

Report in Brief

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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.