

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE IMPROPERLY PAID  
PHYSICIANS FOR MORE THAN  
FIVE SPINAL FACET-JOINT  
INJECTION SESSIONS DURING A  
ROLLING 12-MONTH PERIOD**

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## Report in Brief

Date: October 2020

Report No. A-09-20-03003

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

To address inappropriate billing for pain management tied to overuse of spinal facet-joint injections, the Medicare Administrative Contractors (MACs) developed a limitation of coverage that allows physicians to be reimbursed, during a rolling 12-month period, for a maximum of five sessions in which facet-joint injections are delivered to the lumbar region of the spine (lumbar spine) or the cervical and thoracic regions of the spine (cervical/thoracic spine). (We refer to injection sessions in the two spinal areas during a rolling 12-month period as “selected facet-joint injection sessions”). However, one of the MACs’ audits found that Medicare improperly paid for more than five injection sessions related to the lumbar or cervical/thoracic spines during a rolling 12-month period.

Our objective was to determine whether Medicare paid physicians for selected facet-joint injection sessions in accordance with Federal requirements.

### How OIG Did This Audit

Our audit covered Medicare Part B payments of \$3.3 million for 13,857 selected facet-joint injection sessions from January 1, 2017, through May 31, 2019 (audit period) in the 11 MAC jurisdictions with a coverage limitation. We also identified Part B payments of approximately \$2 million that the MAC for the remaining jurisdiction (which did not have a coverage limitation) made for 6,644 selected injection sessions during our audit period.

## Medicare Improperly Paid Physicians for More Than Five Spinal Facet-Joint Injection Sessions During a Rolling 12-Month Period

### What OIG Found

Medicare did not pay physicians for selected facet-joint injection sessions in accordance with Federal requirements. Specifically, for our audit period, the MACs in the 11 jurisdictions with a coverage limitation made improper payments of \$748,555. During our audit period, the Centers for Medicare & Medicaid Services’ (CMS’s) oversight was not adequate to prevent or detect these improper payments. In addition, if the remaining MAC jurisdiction had kept in place during our audit period the coverage limitation, Medicare could have saved \$513,328.

### What OIG Recommends and CMS Comments

For the 11 MAC jurisdictions with a coverage limitation for the number of facet-joint injection sessions during a rolling 12-month period, we recommend that CMS: (1) direct the MACs that oversee the 11 jurisdictions to recover \$748,555 in improper payments made to physicians; (2) instruct the MACs to, based upon the results of this audit, notify appropriate physicians (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the physicians can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; (3) develop oversight mechanisms for the MACs to implement to prevent or detect payments to physicians for more than 5 facet-joint injection sessions received by beneficiaries during a rolling 12-month period in the lumbar spine or cervical/thoracic spine; and (4) direct the MACs that oversee the 11 jurisdictions to review claims for facet-joint injections after our audit period to identify instances in which Medicare paid physicians for more than 5 injection sessions received by beneficiaries during a rolling 12-month period and recover any improper payments identified.

For the remaining MAC jurisdiction, which did not have a coverage limitation, we recommend that CMS consider working with the MAC to determine whether it should re-implement this coverage limitation, which could have saved \$513,328 during our audit period.

CMS concurred with our recommendations and described actions that it planned to take to address our recommendations, such as directing the MACs to recover overpayments and exploring applicable oversight mechanisms.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

Facet-joint injections of an anesthetic with or without a steroid are used to diagnose or treat chronic neck and back pain. To address inappropriate billing for pain management tied to overuse of spinal facet-joint injections, the Medicare Administrative Contractors (MACs) developed a limitation of coverage.<sup>1</sup> The coverage limitation allows physicians to be reimbursed, during a rolling 12-month period,<sup>2</sup> for a maximum of five sessions<sup>3</sup> in which facet-joint injections are delivered to the lumbar region of the spine (lumber spine) and a maximum of five sessions in which facet-joint injections are delivered to the cervical and thoracic regions of the spine (cervical/thoracic spine).<sup>4</sup> (We refer to injection sessions in these two spinal areas during a rolling 12-month period as “selected facet-joint injection sessions.”) However, Noridian Healthcare Solutions, LLC (Noridian), one of the MACs, confirmed that a common error identified in audits it performed during calendar years 2016 through 2018 was that Medicare paid for more than five sessions in which facet-joint injections were delivered to the lumbar or cervical/thoracic spines during a rolling 12-month period. Therefore, we conducted this audit to determine whether Medicare made improper payments for selected facet-joint sessions in the MAC jurisdictions that had a coverage limitation from January 1, 2017, through May 31, 2019 (audit period).

### OBJECTIVE

Our objective was to determine whether Medicare paid physicians for selected facet-joint injection sessions in accordance with Federal requirements.

### BACKGROUND

#### Medicare Part B

Medicare Part B provides supplementary medical insurance, including coverage for the cost of facet-joint injections when they are medically reasonable and necessary. The Centers for Medicare & Medicaid Services (CMS) administers Part B and contracts with MACs to, among other things, determine reimbursement amounts and pay claims, conduct audits, and safeguard

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<sup>1</sup> At the time of our audit, 11 of the 12 MAC jurisdictions had the coverage limitation in place.

<sup>2</sup> A rolling 12-month period is a date range that starts with the date of an individual service and ends 1 day before that date in the following year. For example, if a service was provided on June 1, 2018, the rolling 12-month period would be June 1, 2018, through May 31, 2019.

<sup>3</sup> A session is a single date of service on which a beneficiary received facet-joint injections.

<sup>4</sup> The lumbar region of the spine is located in the lower back, and the cervical and thoracic regions of the spine are located in the upper back.

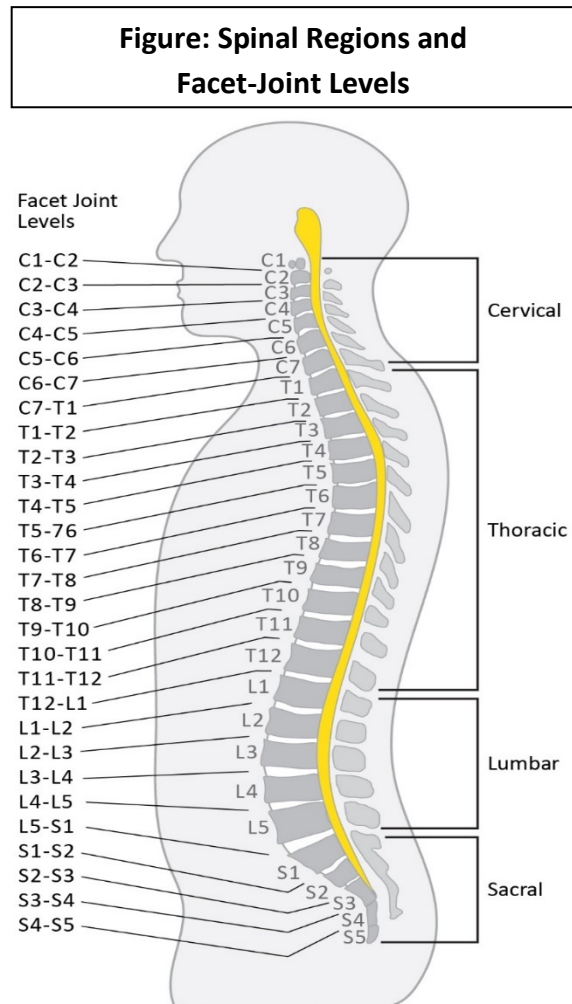
against fraud and abuse. Each MAC is responsible for processing claims submitted by physicians<sup>5</sup> within 1 of 12 designated regions, or jurisdictions, of the United States and its territories. Appendix B shows the MAC and geographic composition for each jurisdiction.

### Spinal Facet Joints and Medicare Coverage of Facet-Joint Injection Sessions

Facet joints in the spine aid stability and allow the spine to bend and twist. They are located between each vertebra in the spinal column. There are 28 levels of facet joints in the spine, which are divided, from top to bottom, into the cervical, thoracic, lumbar, and sacral regions.<sup>6</sup> (See the figure.) Each level has a pair of facet joints: one on the right side and one on the left side of the spine.

A facet-joint injection is an interventional technique used to diagnose or treat neck and back pain. For some people with chronic pain due to a facet-joint injury, these injections help reduce inflammation and relieve pain.

For 11 of the 12 MAC jurisdictions, Medicare Part B covers a limited number of facet-joint injection sessions for beneficiaries during a rolling 12-month period.<sup>7</sup> The MACs' local coverage determinations (LCDs)<sup>8</sup> for facet-joint procedures in those 11 MAC jurisdictions<sup>9</sup> specify that, during a rolling 12-month period, Medicare will cover a maximum of 5 sessions in which facet-joint injections are delivered to the lumbar spine and a



<sup>5</sup> Examples of physicians who administer facet-joint injections include those who specialize in interventional pain management, anesthesiology, and internal medicine.

<sup>6</sup> Three of these facet-joint levels connect one spinal region to another.

<sup>7</sup> The MAC for the 12th jurisdiction (i.e., Jurisdiction N), First Coast Service Options, Inc. (First Coast), confirmed that it no longer limited the number of facet-joint injection sessions for beneficiaries during a rolling 12-month period because of "low volume and minimal risk." It removed the coverage limitation before the start of our audit period (January 1, 2017).

<sup>8</sup> An LCD is a decision by a MAC whether to cover a particular item or service on a contractor-wide basis in accordance with 1862(a)(1)(A) of the Social Security Act.

<sup>9</sup> LCDs L34832 for Jurisdiction (J) 15, L34892 for JH and JL, L34993 for JE, L34995 for JF, L35936 for J6 and JK, L35996 for J5 and J8, and L36471 for JJ and JM.



maximum of 5 sessions in which facet-joint injections are delivered to the cervical/thoracic spine.<sup>10</sup> The MACs established the coverage limitation because evidence of the clinical effectiveness of facet-joint injections has not been well-established in the medical literature. CMS considers use of these injections problematic because of the steroid dosages administered.<sup>11</sup> Steroids alone may relieve the pain that beneficiaries experience but are associated with serious adverse health events.

### **Physician Submission of Claims for Facet-Joint Injection Sessions and the Use of Healthcare Common Procedure Coding System Codes**

Federal law prohibits Medicare payment unless the physician has furnished information necessary to determine the amounts due (Social Security Act § 1833(e)). Each submitted Medicare Part B claim contains detail regarding each provided service.

To receive Medicare payment for a facet-joint injection, the physician submits a claim and indicates on it the spinal region and the number of levels in which injections were administered using Healthcare Common Procedure Coding System (HCPCS) codes.<sup>12</sup> Three HCPCS codes are specific to facet-joint injections administered in levels of the cervical/thoracic spine, and three HCPCS codes are specific to facet joint-injections administered in levels of the lumbar spine.<sup>13</sup> Appendix C lists the HCPCS codes used for billing facet-joint injections.

### **Medicare Requirements for Physicians To Identify and Return Overpayments**

The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, physicians must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Physicians must report and return any identified overpayments by the later of: (1) 60 days after

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<sup>10</sup> This coverage limitation does not apply to facet-joint injection sessions related to the sacral spine. Sacral injections are identified on the physician-submitted claim by specific codes in the *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10).

<sup>11</sup> Of the 11 MAC jurisdictions with the coverage limitation, 9 limited the steroid dosage amounts to be injected during any single session to no more than 100 milligrams of triamcinolone or methylprednisolone, or 15 milligrams of betamethasone or dexamethasone.

<sup>12</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

<sup>13</sup> There are only three HCPCS codes associated with each region of the spine because Medicare pays physicians for up to three levels in which injections were administered during a session. A facet-joint injection session can consist of injections administered to multiple facet-joint levels, but Medicare will pay only for the first three levels.

identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.<sup>14</sup>

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, physicians can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.<sup>15</sup>

## HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicare Part B payments of \$3.3 million for 13,857 selected facet-joint injection sessions for 1,887 beneficiaries from January 1, 2017, through May 31, 2019, in the 11 MAC jurisdictions that limited coverage for the number of injection sessions during a 12-month rolling period.<sup>16</sup> Specifically, our audit covered payments for 1,328 beneficiaries who had more than 5 injection sessions related to the lumbar spine (totaling \$2.2 million for 9,431 sessions) and 623 beneficiaries who had more than 5 injection sessions related to the cervical/thoracic spine (totaling \$1.1 million for 4,426 sessions).<sup>17</sup>

We also identified Medicare Part B payments of approximately \$2 million that First Coast (the MAC for the remaining jurisdiction, which did not have a coverage limitation) made for 6,644 selected facet-joint injection sessions for 801 beneficiaries during our audit period. Specifically, payments were made for 610 beneficiaries who had more than 5 injection sessions related to the lumbar spine (totaling \$1.4 million for 4,639 sessions) and 239 beneficiaries who had more than 5 injection sessions related to the cervical/thoracic spine (totaling \$655,324 for 2,005 sessions).<sup>18</sup>

For each facet-joint injection session, we evaluated compliance with Medicare billing requirements, and we relied on claim information to make our determination. We did not use medical review to determine whether services were medically necessary. We did not contact

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<sup>14</sup> Social Security Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

<sup>15</sup> 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*—Part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. at 7670.

<sup>16</sup> During our audit period, Palmetto GBA, LLC (Palmetto), became the MAC for Jurisdiction J. Before February 26, 2018, Medicare Part B claims for this jurisdiction were processed and paid by Cahaba Government Benefit Administrators, LLC (Cahaba). For this audit, we reviewed facet-joint injection sessions that were processed and paid by Palmetto only from February 26, 2018, through May 31, 2019.

<sup>17</sup> Of the 1,887 beneficiaries, 64 had more than 5 facet-joint injection sessions in both the lumbar and cervical/thoracic spines.

<sup>18</sup> Of the 801 beneficiaries, 48 had more than 5 facet-joint injection sessions in both the lumbar and cervical/thoracic spines.

any of the physicians who administered the injections but relied on the claim information they submitted for Medicare payment.

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 contains the details of our audit scope and methodology.

## **FINDINGS**

Medicare did not pay physicians for selected facet-joint injection sessions in accordance with Federal requirements. Specifically, for our audit period, the MACs in the 11 jurisdictions with a coverage limitation made improper payments of \$748,555. Of this amount, \$482,425 represented payments for 1,328 beneficiaries who received more than 5 injection sessions related to the lumbar spine during a rolling 12-month period, and \$266,130 represented payments for 623 beneficiaries who received more than 5 injection sessions related to the cervical/thoracic spine during a rolling 12-month period. During our audit period, CMS oversight was not adequate to prevent or detect these improper payments.

In addition, if First Coast, the remaining MAC jurisdiction, had kept in place during our audit period the coverage limitation for the number of facet-joint injection sessions during a rolling 12-month period, Medicare could have saved \$513,328.<sup>19</sup> Of this amount, \$334,551 represented payments for 610 beneficiaries who received more than 5 injection sessions related to the lumbar spine during a rolling 12-month period, and \$178,777 represented payments for 239 beneficiaries who received more than 5 injection sessions related to the cervical/thoracic spine during a rolling 12-month period.

## **FEDERAL REQUIREMENTS**

A maximum of five facet-joint injection sessions inclusive of medial-branch blocks, intra-articular injections, facet cyst rupture, and radiofrequency ablations may be performed per rolling 12-month period in the lumbar spine or the cervical/thoracic spine (LCDs L34832, L34892, L34993, L34995, L35936, L35996, and L36471).<sup>20</sup>

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<sup>19</sup> We calculated the amount Medicare could have saved for First Coast's jurisdiction because First Coast did not have a coverage limitation in place during our audit period.

<sup>20</sup> A medial-branch block is an injection of a strong local anesthetic in the medial branch nerves that supply the facet joints. An intra-articular injection is delivered directly into a joint with the primary aim of relieving pain. Facet cyst rupture is a procedure to rupture cysts for treatment of facet-joint cysts. A radiofrequency ablation is a procedure used to reduce pain by using an electrical current produced by a radio wave to heat a small area of nerve tissue, thereby decreasing pain signals from that specific area.

## MEDICARE IMPROPERLY PAID PHYSICIANS IN 11 JURISDICTIONS FOR MORE THAN 5 FACET-JOINT INJECTION SESSIONS RELATED TO THE LUMBAR REGION AND CERVICAL AND THORACIC REGIONS OF THE SPINE

In 11 of 12 jurisdictions with a coverage limitation for the number of facet-joint injection sessions, MACs improperly paid physicians for more than 5 injection sessions related to: (1) the lumbar spine (2,170 sessions for 1,328 beneficiaries) and (2) the cervical/thoracic spine (1,079 sessions for 623 beneficiaries).

For each of the 1,887 beneficiaries in our review, Medicare improperly paid physicians for at least 1 session. The number of improperly paid sessions during a rolling 12-month period ranged from 1 to 18 sessions. Of the 13,857 sessions reviewed, 3,249 (23 percent) were improperly paid.

The example shows an instance in which a physician was improperly paid for 16 facet joint-injection sessions that exceeded the coverage limitation.

### Example: A Physician Was Improperly Paid for 16 Facet-Joint Injection Sessions Related to the Lumbar Spine

One beneficiary received 21 facet-joint injection sessions related to the lumbar spine during the rolling 12-month period January 12, 2017, through January 11, 2018. The physician who administered these injections billed and received payment from Medicare for all 21 sessions instead of just the first 5 sessions. As a result, the physician was paid \$4,266 instead of \$1,391, the amount paid for the first five injection sessions, representing an overpayment of \$2,875.

#### Lumbar Spine Facet-Joint Injection Sessions

Rolling 12-Month Period:  
Jan. 12, 2017 – Jan. 11, 2018

##### Covered by Medicare: First five sessions during rolling 12-month period

1. Jan. 12, 2017
2. Jan. 26, 2017
3. Feb. 3, 2017
4. Feb. 9, 2017
5. Feb. 16, 2017

Amount paid for first five  
sessions: \$1,391

##### NOT Covered by Medicare: Sessions after fifth session during rolling 12-month period

- |                   |                    |
|-------------------|--------------------|
| 6. Mar. 10, 2017  | 17. Sept. 13, 2017 |
| 7. Mar. 16, 2017  | 18. Oct. 12, 2017  |
| 8. Mar. 24, 2017  | 19. Oct. 26, 2017  |
| 9. Mar. 30, 2017  | 20. Nov. 16, 2017  |
| 10. May 15, 2017  | 21. Dec. 27, 2017  |
| 11. June 28, 2017 |                    |
| 12. July 13, 2017 |                    |
| 13. July 19, 2017 |                    |
| 14. Aug. 1, 2017  |                    |
| 15. Aug. 7, 2017  |                    |
| 16. Aug. 16, 2017 |                    |

Amount overpaid  
for more than  
five sessions:  
\$2,875

Beneficiary Name

In total, the MACs in the 11 jurisdictions with a coverage limitation made improper payments of \$748,555 (or 23 percent of \$3.3 million reviewed). Of this amount, \$482,425 represented payments for injection sessions related to the lumbar spine, and \$266,130 represented payments for injection sessions related to the cervical/thoracic spine.

Appendix D provides a summary of the MACs' improper payments to physicians by jurisdiction.

### **CMS OVERSIGHT WAS NOT ADEQUATE TO PREVENT OR DETECT IMPROPER PAYMENTS TO PHYSICIANS FOR SELECTED FACET-JOINT INJECTION SESSIONS**

During our audit period, CMS oversight was not adequate to prevent or detect improper payments to physicians during a rolling 12-month period in which beneficiaries received more than five facet-joint injection sessions related to the lumbar spine or the cervical/thoracic spine. If CMS had had oversight mechanisms (e.g., the MACs' claim processing system edits)<sup>21</sup> in place for the 11 MAC jurisdictions that had a coverage limitation for the number of facet-joint injection sessions during a rolling 12-month period, these mechanisms would have helped to reduce the number of improperly paid injection sessions that we identified (totaling \$748,555 for 3,249 sessions).

### **MEDICARE COULD HAVE SAVED \$513,328 IF ONE JURISDICTION HAD HAD A COVERAGE LIMITATION FOR THE NUMBER OF FACET-JOINT INJECTION SESSIONS**

Medicare could have saved \$513,328 if First Coast had kept the coverage limitation in place during our audit period for the number of facet-joint injection sessions during a rolling 12-month period. Specifically, First Coast paid physicians for 610 beneficiaries who received more than 5 facet-joint injection sessions related to the lumbar spine (totaling \$334,551 for 1,145 sessions) and for 239 beneficiaries who received more than 5 such sessions related to the cervical/thoracic spine (totaling \$178,777 for 547 sessions).

For example, 1 beneficiary received 22 facet-joint injection sessions related to the lumbar spine during the rolling 12-month period from January 3, 2017, through January 2, 2018. The physician who administered these injections billed and received payments from Medicare for all 22 sessions instead of just the first 5 sessions. As a result, the physician was paid \$3,323 instead of \$707, the amount paid for the first five injection sessions, which was a difference of \$2,616.

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<sup>21</sup> CMS, working with MACs, is responsible for developing oversight mechanisms for MACs to implement to prevent increased Medicare program costs caused by improper payments. For example, CMS develops edits that the MACs implement in their claim processing systems to perform the following functions: select certain claims for review; evaluate or compare information on the selected claims or from other accessible sources; and, depending on the evaluation, take action on the claims, such as paying them in full, paying them in part, denying payment for them, or suspending them for manual review.

## RECOMMENDATIONS

For the 11 MAC jurisdictions with a coverage limitation for the number of facet-joint injection sessions during a rolling 12-month period, we recommend that the Centers for Medicare & Medicaid Services:

- direct the MACs that oversee the 11 jurisdictions to recover \$748,555 in improper payments made to physicians;
- instruct the MACs to, based upon the results of this audit, notify appropriate physicians (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the physicians can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation;
- develop oversight mechanisms for the MACs to implement to prevent or detect payments to physicians for more than 5 facet-joint injection sessions received by beneficiaries during a rolling 12-month period in the lumbar spine or cervical/thoracic spine; and
- direct the MACs that oversee the 11 jurisdictions to review claims for facet-joint injections after our audit period to identify instances in which Medicare paid physicians for more than 5 injection sessions received by beneficiaries during a rolling 12-month period and recover any improper payments identified.

For the remaining MAC jurisdiction, which did not have a coverage limitation for the number of facet-joint injection sessions during a rolling 12-month period, we recommend that the Centers for Medicare & Medicaid Services consider working with First Coast to determine whether it should re-implement this coverage limitation, which could have saved \$513,328 during our audit period.

## CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described actions that it planned to take to address our recommendations, such as directing the MACs to recover identified overpayments consistent with relevant law and CMS's policies and procedures and exploring applicable oversight mechanisms. In addition, CMS told us that the MACs are developing a pain management group that will look at facet-joint injections.

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, appear as Appendix E.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered Medicare Part B payments of \$3,276,542 for 13,857 selected facet-joint injection sessions for 1,887 beneficiaries from January 1, 2017, through May 31, 2019, in the 11 MAC jurisdictions that limited coverage for the number of injection sessions during a 12-month rolling period.<sup>22</sup> Specifically, our audit covered payments for 1,328 beneficiaries who had more than 5 injection sessions related to the lumbar spine (totaling \$2,161,619 for 9,431 sessions) and 623 beneficiaries who had more than 5 injection sessions related to the cervical/thoracic spine (totaling \$1,114,923 for 4,426 sessions).<sup>23</sup>

We also identified Medicare Part B payments of \$2,030,895 that First Coast (the MAC that oversaw the jurisdiction that did not have a coverage limitation) made for 6,644 selected facet-joint injection sessions for 801 beneficiaries during our audit period. Specifically, payments were made for 610 beneficiaries who had more than 5 sessions related to injections in the lumbar spine (totaling \$1,375,571 for 4,639 sessions) and 239 beneficiaries who had more than 5 sessions related to injections in the cervical/thoracic spine (totaling \$655,324 for 2,005 sessions).<sup>24</sup>

For each facet-joint injection session, we evaluated compliance with Medicare billing requirements, and we relied on claim information to make our determination. We did not use medical review to determine whether services were medically necessary. We did not contact any of the physicians who administered the injections but relied on the claim information they submitted for Medicare payment.

We did not perform an overall assessment of CMS's internal control structure. Rather, we reviewed only the internal controls that pertained to our objective. Specifically, we interviewed staff at CMS regarding the types of oversight mechanisms it had in place during our audit period and assessed how effective these mechanisms were based on the number of paid facet-joint injection sessions that exceeded the coverage limitation in place for 11 of the 12 MAC jurisdictions during our audit period.

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<sup>22</sup> During our audit period, Palmetto became the MAC for Jurisdiction J. Before February 26, 2018, Medicare Part B claims for this jurisdiction were processed and paid by Cahaba. For this audit, we reviewed facet-joint injection sessions that were processed and paid by Palmetto only from February 26, 2018, through May 31, 2019.

<sup>23</sup> Of the 1,887 beneficiaries, 64 had more than 5 facet-joint injection sessions in both the lumbar and cervical/thoracic spines.

<sup>24</sup> Of the 801 beneficiaries, 48 had more than 5 facet-joint injection sessions in both the lumbar and cervical/thoracic spines.

Our audit enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS’s National Claims History (NCH) file, but we did not assess the completeness of the file.

We conducted our audit from September 2019 to July 2020, which included contacting CMS in Baltimore, Maryland.

## **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations, as well as the MACs’ LCDs;
- interviewed staff at the MACs to verify whether they had a coverage limitation for the number of facet-joint injection sessions related to the lumbar spine or the cervical/thoracic spine during a rolling 12-month period;
- interviewed staff at CMS regarding the types of oversight mechanisms specific to reimbursing physicians in the MAC jurisdictions with a coverage limitation for selected facet-joint injection sessions;
- used CMS’s NCH file to identify claims for facet-joint injections delivered to the lumbar and sacral spines (billed using HCPCS codes 64493 through 64495) and facet-joint injections delivered to the cervical/thoracic spine (billed using HCPCS codes 64490 through 64492) with dates of service for our audit period;
- performed data analysis to identify beneficiaries who received more than 5 facet-joint injection sessions related to the lumbar spine<sup>25</sup> and beneficiaries who received more than 5 such sessions related to the cervical/thoracic spine;
- calculated improper payments in which MACs with the coverage limitation in 11 of 12 jurisdictions paid physicians for more than 5 facet-joint injection sessions related to the lumbar spine and for more than 5 such sessions related to the cervical/thoracic spine;
- calculated the amount Medicare could have saved if the MAC for the remaining jurisdiction (First Coast) had had the coverage limitation in place during our audit period; and
- discussed the results of our audit with CMS officials.

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<sup>25</sup> We excluded facet-joint injections related to the sacral spine because the coverage limitation does not apply to injection sessions related to the sacral spine.



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: MEDICARE ADMINISTRATIVE CONTRACTOR AND GEOGRAPHIC COMPOSITION  
FOR EACH JURISDICTION<sup>26</sup>**

<b>Jurisdiction</b>	<b>MAC</b>	<b>States and Territories</b>
5	Wisconsin Physicians Service Government Health Administrators (WPS)	Iowa, Kansas, Missouri, Nebraska
6	National Government Services, Inc. (NGS)	Illinois, Minnesota, Wisconsin
8	WPS	Indiana, Michigan
15	CGS Administrators, LLC (CGS)	Kentucky, Ohio
E	Noridian	American Samoa, California, Guam, Hawaii, Nevada, Northern Mariana Islands
F	Noridian	Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming
H	Novitas Solutions, Inc. (Novitas)	Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas
J	Palmetto <sup>27</sup>	Alabama, Georgia, Tennessee
K	NGS	Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont
L	Novitas	Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania
M	Palmetto	North Carolina, South Carolina, Virginia, West Virginia
N	First Coast	Florida, Puerto Rico, U.S. Virgin Islands

<sup>26</sup> The jurisdiction designation, MAC, and geographic composition for each jurisdiction are accurate as of November 26, 2019.

<sup>27</sup> During our audit period, Palmetto became the MAC for Jurisdiction J. Before February 26, 2018, Medicare Part B claims for this jurisdiction were processed and paid by Cahaba.

**APPENDIX C: HEALTHCARE COMMON PROCEDURE CODING SYSTEM CODES USED FOR  
BILLING FACET-JOINT INJECTIONS**

<b>HCPCS Code</b>	<b>Description</b>
	<b><i>Cervical/Thoracic Spine Codes</i></b>
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or computed tomography (CT)), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (list separately in addition to code for primary procedure)
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (list separately in addition to code for primary procedure)
	<b><i>Lumbar and Sacral Spine Codes</i></b>
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (list separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (list separately in addition to code for primary procedure)

#### APPENDIX D: IMPROPER PAYMENTS FOR SELECTED FACET-JOINT INJECTION SESSIONS BY JURISDICTION

Jurisdiction*	Medicare Administrative Contractor	Lumbar Spine		Cervical/Thoracic Spine		Total Payment Amount for More Than Five Sessions
		No. of Sessions Above Five Sessions	Payment Amount for More Than Five Sessions	No. of Sessions Above Five Sessions	Payment Amount for More Than Five Sessions	
5	WPS	17	\$2,338	17	\$3,766	\$6,104
6	NGS	19	4,208	3	547	4,755
8	WPS	57	10,322	29	5,007	15,329
15	CGS	6	1,196	9	2,113	3,309
E	Noridian	88	17,990	38	8,152	26,142
F	Noridian	64	13,987	25	5,551	19,538
H	Novitas	902	198,818	493	125,051	323,869
J	Palmetto	1	67	4	1,097	1,164
K	NGS	76	16,622	18	4,398	21,020
L	Novitas	627	143,988	299	76,534	220,522
M	Palmetto	313	72,889	144	33,914	106,803
<b>Total</b>		<b>2,170</b>	<b>\$482,425</b>	<b>1,079</b>	<b>\$266,130</b>	<b>\$748,555</b>
<p>* For all jurisdictions but Jurisdiction J, the limitation of coverage for facet-joint injection sessions was in place for our entire audit period (January 1, 2017, through May 31, 2019). Jurisdiction J's coverage limitation was in place from February 26, 2018, through May 31, 2019.</p>						

## APPENDIX E: CMS COMMENTS




DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

**DATE:** August 27, 2020

**TO:** Amy J. Frontz  
Deputy Inspector General for Audit Services  
Office of Inspector General

**FROM:** Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services 

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Physicians for More Than Five Spinal Facet-Joint Injection Sessions During a Rolling 12-Month Period (A-09-20-03003)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

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. While CMS does not have a national policy to limit coverage of facet-joint injections, 11 of the 12 Medicare Administrative Contractors (MACs) have instituted local coverage determinations (LCDs) to limit Medicare coverage of facet-joint injections to a maximum of five injection sessions per rolling 12-month period in the cervical/thoracic spine as well as five injection sessions in the lumbar spine. These coverage limitations are intended to address inappropriate billing for pain management tied to overuse of spinal facet-joint injections. MACs have the statutory authority to determine which healthcare items and services are medically reasonable and necessary and to develop LCDs for their individual jurisdictions, taking into account local variations in the practice of medicine.<sup>1</sup> LCDs cannot conflict with statutory coverage requirements, Federal regulations, CMS Rulings, national coverage determination, coverage provisions in interpretive manuals, or Medicare payment policies. In the absence of a national coverage determination or other relevant national policies, LCDs are used to determine whether a particular service is considered reasonable and necessary, and therefore covered by Medicare.

CMS and its contractors recognize the importance of providing Medicare beneficiaries with access to medically necessary services and, at the same time, protecting the Medicare Trust Funds from improper payments. Aligning with the MACs' efforts to address inappropriate billing, CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including supporting the MACs' ability to enforce LCDs by creating automated system edits within the claims processing system and prepayment and postpayment medical reviews. As part of this strategy, CMS recovers identified overpayments in accordance with relevant law and agency policies and procedures.

CMS also uses the Fraud Prevention System to analyze Medicare fee-for-service claims using sophisticated algorithms to target investigative resources, generate alerts for suspect claims or

<sup>1</sup> §§1862(l)(5) and 1869(f)(2)(B) of the Social Security Act.

providers and suppliers, provide information to facilitate and support investigations of the most egregious, suspect, or aberrant activity. CMS uses the Fraud Prevention System information to prevent and address improper payments using a variety of administrative tools and actions, including claims denials, payment suspensions, Medicare billing privilege revocations, and law enforcement referrals. CMS leverages the Fraud Prevention System to reflect the coverage limitations set forth by MACs.

It is important to note, however, that the estimated overpayments described in the OIG's report represent less than 0.1 percent of the overall payments made under the Medicare Physician Fee Schedule during the audit timeframe. In addition, of the \$748,555 in improper payments identified by the OIG, \$544,391 were made in two MAC jurisdictions. This was due to an issue with the Fraud Prevention System and it has since been corrected. CMS will continue to educate health care providers on proper billing through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters when appropriate.

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

**OIG Recommendation**

For the 11 MAC jurisdictions with a limitation of coverage for the number of facet joint injection sessions administered during a rolling 12-month period, OIG recommends that CMS direct the MACs that oversee the 11 jurisdictions to recover the portion of the \$748,555 in improper payments made to physicians that are within the 4-year claim-reopening period.

**CMS Response**

CMS concurs with this recommendation. CMS will direct its MACs to recover the identified overpayments consistent with relevant law and the agency's policies and procedures. CMS notes that of the \$748,555 in improper payments identified by the OIG, \$544,391 were made in two MAC jurisdictions.

**OIG Recommendation**

For the 11 MAC jurisdictions with a limitation of coverage for the number of facet-joint injection sessions administered during a rolling 12-month period, OIG recommends that CMS instruct the MACs to, based upon the results of this audit, notify appropriate physicians (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the physicians can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.

**CMS Response**

CMS concurs with this recommendation. CMS will analyze the OIG's data to identify appropriate providers to notify of potential overpayments. Within CMS's policies and procedures, CMS will then instruct its MACs to notify the identified providers of OIG's audit findings. CMS will track any returned overpayments made in accordance with this recommendation and the 60-day rule.

**OIG Recommendation**

For the 11 MAC jurisdictions with a limitation of coverage for the number of facet joint injection sessions administered during a rolling 12-month period, OIG recommends that CMS develop oversight mechanisms specific to paying physicians for a maximum of 5 facet-joint injection



sessions received by beneficiaries during a rolling 12-month period in the in the lumbar spine or cervical/thoracic spine.

**CMS Response**

CMS concurs with this recommendation. CMS will explore oversight mechanisms specific to paying physicians for a maximum of 5 facet-joint injection sessions received by beneficiaries during a rolling 12-month period in the lumbar spine or cervical/thoracic spine for the 11 MAC jurisdictions with a limitation of coverage for the number of facet joint injection sessions administered during a rolling 12-month period.

**OIG Recommendation**

For the 11 MAC jurisdictions with a limitation of coverage for the number of facet joint injection sessions administered during a rolling 12-month period, OIG recommends that CMS direct the MACs that oversee the 11 jurisdictions to review claims for facet-joint injections to identify instances in which Medicare paid physicians for more than 5 injection sessions received by beneficiaries during a rolling 12-month period after our audit period and recover any improper payments identified.

**CMS Response**

CMS concurs with this recommendation. CMS will direct the MACs that oversee the 11 jurisdictions to review claims for facet-joint injections to identify instances in which the given MAC paid physicians for more than 5 injection sessions exceeding the applicable threshold received by a given beneficiary during a rolling 12-month period after the audit period and recover any improper payments identified.

**OIG Recommendation**

For the remaining MAC jurisdiction, which did not have a coverage limitation for the number of facet-joint injection sessions during a rolling 12-month period, we recommend that the Centers for Medicare & Medicaid Services consider working with First Coast to determine whether it should re-implement this coverage limitation, which could have saved \$513,328 during our audit period.

**CMS Response**

CMS concurs with this recommendation. In the absence of a national coverage determination or other national policy, MACs determine local coverage policies and any revisions the MAC chooses to make to its LCD must be implemented through the LCD reconsideration process in accordance with CMS policies and procedures, including a formal notice and comment period.