

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE IMPROPERLY PAID  
PHYSICIANS FOR  
SPINAL FACET-JOINT  
DENERVATION SESSIONS**

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**December 2021  
A-09-21-03002**

# ***Office of Inspector General***

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## Report in Brief

Date: December 2021

Report No. A-09-21-03002

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



### Why OIG Did This Audit

To address inappropriate billing for and overuse of spinal facet-joint denervation for pain management, the Medicare Administrative Contractors (MACs) developed two limitations of coverage. One coverage limitation, in place in 11 of the 12 MAC jurisdictions, allowed reimbursement during a 12-month period for a maximum of 2 denervation sessions per beneficiary related to the lumbar and cervical/thoracic regions of the spine. The other coverage limitation allowed reimbursement for a maximum of 4 or 10 facet joints per denervation session, depending on the MAC jurisdiction. A prior OIG audit found that MACs that limited coverage to five facet-joint injection sessions related to the lumbar and cervical/thoracic spines during a 12-month period had improperly paid physicians.

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

### How OIG Did This Audit

For dates of service from January 2019 through August 2020 (audit period), our audit covered denervation sessions: (1) for beneficiaries who received more than 2 sessions for at least 1 covered spinal region (i.e., the lumbar or cervical/thoracic spines) during a 12-month period (totaling \$16.8 million) and (2) that included denervation of more than 4 or 10 facet joints (totaling \$10.9 million).

## Medicare Improperly Paid Physicians for Spinal Facet-Joint Denervation Sessions

### What OIG Found

Medicare did not pay physicians for selected facet-joint denervation sessions in accordance with Medicare requirements. Specifically, for our audit period, the MACs for the 11 jurisdictions with a coverage limitation of 2 facet-joint denervation sessions per beneficiary for each covered spinal region during a 12-month period made improper payments of \$7.2 million. In addition, the MACs for the 9 jurisdictions with a coverage limitation of 4 facet joints per denervation session and the MACs for the remaining 3 jurisdictions with a coverage limitation of 10 facet joints per denervation session made improper payments of \$2.3 million. In total, Medicare improperly paid physicians \$9.5 million. These improper payments occurred because the Centers for Medicare & Medicaid Services' (CMS's) oversight was not adequate to prevent or detect improper payments for selected facet-joint denervation sessions.

### What OIG Recommends and CMS Comments

We recommend that CMS: (1) direct the MACs to recover \$9.5 million in improper payments made to physicians for selected facet-joint denervation sessions; (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; and (3) assess the effectiveness of oversight mechanisms specific to preventing or detecting improper payments to physicians for facet-joint denervation sessions, and modify the oversight mechanisms based on that assessment. We also made two procedural recommendations to CMS (detailed in the report) to direct the MACs to review claims for denervation sessions after our audit period to recover any improper payments.

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 assessing the effectiveness of its oversight mechanisms.

## TABLE OF CONTENTS

INTRODUCTION.....	1
Why We Did This Audit.....	1
Objective .....	2
Background .....	2
Medicare Part B.....	2
Spinal Facet Joints and Medicare Coverage of Facet-Joint Denervation Sessions.....	2
Physician Submission of Claims for Facet-Joint Denervation Sessions and the Use of Procedure Codes.....	3
Medicare Requirements for Physicians To Identify and Return Overpayments ....	3
How We Conducted This Audit.....	4
FINDINGS .....	5
Medicare Improperly Paid Physicians for Selected Facet-Joint Denervation Sessions .....	5
Improper Medicare Payments for More Than Two Facet-Joint Denervation Sessions per Beneficiary for Each Covered Spinal Region in a 12-Month Period .....	6
Improper Medicare Payments for More Than the Allowable Number of Facet Joints per Denervation Session.....	7
CMS Oversight Was Not Adequate To Prevent or Detect Improper Payments to Physicians for Selected Facet-Joint Denervation Sessions .....	9
The Medicare Administrative Contractors Updated Their Coverage Limitations for Facet-Joint Denervation Sessions After Our Audit Period .....	10
RECOMMENDATIONS.....	10
CMS COMMENTS .....	11
APPENDICES	
A: Audit Scope and Methodology.....	12
B: Medicare Administrative Contractor and Geographic Composition for Each Jurisdiction .....	14

C: Improper Payments for More Than Two Facet-Joint Denervation Sessions  
per Beneficiary for Each Covered Spinal Region in a 12-Month Period ..... 15

D: Improper Payments for More Than the Allowable Number of Facet Joints  
per Denervation Session ..... 16

E: CMS Comments ..... 17

## INTRODUCTION

### WHY WE DID THIS AUDIT

Facet-joint denervation is a procedure that physicians use to treat neck or back pain caused by arthritis in or injury to the facet joints in the spine. To address inappropriate billing for and overuse of spinal facet-joint denervation for pain management, the Medicare Administrative Contractors (MACs) developed two limitations of coverage. One of the coverage limitations, in place in 11 of the 12 MAC jurisdictions, allowed physicians to be reimbursed, during a 12-month period,<sup>1</sup> for a maximum of 2 facet-joint denervation sessions<sup>2</sup> per beneficiary for each covered spinal region: (1) the lumbar region (lumbar spine) and (2) the cervical and thoracic regions (cervical/thoracic spine).<sup>3</sup> The other coverage limitation allowed physicians to be reimbursed for a maximum of 4 or 10 facet joints per denervation session, depending on the MAC jurisdiction.<sup>4</sup> (We refer to denervation sessions in which either coverage limitation was exceeded as “selected facet-joint denervation sessions.”)

A prior Office of Inspector General (OIG) audit found that MACs that limited coverage to five facet-joint injection sessions related to the lumbar and cervical/thoracic spines during a rolling year had improperly paid physicians \$748,555 for sessions that exceeded this coverage limitation from January 1, 2017, through May 31, 2019.<sup>5</sup> Therefore, we conducted this audit to determine whether Medicare made improper payments from January 1, 2019, through August 31, 2020 (audit period), for selected facet-joint denervation sessions in the MAC jurisdictions that had coverage limitations.

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<sup>1</sup> A 12-month period refers to either a calendar year or a rolling year, which is a date range that starts with the date of an individual service and ends 1 day before that date in the following year (e.g., if a service was provided on June 1, 2019, the rolling year would be June 1, 2019, through May 31, 2020).

<sup>2</sup> A session is a single date of service on which a beneficiary received facet-joint denervation.

<sup>3</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, which includes the neck.

<sup>4</sup> Through April 24, 2021, 8 of the 12 MAC jurisdictions had a coverage limitation of 4 facet joints per denervation session, and 3 jurisdictions had a coverage limitation of 10 facet joints per denervation session. Through May 1, 2021, the remaining jurisdiction had a coverage limitation of 4 facet joints per denervation session.

<sup>5</sup> *Medicare Improperly Paid Physicians for More Than Five Spinal Facet-Joint Injection Sessions During a Rolling 12-Month Period* ([A-09-20-03003](#)), issued Oct. 9, 2020. Facet-joint injections of an anesthetic with or without a steroid are used to diagnose or treat chronic neck and back pain. We also issued a report on Medicare payments made by Noridian Healthcare Solutions, LLC, to physicians in Jurisdiction E for spinal facet-joint injections, entitled *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](#)), issued Feb. 19, 2021.

## OBJECTIVE

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

## BACKGROUND

### Medicare Part B

Medicare Part B provides supplementary medical insurance, including coverage for the cost of facet-joint denervation sessions 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 against fraud and abuse. Each MAC is responsible for processing claims submitted by physicians within 1 or more of 12 designated regions, or jurisdictions, of the United States and its territories. Appendix B shows the MAC and geographic composition for each jurisdiction.

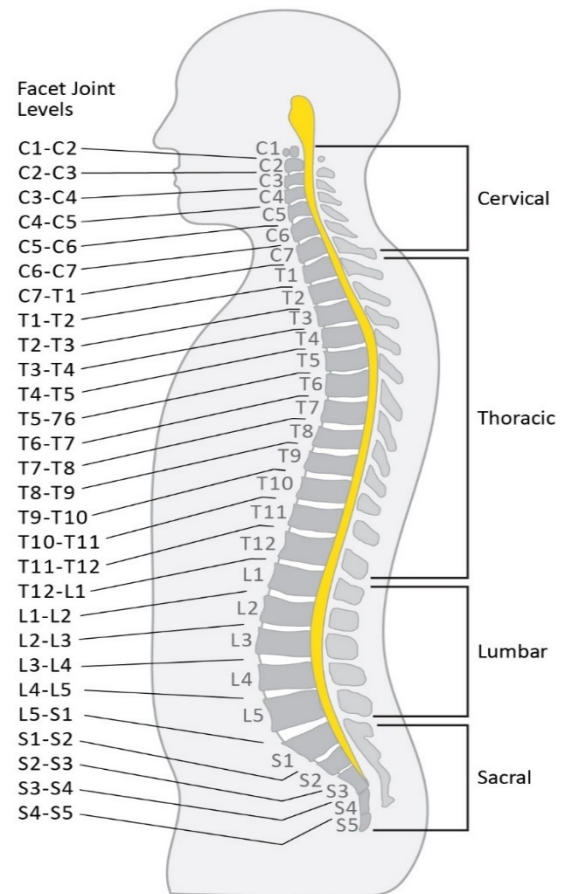
### Spinal Facet Joints and Medicare Coverage of Facet-Joint Denervation Sessions

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 to the right.) Each level has a pair of facet joints: one on the left side and one on the right side of the spine.

Facet-joint denervation is an interventional technique used by physicians to treat central neck or back pain caused by arthritis in or injury to the facet joints.<sup>7</sup> The procedure involves using a special needle with a heated tip to destroy the nerves that supply the joints.

For 11 of the 12 MAC jurisdictions, Medicare Part B covers a limited number of facet-joint denervation sessions for a beneficiary during a 12-month period. The MACs' local

**Figure: Spinal Regions and Facet-Joint Levels**



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

<sup>7</sup> Examples of physicians who administer facet-joint denervation sessions include those who specialize in interventional pain management, anesthesiology, and internal medicine.



coverage determinations (LCDs) for facet-joint procedures in those 11 jurisdictions specify that, during a 12-month period, Medicare will cover a maximum of 2 sessions in which facet-joint denervation is performed on the lumbar spine and a maximum of 2 sessions in which facet-joint denervation is performed on the cervical/thoracic spine.<sup>8</sup> In addition, the LCDs for 9 of the 12 MAC jurisdictions specify that Medicare will cover a maximum of 4 facet joints per denervation session, and the LCDs for the remaining 3 jurisdictions specify that Medicare will cover a maximum of 10 facet joints per denervation session.<sup>9</sup> The MACs established these coverage limitations because evidence of the clinical effectiveness of facet-joint denervation has not been well-established in the medical literature.

### **Physician Submission of Claims for Facet-Joint Denervation Sessions and the Use of Procedure 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.

Medicare requires a uniform procedure coding system for all physicians' services (Social Security Act § 1848(c)(5)). Physicians bill Medicare for denervation of a single facet joint in the cervical/thoracic spine or the lumbar spine using one of two primary Current Procedural Terminology (CPT)<sup>10</sup> codes depending on the spinal region: 64633 for the cervical/thoracic spine and 64635 for the lumbar spine. Each primary CPT code has an associated add-on code for use when additional facet joints are included in the denervation session: 64634 for the cervical/thoracic spine and 64636 for the lumbar spine. For CPT codes 64633 and 64635, a unit of service is a single facet joint, and for CPT codes 64634 and 64636, a unit of service is each additional facet joint.

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

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, physicians must exercise

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<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. First Coast Service Options, Inc. (First Coast), did not limit the number of facet-joint denervation sessions to be reimbursed during a 12-month period for the remaining MAC jurisdiction (LCD L33814 for jurisdiction N).

<sup>9</sup> These coverage limitations do not apply to facet-joint denervation sessions related to the sacral spine. Sacral-spine conditions are identified on the physician-submitted claim by specific codes in the *International Classification of Diseases*, Tenth Revision, Clinical Modification (ICD-10).

<sup>10</sup> **The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2018–2020 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

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 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>11</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>12</sup>

## **HOW WE CONDUCTED THIS AUDIT**

During our audit period, the MACs paid physicians \$165.4 million for 393,427 facet-joint denervation sessions related to the lumbar spine and \$44.1 million for 103,017 facet-joint denervation sessions related to the cervical/thoracic spine. Our audit covered: (1) facet-joint denervation sessions for beneficiaries who received more than 2 denervation sessions for at least 1 covered spinal region (i.e., the lumbar or cervical/thoracic spines) during a 12-month period (40,026 sessions totaling \$16.8 million) and (2) denervation sessions that included denervation of more than 4 or 10 facet joints, depending on the MAC jurisdiction's specific coverage limitation (19,077 sessions totaling \$10.9 million).

For each facet-joint denervation 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 facet-joint denervation sessions.

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.

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<sup>11</sup> Social Security Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

<sup>12</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.

## FINDINGS

Medicare did not pay physicians for selected facet-joint denervation sessions in accordance with Medicare requirements. Specifically, for our audit period, we identified the following deficiencies:

- The MACs for the 11 jurisdictions with a coverage limitation of 2 facet-joint denervation sessions per beneficiary for each covered spinal region during a 12-month period made improper payments of \$7.2 million, consisting of \$5.5 million in payments for more than 2 sessions related to the lumbar spine and \$1.7 million in payments for more than 2 sessions related to the cervical/thoracic spine.<sup>13</sup>
- The MACs for the 9 jurisdictions with a coverage limitation of 4 facet joints per denervation session and the MACs for the remaining 3 jurisdictions with a coverage limitation of 10 facet joints per denervation session made improper payments of \$2.3 million. Of this amount, approximately \$2 million represented payments for sessions that had denervation of more than 4 or 10 facet joints related to the lumbar spine, and \$330,691 represented payments for sessions that had denervation of more than 4 or 10 facet joints related to the cervical/thoracic spine, depending on the MAC jurisdiction's specific coverage limitation.<sup>14</sup>

In total, Medicare improperly paid physicians \$9.5 million.<sup>15</sup> These improper payments occurred because CMS's oversight was not adequate to prevent or detect improper payments for selected facet-joint denervation sessions.

### **MEDICARE IMPROPERLY PAID PHYSICIANS FOR SELECTED FACET-JOINT DENERVATION SESSIONS**

Medicare made improper payments of \$9.5 million for facet-joint denervation sessions related to the lumbar and cervical/thoracic spines for more than 2 facet-joint denervation sessions per beneficiary for each covered spinal region in a 12-month period and for more than the allowable number of facet joints (i.e., 4 or 10, depending on the MAC jurisdiction's specific coverage limitation) per denervation session.

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<sup>13</sup> The total improper payment amount was \$7,207,425, consisting of \$5,488,115 related to the lumbar spine and \$1,719,310 related to the cervical/thoracic spine. First Coast did not limit the number of facet-joint denervation sessions to be reimbursed during a 12-month period for the remaining MAC jurisdiction.

<sup>14</sup> The total improper payment amount was \$2,320,871, consisting of \$1,990,180 related to the lumbar spine and \$330,691 related to the cervical/thoracic spine.

<sup>15</sup> The unrounded amount was \$9,528,296.

## **Improper Medicare Payments for More Than Two Facet-Joint Denervation Sessions per Beneficiary for Each Covered Spinal Region in a 12-Month Period**

During our audit period, for 11 of the 12 MAC jurisdictions, for each covered spinal region (lumbar or cervical/thoracic), no more than 2 facet-joint denervation sessions per beneficiary would be reimbursed in a 12-month period (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).<sup>16</sup>

In the 11 jurisdictions with a coverage limitation for the number of facet-joint denervation sessions per beneficiary, MACs improperly paid physicians for more than 2 denervation sessions related to: (1) the lumbar spine (13,064 sessions for 8,838 beneficiaries) and (2) the cervical/thoracic spine (3,886 sessions for 2,451 beneficiaries). For each of these beneficiaries, Medicare improperly paid physicians for at least one facet-joint denervation session above the two-session maximum per beneficiary in a 12-month period.<sup>17</sup> The number of improperly paid sessions during a 12-month period ranged from 1 to 11 sessions.

The example on the following page shows an instance in which a physician was improperly paid during a 12-month period for six facet-joint denervation sessions that exceeded the coverage limitation.

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<sup>16</sup> We identified improperly paid sessions for each jurisdiction based on how a 12-month period was defined in the applicable LCD (i.e., a rolling year for J5, J8, JE, JF, JH, JJ, JL, and JM, and a calendar year for J6, J15, and JK).

<sup>17</sup> In total, we identified 10,962 beneficiaries. Of these beneficiaries, 327 had more than 2 denervation sessions related to the lumbar spine and more than 2 denervation sessions related to the cervical/thoracic spine.

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

One beneficiary had eight facet-joint denervation sessions related to the lumbar spine during the rolling year January 23, 2019, through January 22, 2020. The physician who administered these denervation sessions billed and received payment from Medicare for all eight sessions instead of just the first two sessions. As a result, the physician was paid \$3,495 instead of \$874, the amount paid for the first two denervation sessions, representing an overpayment of \$2,621.

**Lumbar Spine Facet-Joint Denervation Sessions**

Rolling Year:  
Jan. 23, 2019 – Jan. 22, 2020

**Covered by Medicare:**  
First two sessions during rolling year

1. January 23, 2019
2. February 6, 2019

Amount paid for first two sessions: \$874

**NOT Covered by Medicare:**  
Sessions after second session during rolling year

3. June 19, 2019
4. July 12, 2019
5. July 23, 2019
6. August 9, 2019
7. October 30, 2019
8. November 26, 2019

Amount overpaid for more than two sessions: \$2,621

Beneficiary Name

In total, the MACs for the 11 jurisdictions with a coverage limitation made improper payments of \$7.2 million for 16,948 sessions.<sup>18</sup> Of this amount, \$5.5 million represented payments for denervation sessions related to the lumbar spine, and \$1.7 million represented payments for denervation sessions related to the cervical/thoracic spine.

Appendix C provides a summary, by jurisdiction, of the MACs' improper payments to physicians for more than two facet-joint denervation sessions per beneficiary for each covered spinal region (i.e., the lumbar or cervical/thoracic spines) in a 12-month period.

### Improper Medicare Payments for More Than the Allowable Number of Facet Joints per Denervation Session

During our audit period, for 9 of the 12 MAC jurisdictions, no more than 2 bilateral or 4 unilateral facet-joint levels, which equated to a maximum of 4 facet joints, would be reimbursed for each facet-joint denervation session (LCDs L34832 for J15, L34993 for JE, L34995

<sup>18</sup> Of these 16,948 sessions, 2 resulted in improper payments for both the lumbar and cervical/thoracic spines.

for JF, L35936 for J6 and JK, L35996 for J5 and J8, and L36471 for JJ and JM).<sup>19</sup> For the remaining 3 MAC jurisdictions, no more than 5 facet-joint levels, bilateral or unilateral, which equated to a maximum of 10 facet joints, would be reimbursed for each facet-joint denervation session (LCDs L33814 for JN and L34892 for JH and JL).<sup>20</sup>

In the 9 jurisdictions with a coverage limitation of 4 facet joints per denervation session, MACs improperly paid physicians for denervation of more than 4 facet joints related to the lumbar spine (35,487 facet joints for 16,360 sessions for 13,563 beneficiaries) and the cervical/thoracic spine (4,958 facet joints for 2,463 sessions for 2,053 beneficiaries). In the remaining 3 jurisdictions with a coverage limitation of 10 facet joints per denervation session, MACs improperly paid physicians for denervation of more than 10 facet joints related to the lumbar spine (2 facet joints for 1 session for 1 beneficiary) and the cervical/thoracic spine (63 facet joints for 12 sessions for 11 beneficiaries).

The number of improperly paid facet joints for a denervation session ranged from 1 to 41 facet joints.<sup>21</sup> The example shows an instance in which a physician was improperly paid for denervation of 41 facet joints that exceeded the coverage limitation of 10 facet joints.

**Example: A Physician Was Improperly Paid for 41 Facet Joints for a Denervation Session Related to the Cervical/Thoracic Spine**

A physician billed for facet-joint denervation of 51 facet joints related to the cervical/thoracic spine. The physician received payment from Medicare for all 51 facet joints instead of just the first 10 facet joints (the allowable number in this MAC jurisdiction). As a result, the physician was paid \$2,869 instead of \$661, the amount paid for the first 10 facet joints, representing an overpayment of \$2,208.

In total, the MACs for the 12 jurisdictions made improper payments of \$2.3 million for 18,832 sessions.<sup>22</sup> Of this amount, approximately \$2 million represented payments for denervation of facet joints related to the lumbar spine, and \$330,691 represented payments for denervation of facet joints related to the cervical/thoracic spine.<sup>23</sup>

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<sup>19</sup> If denervation is performed bilaterally, four facet joints are calculated as two facet-joint levels multiplied by two facet joints per level. If denervation is performed unilaterally, four facet joints are calculated as four facet-joint levels multiplied by one facet joint per level.

<sup>20</sup> A maximum of 10 facet joints is calculated as 5 facet-joint levels multiplied by 2 facet joints per level.

<sup>21</sup> In total, we identified 15,271 beneficiaries. Of these beneficiaries, 357 had denervation of more than 4 facet joints per denervation session related to the lumbar spine and denervation of more than 4 facet joints per denervation session related to the cervical/thoracic spine.

<sup>22</sup> Of these 18,832 sessions, 4 resulted in improper payments for both the lumbar and cervical/thoracic spines.

<sup>23</sup> This finding does not include improper payments that were already identified in the previous finding (payments for more than two facet-joint denervation sessions per beneficiary for each covered spinal region in a 12-month period).

Appendix D provides a summary, by jurisdiction, of the MACs' improper payments to physicians for more than the allowable number of facet joints per denervation session.

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

During our audit period, CMS oversight was not adequate to prevent or detect improper payments to physicians during a 12-month period in which beneficiaries received more than two facet-joint denervation sessions related to the lumbar spine or the cervical/thoracic spine. If CMS had had oversight mechanisms (e.g., the MACs' claims processing system edits) in place for the 11 MAC jurisdictions that had a coverage limitation for the number of facet-joint denervation sessions during a 12-month period, these mechanisms would have helped to reduce the number of improperly paid denervation sessions that we identified (totaling \$7.2 million for 16,948 sessions).<sup>24</sup>

CMS's oversight was also not adequate to prevent or detect improper payments to physicians who billed for denervation of more than 4 or 10 facet joints (depending on the MAC jurisdiction's specific coverage limitation) during a denervation session related to the lumbar spine or the cervical/thoracic spine. For example, during our audit period, CMS had medically unlikely edits (MUEs) in place that would deny payment for facet-joint denervation services if physicians billed for more than one facet joint for the primary facet-joint denervation CPT codes (64633 and 64635) and more than four facet joints for the add-on facet-joint denervation CPT codes (64634 and 64636).<sup>25</sup> However, the MUEs did not prevent payment for the number of improperly billed facet joints for denervation sessions we identified (totaling \$2.3 million for 18,832 sessions). CMS stated that the MUEs should have denied payment for denervation sessions billed with denervation CPT codes that exceeded the MUE values. CMS would need to confirm with the MACs why they allowed payment for these sessions.

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<sup>24</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 claims 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.

<sup>25</sup> An MUE for a CPT code is a claims processing edit that is based on the maximum number of units of service that a provider would bill under most circumstances for a single beneficiary on a single date of service. MUEs are prepayment edits to reduce the improper payment rate for certain types of services. A MAC denies the entire service for payment when the billed units of service exceed MUE criteria. CMS publishes most MUE values on its website. For facet-joint denervation sessions, 1 unit of service for the primary CPT codes equates to a single facet joint, and 1 unit of service for the add-on CPT codes equates to each additional facet joint that is listed separately from the primary CPT codes.

## THE MEDICARE ADMINISTRATIVE CONTRACTORS UPDATED THEIR COVERAGE LIMITATIONS FOR FACET-JOINT DENERVATION SESSIONS AFTER OUR AUDIT PERIOD

After our audit period, all 12 MACs updated their LCDs specific to facet-joint denervation sessions to limit the number per beneficiary of reimbursable: (1) sessions for each covered spinal region to no more than 2 sessions per rolling year<sup>26</sup> and (2) facet-joint levels to 4, bilateral or unilateral, for each facet-joint denervation session, which equates to a maximum of 8 facet joints per session.<sup>27</sup> These revised coverage limitations became effective for 11 of the 12 MAC jurisdictions for denervation sessions on or after April 25, 2021 (LCDs L33930 for JN, L34892 for JH and JL, L35936 for J6 and JK, L38765 for JJ and JM, L38801 for JE, L38803 for JF, and L38841 for J5 and J8), and for the remaining MAC jurisdiction for denervation sessions on or after May 2, 2021 (LCD L38773 for J15).

### RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- direct the MACs to recover \$9,528,296 in improper payments made to physicians for selected facet-joint denervation sessions;
- 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;
- assess the effectiveness of oversight mechanisms specific to preventing or detecting improper payments to physicians for more than two facet-joint denervation sessions related to the lumbar spine or cervical/thoracic spine per beneficiary during a rolling year and modify the oversight mechanisms based on that assessment;
- assess the effectiveness of oversight mechanisms specific to preventing or detecting improper payments to physicians for more than the allowed number of facet joints per denervation session to determine why the MACs allowed more than the MUE values

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<sup>26</sup> CMS stated that it developed oversight mechanisms that could potentially prevent future improper payments for more than two denervation sessions during a rolling year. Because the oversight mechanisms were implemented after our audit period, we did not assess them or verify their effectiveness.

<sup>27</sup> A maximum of eight facet joints is calculated as four facet-joint levels multiplied by two facet joints per level. According to the LCDs, one to two levels, either unilateral or bilateral, are allowed per session per spinal region. The need for a three-level or four-level procedure bilaterally may be considered under unique circumstances and with sufficient documentation of medical necessity on appeal.



that were applicable during our audit period, and modify the oversight mechanisms based on that assessment;

- direct the MACs to review claims for facet-joint denervation sessions after our audit period to identify instances in which Medicare paid physicians for denervation sessions that exceeded the number of allowable sessions in a 12-month period (in accordance with the applicable LCDs) and recover any improper payments identified; and
- direct the MACs to review claims for facet-joint denervation sessions after our audit period to identify instances in which Medicare paid physicians for facet joints that exceeded the number of allowable facet joints per session (in accordance with the applicable LCDs) and recover any improper payments identified.

### **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. These actions included, among others, directing the MACs to recover the identified overpayments consistent with relevant law and CMS's policies and procedures, as well as assessing the effectiveness of oversight mechanisms specific to preventing or detecting improper payments to physicians for more than: (1) two facet-joint denervation sessions related to the lumbar spine or cervical/thoracic spine per beneficiary during a rolling year and (2) the allowed number of facet joints per denervation session. CMS's comments appear in their entirety as Appendix E.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

During our audit period, the MACs paid physicians \$165,410,160 for 393,427 facet-joint denervation sessions related to the lumbar spine and \$44,113,097 for 103,017 facet-joint denervation sessions related to the cervical/thoracic spine.<sup>28</sup> Our audit covered: (1) facet-joint denervation sessions for beneficiaries who received more than 2 denervation sessions for at least 1 covered spinal region (i.e., the lumbar or cervical/thoracic spines) during a 12-month period (40,026 sessions totaling \$16,791,533) and (2) denervation sessions that included denervation of more than 4 or 10 facet joints (19,077 sessions totaling \$10,913,371).

For each facet-joint denervation 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 facet-joint denervation sessions.

We assessed CMS's internal controls and compliance with laws and regulations necessary to satisfy the audit objective. In particular, we assessed principles related to risk assessment and control activities. However, because our audit was limited to these internal control components and underlying principles, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

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 November 2020 to September 2021, 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 coverage limitations for the number of: (1) facet-joint denervation sessions related to the lumbar spine or the

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<sup>28</sup> From August 16, 2018, through January 2, 2019, Novitas Solutions, Inc. (Novitas), placed a hold on LCD 34892, which resulted in the MAC not applying the requirements for facet-joint denervation sessions in JH and JL for these dates of service. For this audit, we included facet-joint denervation sessions that: (1) Novitas processed and paid in JH and JL that had dates of service from January 3, 2019, through August 31, 2020, and (2) the MACs for the remaining jurisdictions processed and paid that had dates of service for our entire audit period (January 1, 2019, through August 31, 2020).

cervical/thoracic spine during a 12-month period and (2) facet joints related to the lumbar spine or the cervical/thoracic spine to be included in a denervation session;

- interviewed staff at CMS regarding the types of oversight mechanisms specific to reimbursing physicians in the MAC jurisdictions with coverage limitations for selected facet-joint denervation sessions;
- used CMS's NCH file to identify claims for denervation of facet joints in the lumbar and sacral spines (billed using CPT<sup>29</sup> codes 64635 and 64636) and denervation of facet joints in the cervical/thoracic spine (billed using CPT codes 64633 and 64634) with dates of service during our audit period;
- performed data analysis to identify during our audit period: (1) beneficiaries who received more than 2 facet-joint denervation sessions related to the lumbar spine<sup>30</sup> and beneficiaries who received more than 2 denervation sessions related to the cervical/thoracic spine during a 12-month period and (2) denervation sessions in which physicians billed for more than 4 or 10 facet joints per denervation session, depending on the MAC jurisdiction's specific coverage limitation;
- calculated improper payments in which: (1) MACs with the coverage limitation in 11 of 12 jurisdictions<sup>31</sup> paid physicians for more than 2 facet-joint denervation sessions per beneficiary related to the lumbar spine and for more than 2 denervation sessions per beneficiary related to the cervical/thoracic spine during a 12-month period and (2) physicians billed for more than 4 or 10 facet joints per denervation session; and
- discussed the results of our audit with CMS officials.

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.

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<sup>29</sup> The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2018–2020 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.

<sup>30</sup> We excluded facet-joint denervation sessions related to the sacral spine because the coverage limitation does not apply to denervation sessions related to the sacral spine.

<sup>31</sup> First Coast did not limit the number of facet-joint denervation sessions to be reimbursed during a 12-month period for the remaining MAC jurisdiction.

**APPENDIX B: MEDICARE ADMINISTRATIVE CONTRACTOR AND GEOGRAPHIC COMPOSITION  
FOR EACH JURISDICTION<sup>32</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 Healthcare Solutions, LLC (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 GBA, LLC (Palmetto)	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 Service Options, Inc. (First Coast)	Florida, Puerto Rico, U.S. Virgin Islands

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<sup>32</sup> The jurisdiction designation, MAC, and geographic composition for each jurisdiction are accurate as of April 23, 2021.

**APPENDIX C: IMPROPER PAYMENTS FOR MORE THAN TWO FACET-JOINT DENERVATION SESSIONS  
PER BENEFICIARY FOR EACH COVERED SPINAL REGION IN A 12-MONTH PERIOD**

Jurisdiction*	Medicare Administrative Contractor	Type of Year for Counting Denervation Sessions for a 12-Month Period	Lumbar Spine		Cervical/Thoracic Spine		Total Improper Payment Amount
			No. of Sessions Above Two Sessions	Payment Amount for More Than Two Sessions	No. of Sessions Above Two Sessions	Payment Amount for More Than Two Sessions	
5	WPS	Rolling	43	\$13,937	13	\$6,117	\$20,054
6	NGS	Calendar	898	307,121	274	102,435	409,556
8	WPS	Rolling	35	14,896	16	7,785	22,681
15	CGS	Calendar	1,121	460,035	299	123,520	583,555
E	Noridian	Rolling	1,762	689,559	613	240,384	929,943
F	Noridian	Rolling	2,277	979,622	927	430,717	1,410,339
H	Novitas	Rolling	691	270,925	220	96,671	367,596
J	Palmetto	Rolling	1,822	646,330	541	196,843	843,173
K	NGS	Calendar	1,233	643,484	291	180,876	824,360
L	Novitas	Rolling	215	88,783	41	17,702	106,485
M	Palmetto	Rolling	2,967	1,373,423	651	316,260	1,689,683
<b>Total</b>			<b>13,064</b>	<b>\$5,488,115</b>	<b>3,886</b>	<b>\$1,719,310</b>	<b>\$7,207,425</b>

\* For all jurisdictions but JH and JL, the coverage limitation that allowed for reimbursing physicians for no more than two facet-joint denervation sessions per beneficiary for each covered spinal region was in place for our entire audit period. For JH and JL, the coverage limitation was in place from January 3, 2019, through August 31, 2020.

**APPENDIX D: IMPROPER PAYMENTS FOR MORE THAN THE ALLOWABLE NUMBER OF FACET JOINTS PER DENERVATION SESSION**

Jurisdiction*	Medicare Administrative Contractor	Allowable Number of Facet Joints per Denervation Session	Lumbar Spine		Cervical/Thoracic Spine		Total Improper Payment Amount
			No. of Sessions With Facet Joints Above Allowable Number per Session	Payment Amount for Sessions With Facet Joints Above Allowable Number per Session	No. of Sessions With Facet Joints Above Allowable Number per Session	Payment Amount for Sessions With Facet Joints Above Allowable Number per Session	
5	WPS	4	1,585	\$161,448	255	\$26,025	\$187,473
6	NGS	4	1,692	189,758	296	38,717	228,475
8	WPS	4	1,969	261,524	285	43,646	305,170
15	CGS	4	489	57,273	61	8,377	65,650
E	Noridian	4	1,190	130,598	278	32,412	163,010
F	Noridian	4	1,533	199,530	197	24,386	223,916
H	Novitas	10	0	0	3	2,368	2,368
J	Palmetto	4	4,155	473,838	517	69,814	543,652
K	NGS	4	2,398	309,262	351	46,484	355,746
L	Novitas	10	0	0	0	0	0
M	Palmetto	4	1,349	206,875	223	37,704	244,579
N	First Coast	10	1	74	9	758	832
<b>Total</b>			<b>16,361</b>	<b>\$1,990,180</b>	<b>2,475</b>	<b>\$330,691</b>	<b>\$2,320,871</b>

\* For all jurisdictions but JH and JL, the coverage limitation that allowed for reimbursing physicians for denervation of no more than 4 or 10 facet joints per denervation session of each covered spinal region was in place for our entire audit period. For JH and JL, the coverage limitation was in place from January 3, 2019, through August 31, 2020.

## APPENDIX E: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

**DATE:** October 21, 2021

**TO:** Amy K. Frontz  
Deputy Inspector General  
Office of Inspector General

**FROM:** Chiquita Brooks-LaSure *Chiquita Brooks-LaSure*  
Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid  
Physicians for Spinal Facet-Joint Denervation Sessions (A-09-21-03002)

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 is committed to providing Medicare beneficiaries with high quality health care while protecting taxpayer dollars.

Facet-joint denervation is a therapeutic intervention used to provide both long-term pain relief and reduce the likelihood of recurrence of chronic back pain caused by arthritis or an injury. CMS contracts with Medicare Administrative Contractors (MACs) to review and process claims, educate providers and suppliers on billing requirements, handle claims appeals, and detect and prevent fraud and abuse, among other tasks. MACs have the statutory authority to determine which healthcare items and services are 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.

During the OIG's audit period of January 2019 to August 2020, 11 of the 12 MACs had instituted LCDs to limit Medicare coverage of facet-joint denervation to a maximum of two denervation sessions per rolling 12-month period in the lumbar and cervical/thoracic regions of the spine. In addition, nine of the 12 MACs had coverage limitations of four facet joints per denervation session, while three jurisdictions had a coverage limitation of 10 facet joints per denervation session. As OIG noted, after the OIG's audit period, all 12 MAC jurisdictions updated their LCDs specific to facet-joint denervation sessions to limit the number of sessions per beneficiary for each covered spinal region to a maximum of two sessions per rolling year and a maximum of eight facet joints per session. These revised coverage limitations became effective for 11 of the 12 MAC jurisdictions for denervation sessions on or after April 25, 2021, and on or after May 2, 2021 for the remaining MAC jurisdiction.

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 (FPS) to analyze Medicare fee-for-service claims using sophisticated algorithms to target investigative resources, generate alerts for suspect claims or providers and suppliers, and provide information to facilitate and support investigations of the most egregious, suspect, or aberrant activity. CMS uses the FPS 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 FPS to reflect the coverage limitations set forth by MACs.

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 review to determine whether services were medically necessary. OIG also did not contact any of the physicians who administered the facet-joint denervation sessions. Without conducting medical record review, it is unclear whether the potential overpayments that the OIG identified were the result of medically necessary procedures. Through the administrative appeals process, a medical necessity review may be conducted and the denied services may be subsequently deemed medically necessary.

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

**OIG Recommendation**

Direct the MACs to recover \$9,528,296 in improper payments made to physicians for selected facet-joint denervation sessions.

**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.

**OIG Recommendation**

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

**OIG Recommendation**

Assess the effectiveness of oversight mechanisms specific to preventing or detecting improper payments to physicians for more than two facet-joint denervation sessions related to the lumbar spine or cervical/thoracic spine per beneficiary during a rolling year and modify the oversight mechanisms based on that assessment.

**CMS Response**

CMS concurs with the recommendation. CMS will assess the effectiveness of oversight mechanisms specific to preventing or detecting improper payments to physicians for more than



two facet-joint denervation sessions related to the lumbar spine or cervical/thoracic spine per beneficiary during a rolling year.

**OIG Recommendation**

Assess the effectiveness of oversight mechanisms specific to preventing or detecting improper payments to physicians for more than the allowed number of facet joints per denervation session to determine why the MACs allowed more than the MUE values that were applicable during our audit period, and modify the oversight mechanisms based on that assessment.

**CMS Response**

CMS concurs with the recommendation. CMS will assess the effectiveness of mechanisms specific to preventing or detecting improper payments to physicians for more than the allowed number of facet joints per denervation session to determine why the claims processing contractors allowed more than the MUE values that were applicable during the OIG's audit period. CMS will then work with the MACs and shared system maintainers to modify the oversight mechanisms based on this assessment.

**OIG Recommendation**

Direct the MACs to review claims for facet-joint denervation sessions after our audit period to identify instances in which Medicare paid physicians for denervation sessions that exceeded the number of allowable sessions in a 12-month period (in accordance with the applicable LCDs) and recover any improper payments identified.

**CMS Response**

CMS concurs with this recommendation. CMS will consider our oversight mechanisms for this claim type and determine the appropriate course of action. If appropriate, CMS will instruct Medicare contractor(s) to review a sample of claims after the OIG's audit period. CMS will recover, as appropriate, any identified overpayments associated with the reviews, in accordance with agency policies and procedures.

**OIG Recommendation**

Direct the MACs to review claims for facet-joint denervation sessions after our audit period to identify instances in which Medicare paid physicians for facet joints that exceeded the number of allowable facet joints per session (in accordance with the applicable LCDs) and recover any improper payments identified.

**CMS Response**

CMS concurs with this recommendation. CMS will consider our oversight mechanisms for this claim type and determine the appropriate course of action. If appropriate, CMS will instruct Medicare contractor(s) to review a sample of claims after the OIG's audit period. CMS will recover, as appropriate, any identified overpayments associated with the reviews, in accordance with agency policies and procedures.