estimated Number of Incorrectly Billed Therapeutic Sacroiliac Joint injection Sessions That Should Have Been Billed as Diagnostic Injection Sessions in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)

Point estimate	46,711
Lower limit	33,664
Upper limit	61,900

APPENDIX F: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: June 5, 2026

TO: Carla J. Lewis
Acting Deputy Inspector General for Audit Services

FROM: Dr. Mehmet Oz DR
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Physicians an Estimated $15.2 Million for Sacroiliac Joint Injections (OAS-25-09-021)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS takes the health and safety of individuals with Medicare seriously and is committed to providing them with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments.

CMS contracts with Medicare Administrative Contractors (MACs), which serve as the primary operational contact between the Medicare Fee-For-Service (FFS) program and the health care providers and suppliers enrolled in the program. The MACs perform many activities including processing Medicare FFS claims, educating providers and suppliers about Medicare FFS billing requirements, and reducing the number of improper payments for claims that do not comply with Medicare's coverage, coding, payment, and billing policies. Additionally, where there is no national coverage determination (NCD), MACs have the statutory authority to determine which healthcare items and services are covered as medically reasonable and necessary and to develop local coverage determinations (LCDs) for their individual jurisdictions, taking into account local variations in the practice of medicine. LCDs cannot conflict with statutory coverage requirements, Federal regulations, CMS Rulings, NCDs, coverage provisions in interpretive manuals, or Medicare payment policies.

Sacroiliac joints are joints that connect the lower spine to the pelvis supporting upper-body weight, walking, and changes in posture. Sacroiliac joint injections are used to diagnose or treat back pain. While CMS does not have a national policy to limit coverage of sacroiliac joint injections, five of the seven MACs have instituted LCDs to limit the number of sessions of therapeutic sacroiliac joint injections covered by Medicare. These coverage limitations are intended to address inappropriate billing for pain management tied to overuse of spinal sacroiliac joint injections.

In addition to the MACs' efforts to administer Medicare FFS claims, CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated

system edits within the claims processing system and prepayment and post payment medical reviews. As part of the program integrity strategy, CMS recovers identified overpayments in accordance with relevant law and agency policies and procedures. While CMS appreciates the OIG's work in this area, CMS notes that OIG relied solely on claim information for this study. OIG did not conduct medical reviews to determine whether services were medically necessary.

The OIG's recommendations and CMS's responses are below.

OIG Recommendation 1

The OIG recommends that CMS work with the five MACs with LCDs and LCAs to develop education specific to the Medicare requirements and billing guidance for sacroiliac joint injections to be used for all of the five MACs, which could have saved an estimated $15,156,922 during our audit period.

CMS Response

CMS concurs with this recommendation. CMS has provided technical assistance as needed for the MACs to successfully collaborate on their LCDs. CMS will notify the MACs of this audit so that they may determine whether additional education on proper billing and Medicare requirements for sacroiliac joint injections is necessary. CMS's current funding and resources allow for provider education around national coverage requirements. In the absence of a national coverage requirement on this topic, the MACs would be responsible for conducting any provider education.

OIG Recommendation 2

The OIG recommends that CMS work with the five MACs with LCDs and LCAs to develop solutions to prevent the incorrect billing of diagnostic sacroiliac joint injections as therapeutic sacroiliac joint injections, such as developing additional education specific to billing injections with modifier "KX."

CMS Response

CMS concurs with this recommendation. CMS has provided technical assistance as needed for the MACs to successfully collaborate on their LCDs. CMS will notify the MACs of this audit so that they may determine whether additional education on proper billing and Medicare requirements for diagnostic sacroiliac joint injections is necessary. CMS's current funding and resources allow for provider education around national coverage requirements. In the absence of a national coverage requirement on this topic, the MACs would be responsible for conducting any provider education.

OIG Recommendation 3

The OIG recommends that CMS use the results of this audit and other pertinent information to either adopt a national coverage determination for sacroiliac joint injections or work with the two MACs without an LCD and LCA for sacroiliac joint injections to develop them, thereby promoting greater consistency and reducing duplication of effort.

CMS Response

CMS non-concurs with the recommendation. While CMS does not have a national policy to limit coverage of sacroiliac joint injections, five of the seven MACs have instituted LCDs and LCD Reference Articles to limit the number of sessions of therapeutic sacroiliac joint injections covered by Medicare. These coverage limitations are intended to address inappropriate billing for pain management tied to overuse of spinal sacroiliac joint injections.

CMS has provided technical assistance as needed for the MACs to successfully collaborate on their LCDs and LCD Reference Articles. CMS has established procedures for MACs to collaborate on LCDs, where applicable, including collaborative forums for MACs to discuss LCDs, creating a list serv for Contractor Medical Directors to share information related to LCD development, establishing a centralized database of LCD policies, and incorporating language into the MAC award fee metrics to encourage more collaboration amongst the MACs when developing LCDs. Note, Congress expressly delegated to MACs the function of developing LCDs, as defined in section 1869(f)(2)(B) of the Social Security Act. The statute does not mandate that LCDs be uniform across all jurisdictions, and MACs have the authority to prioritize their workload and determine if and when an LCD should be developed. CMS has oversight to make certain that the MACs follow the LCD process that CMS has established, as described in Chapter 13 of the Program Integrity Manual (PIM).

Additionally, an NCD would not resolve the issues with MAC's adjudicating claims that are inconsistent with coverage criteria. Implementation of LCDs and NCDs are carried out in the same manner by the same adjudication systems, so the criteria adherence issues that are occurring with the LCDs would likely continue if an NCD were in place. The education mechanisms in the other two recommendations more precisely address the root of the issue.

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