Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE IMPROPERLY PAID PHYSICIANS AN ESTIMATED $30 MILLION FOR SPINAL FACET-JOINT INTERVENTIONS

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Office of Inspector General

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Report in Brief
Date: March 2023
Report No. A-09-22-03006

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

Medicare Improperly Paid Physicians an Estimated $30 Million for Spinal Facet-Joint Interventions

Why OIG Did This Audit

Medicare covers pain management procedures, such as facet-joint interventions, to treat neck or back pain resulting from arthritis in or injury to the spinal facet joints. A prior OIG audit found that for 51 of 100 sampled sessions, a Medicare contractor did not pay physicians in 1 jurisdiction for facet-joint injections in accordance with Medicare requirements. Another OIG audit found that Medicare improperly paid for facet-joint denervation sessions. Because facet-joint interventions are at risk for overutilization and prior audits have found improper payments for these services, we conducted this audit to determine whether Medicare improperly paid for these interventions from August 1 through October 31, 2021 (audit period).

Our objective was to determine whether Medicare paid physicians for spinal facet-joint interventions in accordance with Medicare requirements and guidance.

How OIG Did This Audit

Our audit covered Medicare Part B payments of $62.2 million for 425,843 claim lines for facet-joint interventions, which we grouped into 218,421 sessions, with dates of service during our audit period. We selected a statistical sample of 120 sessions. For each session, we reviewed beneficiaries' medical records to evaluate compliance with Medicare billing requirements and guidance but did not use medical review to determine whether interventions were medically necessary.

What OIG Found

Medicare did not pay physicians for some spinal facet-joint interventions in accordance with Medicare requirements and guidance. Of the 120 sampled sessions, 54 complied with Medicare requirements; however, the remaining 66 sessions did not comply with 1 or more of the requirements. As a result, Medicare made improper payments to physicians of $18,084. On the basis of our sample results, we estimated that Medicare improperly paid physicians $29.6 million for facet-joint interventions for our audit period.

In addition, of the 120 sampled sessions, 43 had claim lines that were billed for at least 1 therapeutic facet-joint injection. Of these 43 sessions, 33 sessions did not meet Medicare guidance. Specifically, 33 sessions had claim lines that should have been billed for diagnostic instead of therapeutic facet-joint injections. This improper billing did not result in improper payments because Medicare pays the same amount for diagnostic and therapeutic facet-joint injections.

The Medicare Administrative Contractors' (MACs') education of physicians and their billing staff varied across their jurisdictions and was not always sufficient to ensure compliance with Medicare requirements and guidance.

What OIG Recommends and CMS Comments

We recommend that the Centers for Medicare & Medicaid Services (CMS) direct the MACs to recover $18,084 in improper payments made to physicians for the 66 sampled sessions. We also recommend that CMS encourage the MACs to: (1) develop collaborative training programs to be used for all of the MAC jurisdictions and that are specific to Medicare requirements for facet-joint interventions, which could have saved an estimated $29.6 million for our audit period; and (2) develop solutions to prevent the incorrect billing of diagnostic facet-joint injections as therapeutic facet-joint injections, such as developing additional education or updating guidance on how each type of injection should be billed. The report contains one other recommendation.

CMS concurred with our recommendations and described actions that it had taken or 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 notifying the MACs of this audit so that they may determine whether additional education on proper billing and Medicare requirements for facet-joint interventions is necessary.

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INTRODUCTION

WHY WE DID THIS AUDIT

Facet-joint injections and facet-joint denervation treat neck or back pain resulting from arthritis in or injury to the spinal facet joints.[1] (In this report, we refer to facet-joint injections and facet-joint denervation collectively as "facet-joint interventions.") Medicare covers pain management procedures, such as facet-joint interventions, but according to the Centers for Medicare & Medicaid Services' (CMS's) and the Medicare Administrative Contractors' (MACs') national and local data, these are high-volume, high-dollar services that may be overutilized. A prior OIG audit found that for 51 of the 100 sessions in the statistical sample, a MAC did not pay physicians in 1 jurisdiction for facet-joint injections in accordance with Medicare requirements.[2, 3] Another OIG audit found that Medicare made improper payments for facet-joint denervation sessions.[4] (See Appendix B for related OIG reports.) Because facet-joint interventions are at risk for overutilization and prior audits have found improper payments for these services, we conducted this audit to determine whether Medicare made improper payments for facet-joint interventions from August 1 through October 31, 2021 (audit period).

OBJECTIVE

Our objective was to determine whether Medicare paid physicians for spinal facet-joint interventions in accordance with Medicare requirements and guidance.

BACKGROUND

Medicare Part B

Medicare Part B provides supplementary medical insurance, including coverage for the cost of facet-joint interventions when they are medically reasonable and necessary. The CMS administers Part B and contracts with MACs to, among other things, determine reimbursement amounts and pay claims, conduct audits, safeguard against fraud and abuse, establish local

[1] Facet joints in the spine aid stability and allow the spine to bend and twist. A facet-joint injection involves the injection of local anesthetic and possibly a corticosteroid in the facet-joint capsule (i.e., an area of connective tissue that covers and closes the facet joint) or along the medial branch nerves supplying the facet joints. Facet-joint denervation is a procedure that involves using a special needle with a heated tip to destroy the nerves that supply the facet joints.

[2] A session included all Medicare Part B claim lines for facet-joint interventions for a single date of service for a beneficiary.

[3] *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 February 19, 2021.

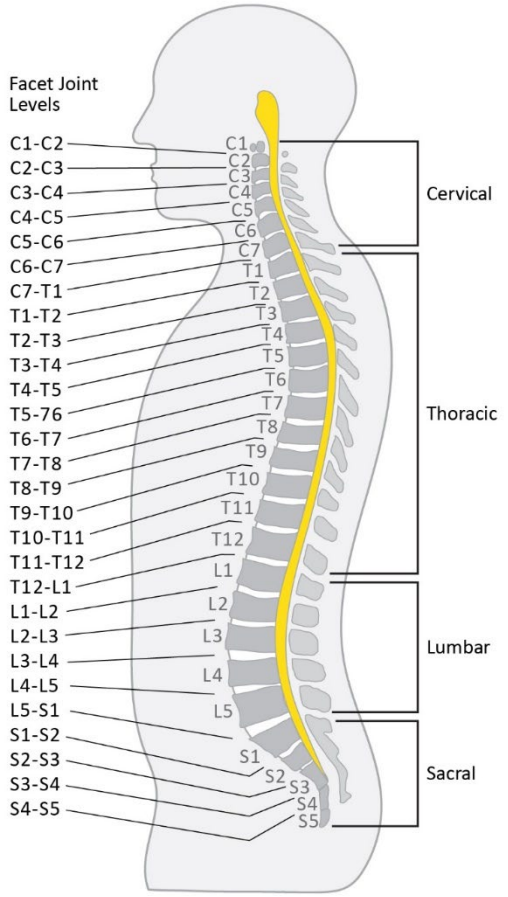
[4] *Medicare Improperly Paid Physicians for Spinal Facet-Joint Denervation Sessions* (A-09-21-03002), issued December 3, 2021.

coverage determinations (LCDs), and educate providers about Medicare billing requirements.[5] Each of the 7 MACs is responsible for processing claims submitted by physicians within 1 of 12 designated regions, or jurisdictions, of the United States and its territories.[6]

Spinal Facet Joints and Types of Facet-Joint Interventions

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. (See Figure 1.) Three of these facet-joint levels connect one spinal region to another. Each level has a pair of facet joints: one on the left side and one on the right side of the spine.

Figure 1: Spinal Regions and Facet-Joint Levels



There are two types of facet-joint interventions: facet-joint injections and facet-joint denervation. Facet-joint injections can be either diagnostic or therapeutic, depending on a beneficiary's medical condition. Facet-joint interventions are performed in the following order: diagnostic facet-joint injections followed by facet-joint denervation or therapeutic facet-joint injections (if the beneficiary is not a candidate for facet-joint denervation).

Diagnostic Facet-Joint Injections

A diagnostic facet-joint injection is an interventional technique used by physicians 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.

Diagnostic facet-joint injections are administered first to confirm whether a facet joint is the source of pain. After the initial diagnostic facet-joint injections, a second diagnostic facet-joint injection session is performed to confirm validity of the initial diagnostic facet-joint injections administered at the same level.

[5] 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.

[6] Physicians who administer facet-joint interventions include those who specialize in interventional pain management, anesthesiology, and internal medicine.

According to the MACs' LCDs, diagnostic facet-joint injections should be performed with the intent that if successful, facet-joint denervation would be considered the primary treatment goal at the diagnosed level.

Facet-Joint Denervation

Facet-joint denervation is an interventional technique that physicians use to treat central neck or back pain caused by arthritis in or injury to the facet joints. Facet-joint denervation is administered after diagnostic facet-joint injections have identified a facet joint as the source of the pain. The procedure involves using a special needle with a heated tip to destroy the nerves that supply the joints. The goal of facet-joint denervation is to reduce neck or back pain for more than 6 months.

Therapeutic Facet-Joint Injections

According to the MACs' LCDs, therapeutic facet-joint injections are medically reasonable and necessary only if a beneficiary is not a candidate for facet-joint denervation.[7] Therapeutic facet-joint injections are administered to treat pain after diagnostic facet-joint injections have identified a facet joint as the source of the pain. The goal of therapeutic facet-joint injections is to provide pain relief for at least 3 months.

Physician Submission of Medicare Claims for Facet-Joint Interventions and the Use of Procedure Codes

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

To receive Medicare payment for a facet-joint injection, a physician submits a claim and uses Current Procedural Terminology (CPT)[8] codes on the claim to indicate the spinal region and the number of levels in which injections were administered. Physicians bill Medicare for a single injection to a facet-joint level in the cervical/thoracic or lumbar/sacral spines using one of two primary CPT codes: 64490 for the cervical/thoracic spine and 64493 for the lumbar/sacral spine. Each primary CPT code has associated add-on codes for use when injections are administered to the second and third levels of the spine: 64491 and 64492 for the cervical/thoracic spine and

[7] A Medicare beneficiary is not a candidate for facet-joint denervation if, for example, the beneficiary has established spinal pseudarthrosis (which is the result of a failed attempted spinal fusion) or has an implanted electrical device.

[8] **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2020–2021 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.**

64494 and 64495 for the lumbar/sacral spine.[9] If a diagnostic facet-joint injection was administered, the physician should append to each claim line the modifier KX to distinguish the injection from a therapeutic facet-joint injection. (Physicians do not use this modifier for therapeutic-related claim lines.[10])

To receive Medicare payment for facet-joint denervation, a physician submits a claim and uses CPT codes to indicate on the claim the spinal region and the number of facet joints in which denervation was administered. Physicians bill Medicare for denervation of a single facet joint in the cervical/thoracic or lumbar/sacral spines using one of two primary CPT codes depending on the spinal region: 64633 for the cervical/thoracic spine and 64635 for the lumbar/sacral 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/sacral spine. For CPT codes 64633 and 64635, a unit of service is a single facet joint; for CPT codes 64634 and 64636, a unit of service is each additional facet joint.

Medicare Coverage of Facet-Joint Interventions

Medicare Part B covers facet-joint interventions based on the CPT codes' narrative descriptions, which include the number of levels in which facet-joint injections were administered and the number of facet joints in which facet-joint denervation was administered. Medicare also increases the reimbursement rate for each CPT code if a physician indicates that the intervention was performed bilaterally. (A bilateral intervention is performed on the left and right sides of a facet-joint level; the physician indicates it by appending modifier 50 to the claim line. A unilateral intervention is performed on only one side of a facet-joint level.)

The MACs' LCDs include requirements that physicians must meet to receive Medicare reimbursement for facet-joint interventions.[11] The MACs' local coverage articles (LCAs) for facet-joint interventions include billing, coding, and other guidance that complement these LCDs; CMS considers LCAs guidance rather than Medicare requirements.[12] The MACs updated the LCDs and LCAs for facet-joint interventions in calendar year 2021. Specifically, for 11 of the 12 MAC jurisdictions, the updated LCDs and LCAs took effect for interventions performed on or after April 25, 2021, and for the remaining MAC jurisdiction, the updated LCD and LCA took effect for interventions performed on or after May 2, 2021.

[9] CPT codes 64492 and 64495 are billed for the third and any additional levels in which facet-joint injections were administered.

[10] A modifier is a two-character code reported with a CPT code and is used to give Medicare additional information needed to process a claim (*National Correct Coding Initiative Policy Manual for Medicare Services*, chapter I, § E(1)).

[11] LCDs L33930 for jurisdiction (J) N, L34892 for JH and JL, L35936 for J6 and JK, L38765 for JJ and JM, L38773 for J15, L38801 for JE, L38803 for JF, and L38841 for J5 and J8.

[12] LCAs A56670 for JH and JL, A57787 for JN, A57826 for J6 and JK, A58350 for JJ and JM, A58364 for J15, A58403 for JE, A58405 for JF, and A58477 for J5 and J8.

According to the lead Contractor Medical Director (CMD), who oversaw development of the updated LCDs and LCAs for facet-joint interventions, the LCD requirements and LCA guidance were updated for various reasons, including the following:[13]

- CMS's and the MACs' national and local data identified facet-joint interventions as high-volume and high-dollar at-risk procedures for all of the MACs.

- Policies varied widely among Medicare jurisdictions, creating confusion for physicians.

- Policies were outdated because they did not reflect updated guidelines and evidence.

The updated LCDs include new requirements that were not in the previous LCDs, and the updated LCAs include new guidance that was not in the previous LCAs.[14] For example, the updated LCAs state that a physician should append modifier KX to a claim line if a diagnostic facet-joint injection was administered—to distinguish the injection from a therapeutic facet-joint injection. Previously, physicians billed diagnostic and therapeutic injections in the same way and did not have to make a distinction on the claim between the types of injection administered.

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 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.[15]

[13] A CMD is a physician who works for a MAC and has expertise in medicine and the development of Medicare clinical coverage determinations (e.g., LCDs). The CMD works collaboratively with all contractor teams, including the other MACs, and is also responsible for training staff on clinical matters and collaborating with medical societies and peer groups to share information and provide education. Each MAC had at least one CMD assist in updating the LCDs for facet-joint interventions. The lead CMD oversaw the workgroup (made up of other MACs' CMDs and subject matter experts) that developed the updated LCDs and LCAs for facet-joint interventions.

[14] The previous LCDs for facet-joint interventions were L33814 and L33930 for JN, L34832 for J15, 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. The previous LCAs for facet-joint interventions were A57639 and A55906 for JN, A56463 for J15, A56670 for JH and JL, A57727 for JE, A57728 for JF, A57826 for J6 and JK, A57553 for J5 and J8, and A56687 for JJ and JM. The MACs for JN, JH, JL, J6, and JK used the same LCD numbers when updating their LCDs for facet-joint interventions, and the MACs for JH, JL, J6, and JK used the same LCA numbers when updating their LCAs for facet-joint interventions.

[15] The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

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.[16]

HOW WE CONDUCTED THIS AUDIT

Our audit covered Medicare Part B payments of $62.2 million for 425,843 claim lines for facet-joint interventions, which we grouped into 218,421 sessions, with dates of service during our audit period.[17] We selected for review a stratified random sample of 120 of these sessions, for which Medicare paid $35,892. Our sample consisted of the following:

- 35 sessions billed with claim lines for diagnostic facet-joint injections;
- 43 sessions billed with claim lines for facet-joint denervation, and
- 43 sessions billed with claim lines for therapeutic facet-joint injections.[18]

For each session, we reviewed beneficiaries' medical records to evaluate compliance with selected Medicare billing requirements and guidance, but we did not use medical review to determine whether facet-joint interventions were medically necessary. However, we shared our findings with the medical review staff at the seven MACs to confirm that the MACs agreed with our determinations of sessions that did not comply with Medicare requirements.

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

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

[16] 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.

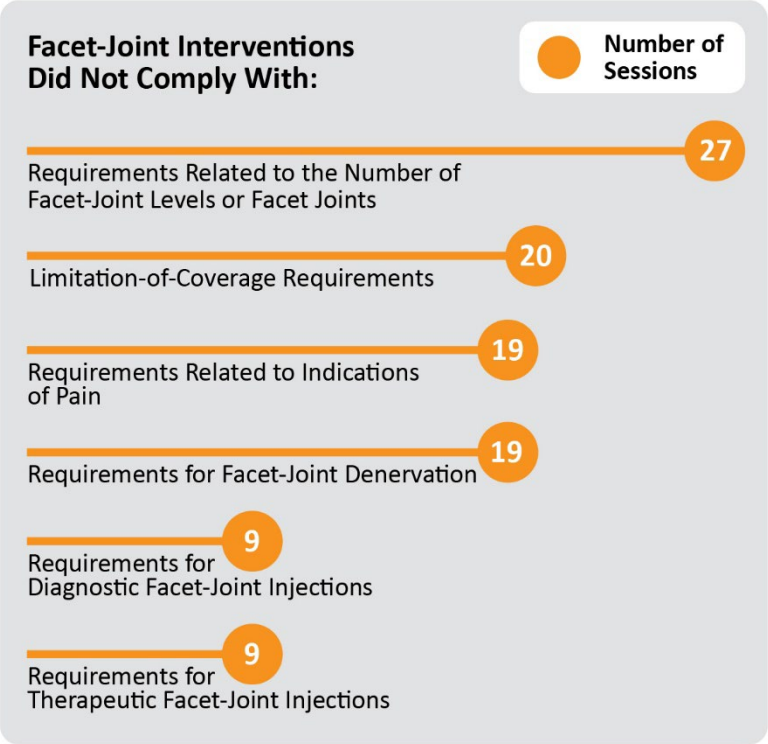
[17] A session consisted of all Medicare Part B claim lines for facet-joint interventions for a single date of service for a Medicare beneficiary.

[18] The total number of sessions is greater than 120 because 1 session had claim lines for both diagnostic and therapeutic facet-joint injections.

FINDINGS

Medicare did not pay physicians for some spinal facet-joint interventions in accordance with Medicare requirements and guidance. Of the 120 sampled sessions, 54 complied with Medicare requirements; however, the remaining 66 sessions did not comply with 1 or more of the requirements. Figure 2 shows the number of sampled sessions that did not comply with Medicare requirements by type of deficiency. (The number of deficiencies is greater than 66 because 30 sessions had more than 1 type of deficiency.)

Figure 2: Number of Sampled Sessions That Did Not Comply With Medicare Requirements by Type of Deficiency



As a result, Medicare made improper payments to physicians of $18,084.[19] On the basis of our sample results, we estimated that Medicare improperly paid physicians $29.6 million for facet-joint interventions for our audit period.[20]

In addition, of the 120 sampled sessions, 43 had claim lines that were billed for at least 1 therapeutic facet-joint injection. Of these 43 sessions, 33 sessions did not meet Medicare guidance. Specifically, 33 sessions had claim lines that should have been billed for diagnostic

[19] To calculate the total improper payment amount, we combined overpayments of $18,406 for 62 sampled sessions and underpayments of $322 for 4 sampled sessions.

[20] We estimated that Medicare improperly paid physicians $29,566,172 for our audit period.

facet-joint injections (i.e., billed with modifier KX) instead of being billed for therapeutic facet-joint injections. However, this improper billing did not result in improper payments because Medicare pays the same amount for diagnostic and therapeutic facet-joint injections.

The improper payments that resulted from physicians not complying with Medicare requirements and the improper billing that resulted from physicians not meeting Medicare guidance occurred because the MACs' education of physicians and their billing staff varied across jurisdictions and was not always sufficient to ensure compliance with these requirements and guidance.

Compliance With Medicare Requirements Is Important for Medicare Beneficiary Quality of Care

According to the MACs' LCDs, facet-joint interventions are a challenging area because of variability in the medical literature, lack of consensus among experts, differences in societal guidelines, and a historical pattern that demonstrates high risk for overutilization. When there is a lack of consensus on best practices, careful evaluation of the medical literature and use of the best available evidence serves as a basis for determinations in coverage and guidelines. This information is supplemented with knowledge shared from the MACs' subject-matter-expert panel to ensure that the LCDs represent the best quality of care for beneficiaries.

MEDICARE REQUIREMENTS AND GUIDANCE

Federal law prohibits Medicare payment unless the physician has furnished information necessary to determine the amounts due (the Act § 1833(e)).

Medicare Part B covers facet-joint interventions based on the CPT codes' narrative descriptions, including the number of facet-joint levels in which facet-joint injections were administered and the number of facet joints in which facet-joint denervation was administered. Medicare also increases the reimbursement rate for each CPT code if the physician indicates that the interventions were performed bilaterally by billing the claim line with modifier 50. Each submitted Medicare Part B claim contains detail regarding each provided service.

The MACs' LCDs for facet-joint interventions list specific documentation requirements that must be met for diagnostic facet-joint injections, facet-joint denervation, and therapeutic facet-joint injections. Appendix E contains details on the Medicare requirements related to facet-joint interventions.

The MACs' LCAs for facet-joint interventions state that modifier KX should be appended to claim lines for diagnostic facet-joint injections to distinguish these injections from therapeutic facet-joint injections.

FACET-JOINT INTERVENTIONS DID NOT COMPLY WITH MEDICARE DOCUMENTATION REQUIREMENTS

Of the 120 sampled sessions, 66 did not comply with 1 or more Medicare requirements related to: (1) the number of facet-joint levels or facet joints, (2) limitation of coverage, (3) indications

of pain, (4) facet-joint denervation, (5) diagnostic facet-joint injections, and (6) therapeutic facet-joint injections.

Facet-Joint Interventions Did Not Comply With Requirements Related to the Number of Facet-Joint Levels or Facet Joints

For 27 sampled sessions, facet-joint interventions did not comply with requirements related to the number of facet-joint levels or facet joints.[21] Specifically:

- Physicians billed for facet-joint injections administered to fewer levels of the spine than the number of levels shown in the beneficiaries' medical records (10 sessions).[22]

- Physicians billed for facet-joint injections administered to more levels of the spine than the number of levels shown in the beneficiaries' medical records (six sessions).

- Physicians billed for facet-joint injections or denervation using CPT codes for different regions of the spine than the regions shown in the beneficiaries' medical records (four sessions).

- Physicians billed for at least one unilateral facet-joint injection to a facet-joint level or denervation to a facet joint, but the injections or denervation was administered bilaterally and should have been billed with modifier 50 (four sessions).[23]

- Physicians billed for facet-joint denervation administered to more facet joints of the spine than the number of facet joints shown in the beneficiaries' medical records (two sessions).

- Physicians billed for bilateral facet-joint injections, but the beneficiaries' medical records did not indicate which levels of the spine received injections (two sessions) or whether the facet-joint injections were unilateral or bilateral (one session).

The following are examples of facet-joint interventions that did not comply with requirements related to the number of facet-joint levels or facet joints.

[21] Of the 27 sampled sessions, 2 did not meet more than 1 of the requirements related to the number of facet-joint levels or facet joints.

[22] The improper billing of these 10 sampled sessions resulted in underpayments. However, billing of 6 of these sessions did not comply with other Medicare requirements for facet-joint interventions, resulting in overpayment amounts for 6 of the 10 sessions.

[23] The improper billing of these four sampled sessions resulted in underpayments. However, billing of these sessions did not comply with other Medicare requirements for facet-joint interventions, resulting in an overpayment amount for each of the four sessions.

A Physician Billed for Facet-Joint Injections Administered to More Facet-Joint Levels Than the Number of Levels Shown in the Beneficiary's Medical Record

A physician received a Medicare payment of $220 for billing diagnostic facet-joint injections administered unilaterally to two facet-joint levels on the left side of a beneficiary's lumbar spine. However, according to the medical records provided, the physician administered unilateral injections to only one facet-joint level.

Therefore, the physician should have been paid $146 instead of the $220, which was an overpayment of $74.

A Physician Billed for Facet-Joint Denervation Administered to More Facet Joints of the Spine Than the Number of Facet Joints Shown in the Beneficiary's Medical Record

A physician received a Medicare payment of $268 for billing facet-joint denervation administered unilaterally to three facet joints on three levels on the right side of a beneficiary's lumbar spine. However, according to the medical records provided, the physician administered denervation unilaterally to two facet joints.

Therefore, the physician should have been paid $221 instead of the $268, which was an overpayment of $47.

Facet-Joint Interventions Did Not Comply With Limitation-of-Coverage Requirements

For 20 sampled sessions, facet-joint interventions did not comply with limitation-of-coverage requirements.[24] Specifically:

- Physicians performed facet-joint interventions on more than two facet-joint levels and did not document the medical necessity of interventions performed on any additional levels (eight sessions).
- Physicians performed facet-joint interventions on two spinal regions (seven sessions).[25]
- Physicians administered diagnostic facet-joint injections to beneficiaries at the same levels as previously successful facet-joint denervation (five sessions).
- Physicians performed facet-joint interventions after the beneficiaries had received anterior lumbar interbody fusion (four sessions).[26]

[24] Of the 20 sampled sessions, 7 did not meet more than 1 of the requirements related to limitation of coverage.

[25] We reviewed the medical records for any documentation to support the necessity of interventions on two spinal regions. If there was no such documentation, we confirmed our findings with the MACs' medical review staff.

[26] Anterior lumbar interbody fusion is a type of spinal fusion that uses an anterior approach (i.e., from the front of the body, through the abdominal region) to fuse (i.e., mend together) the bones of the lumbar spine.

- Physicians performed facet-joint interventions on beneficiaries even though clinical or imaging findings pointed to a specific diagnosis other than facet-joint syndrome (two sessions).[27]

- A physician administered facet-joint denervation to a beneficiary using low-grade thermal energy at 70 degrees Celsius, which was less than the required 80 degrees Celsius (one session).

The following is an example of a facet-joint intervention that did not comply with limitation-of-coverage requirements.

A Physician Administered Diagnostic Facet-Joint Injections to a Beneficiary at the Same Levels as Previously Successful Facet-Joint Denervation

A physician received a Medicare payment of $324 for billing diagnostic facet-joint injections administered bilaterally to two levels of a beneficiary's lumbar spine. According to the medical records provided, the beneficiary had facet-joint denervation successfully administered to these levels of the lumbar spine before receiving these diagnostic facet-joint injections. Administering diagnostic facet-joint injections at the same levels as previously successful denervation is not considered reasonable and necessary.

Therefore, the physician should not have been paid the $324.

Facet-Joint Interventions Did Not Comply With Requirements Related to Indications of Pain

For 19 sampled sessions, facet-joint interventions did not comply with requirements related to indications of pain.[28] Specifically:

- Beneficiaries did not have moderate to severe chronic neck or low back pain, predominantly axial (i.e., confined to one spot or region), that caused a functional deficit measured on a pain or disability scale (nine sessions).
- Beneficiaries had nonfacet pathologies (i.e., that had origins or causes other than the facet joints) that could explain the source of their pain (seven sessions).
- Beneficiaries' pain was not present for a minimum of 3 months with documented failure to respond to noninvasive conservative management as tolerated (five sessions).[29]

[27] Facet-joint syndrome is a set of concurrent signs or symptoms to describe facet-joint pain as the pain generator.

[28] Of the 19 sampled sessions, 5 did not meet more than 1 of the requirements related to indications of pain.

[29] Noninvasive conservative management is the use of nonsteroidal anti-inflammatory drugs, acetaminophen (a drug used to treat mild to moderate pain), physical therapy, acupuncture (applies only to chronic low back pain), or spinal manipulation. This management includes the application of biopsychosocial treatment techniques (i.e., techniques used to see how an individual's inner thoughts and feelings, and the society around the individual, influence the individual's perception and determination of health).

- Beneficiaries had untreated radiculopathy (i.e., a disease of the root of a nerve, such as from a pinched nerve or a tumor) that was not caused by a facet-joint cyst (three sessions).

The following is an example of a facet-joint intervention that did not comply with requirements related to indications of pain.

A Beneficiary Had a Nonfacet Pathology That Could Explain the Source of Their Pain
A physician received a Medicare payment of $306 for billing therapeutic facet-joint injections administered bilaterally to two levels of a beneficiary's lumbar spine. According to the medical records provided, the source of the beneficiary's pain was likely a compression fracture, and the notes for the office visit before the beneficiary received these injections did not identify facet joints as a source of pain.
Therefore, the physician should not have been paid the $306.

Facet-Joint Interventions Did Not Comply With Requirements for Facet-Joint Denervation

For 19 sampled sessions, facet-joint interventions did comply with requirements for facet-joint denervation.[30] Specifically:

- Before beneficiaries received facet-joint denervation, they did not have 2 medically reasonable and necessary diagnostic facet-joint injection sessions in which each session provided a consistent minimum of 80-percent sustained relief of primary pain, with the duration of relief being consistent with the agent used (18 sessions).

- Repeat facet-joint denervation was administered at the same anatomic site, but the prior denervation session did not provide beneficiaries a minimum of consistent 50-percent improvement in pain for at least 6 months or at least 50-percent consistent improvement in the ability to perform previously painful movements and activities of daily living (ADLs) as compared with the baseline measurement using the same scale (three sessions).[31]

The following is an example of a facet-joint intervention that did not comply with requirements for facet-joint denervation.

[30] Of the 19 sampled sessions, 2 did not meet more than 1 of the requirements related to facet-joint denervation.

[31] ADLs are activities related to personal care that include bathing, showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

Before Receiving Facet-Joint Denervation, a Beneficiary Did Not Have Two Diagnostic Facet-Joint Injection Sessions that Provided 80-Percent Sustained Relief of Primary Pain

A physician received a Medicare payment of $460 for billing facet-joint denervation administered unilaterally to two facet joints on two levels on the right side of a beneficiary's lumbar spine. According to the medical records provided, before receiving denervation, the beneficiary had only one of the required two sessions of diagnostic facet-joint injections, which resulted in 70-percent sustained relief of primary pain instead of the minimum 80 percent.

Therefore, the physician should not have been paid the $460.

Facet-Joint Interventions Did Not Comply With Requirements for Diagnostic Facet-Joint Injections

For nine sampled sessions, facet-joint interventions did not comply with requirements for diagnostic facet-joint injections.[32] Specifically:

- Physicians administered a second diagnostic facet-joint injection to beneficiaries even though the first injection did not provide a positive response of at least 80-percent relief of primary pain, with the duration of relief being consistent with the agent used (five sessions).

- Physicians administered a second diagnostic facet-joint injection to beneficiaries less than 2 weeks after administering the first diagnostic injection and did not document in the beneficiaries' medical records any clinical circumstances that necessitated an exception to the 2-week duration (four sessions).

- Physicians administered intra-articular instead of medial-branch facet blocks to beneficiaries for diagnostic tests and did not document in the medical records any anatomic restrictions or an indication to proceed with therapeutic facet-joint injections (two sessions).[33]

The following is an example of a facet-joint intervention that did not comply with requirements for diagnostic facet-joint injections.

[32] Of the nine sampled sessions, two did not meet more than one of the requirements for diagnostic facet-joint injections.

[33] Intra-articular facet blocks and medial branch blocks are types of facet-joint injections. An intra-articular facet block is an injection of local anesthetic and possibly a corticosteroid into the facet-joint capsule. A medial-branch facet block is the placement of local anesthetic and possibly a corticosteroid near the medial branch nerve, which supplies the sensory innervation to a specific facet joint. An indication is a condition that makes a particular treatment or procedure advisable.

A Physician Administered a Second Diagnostic Facet-Joint Injection to a Beneficiary Less Than 2 Weeks After Administering the First Diagnostic Injection, and the First Injection Did Not Provide a Positive Response of at Least 80-Percent Relief of Primary Pain

A physician received a Medicare payment of $224 for billing diagnostic facet-joint injections administered unilaterally to two levels on the left side of a beneficiary's lumbar spine. The medical records showed that the facet-joint intervention did not comply with the following requirements for diagnostic facet-joint injections:

- The injections were part of a second diagnostic facet-joint injection session for the beneficiary, but the session was administered 8 days instead of 2 weeks after the first diagnostic facet-joint injection session, and the physician did not document any clinical circumstances that necessitated an exception to the 2-week duration.

- The beneficiary had greater than 50-percent relief of their primary pain after the first diagnostic facet-joint injection session, but the physician did not document whether the pain relief was greater than 80 percent.

Therefore, the physician should not have been paid the $224.

Facet-Joint Interventions Did Not Comply With Requirements for Therapeutic Facet-Joint Injections

For nine sampled sessions, facet-joint interventions did not comply with requirements for therapeutic facet-joint injections.[34] Specifically:

- Before beneficiaries received therapeutic facet-joint injections, they did not have two medically reasonable and necessary diagnostic facet-joint injection sessions in which each one provided a consistent minimum of 80-percent relief of primary pain, with the duration of relief being consistent with the agent used (nine sessions).

- The beneficiaries' medical records did not contain documentation explaining why the beneficiaries were not candidates for facet-joint denervation (seven sessions).

- Subsequent therapeutic facet-joint injections at the same anatomic site did not result in at least 50-percent consistent pain relief for at least 3 months from the prior therapeutic facet-joint injection or at least 50-percent consistent improvement in the ability to perform previously painful ADLs as compared with the baseline measurement using the same scale (four sessions).

[34] Of the nine sampled sessions, seven did not meet more than one of the requirements for therapeutic facet-joint injections.

The following is an example of a facet-joint intervention that did not comply with requirements for therapeutic facet-joint injections.

A Physician Administered Therapeutic Facet-Joint Injections That Did Not Comply With Any of the Three Requirements for Therapeutic Facet-Joint Injections

A physician received a Medicare payment of $336 for billing therapeutic facet-joint injections administered: (1) unilaterally to two levels on the left side of a beneficiary's cervical spine and (2) bilaterally to one level of the beneficiary's lumbar spine. The medical records provided showed that the injections did not comply with the following requirements related to therapeutic facet-joint injections:

- The beneficiary did not have any diagnostic facet-joint injection sessions before receiving therapeutic facet-joint injections.
- The beneficiary had previous therapeutic facet-joint injections that did not result in at least 50-percent consistent pain relief for 3 months. Specifically, the beneficiary had 80-percent pain relief for 3 weeks after one therapeutic facet-joint injection session and 60-percent pain relief for 4 weeks after another therapeutic facet-joint injection session.
- The physician did not document in the medical records why the beneficiary was not a candidate for facet-joint denervation. According to the physician, the physician did not intend to perform facet-joint denervation.

Therefore, the physician should not have been paid the $336.

MEDICARE IMPROPERLY PAID PHYSICIANS AN ESTIMATED $29.6 MILLION FOR FACET-JOINT INTERVENTIONS THAT DID NOT MEET MEDICARE REQUIREMENTS

The improper payments for the 66 sampled sessions that did not comply with Medicare requirements totaled $18,084. On the basis of our sample results, we estimated that $29.6 million (48 percent) of the $62.2 million that Medicare paid to physicians for facet-joint interventions was improperly paid.

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

Of the 120 sampled sessions, 43 had claim lines that were billed for at least 1 therapeutic facet-joint injection. Of these 43 sessions, 33 sessions did not meet Medicare guidance. Specifically, 33 sessions had claim lines that should have been billed for diagnostic facet-joint injections (i.e., billed with modifier KX) instead of being billed for therapeutic facet-joint injections.

Although billing for therapeutic instead of diagnostic facet-joint injections does not affect the payment amounts that a physician receives (because Medicare pays the same amount for

diagnostic and therapeutic facet-joint injections), incorrectly classifying the type of facet-joint injections administered could result in the MAC paying a physician for more than the allowable number of diagnostic and therapeutic facet-joint injection sessions during a rolling 12-month period.[35] Specifically, as stated in their LCDs, each of the MACs will reimburse a physician for up to four diagnostic and up to four therapeutic facet-joint injection sessions per beneficiary for each covered spinal region during a rolling 12-month period.[36]

MEDICARE ADMINISTRATIVE CONTRACTORS' EDUCATION OF PHYSICIANS AND BILLING STAFF VARIED ACROSS JURISDICTIONS AND WAS NOT ALWAYS SUFFICIENT TO ENSURE COMPLIANCE WITH BILLING REQUIREMENTS AND GUIDANCE

During our audit period, the MACs provided education on billing for spinal facet-joint interventions. However, the MACs' education to physicians and billing staff varied across the 12 jurisdictions and was not always sufficient to ensure compliance with billing requirements and guidance for spinal facet-joint interventions.

For example, one MAC did not conduct any live presentations (e.g., in-person events or webinars) to go over the requirements in its LCD and the guidance in its LCA for facet-joint interventions but rather posted on its website when the updated LCD and LCA would take effect. The MAC included links to the LCD and LCA and sent emails to those physicians on its email notification list to inform them that these updates had been posted.

Another MAC conducted a live training session before implementing its LCD and LCA to inform physicians when the updated LCD and LCA would take effect. The MAC also conducted a live training session to go over the requirements in the LCD and the guidance in its LCA, answer frequently asked questions, and answer any questions from the training participants.

Finally, another MAC conducted a presentation that focused on where to locate the LCD and LCA on the CMS and MAC websites, as well as emphasizing requirements in the LCD specific to the limited number of facet-joint interventions that Medicare would reimburse during a rolling 12-month period. After our audit period, this MAC posted a YouTube video that covered the LCD requirements that facet-joint interventions must meet for physicians to receive Medicare reimbursement, as well as LCA guidance specific to billing for diagnostic facet-joint injections with modifier KX.

[35] A rolling 12-month period refers to 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 August 1, 2021, the rolling 12-month period would be August 1, 2021, through July 31, 2022.

[36] In the MACs' previous LCDs for 11 of the 12 jurisdictions, Medicare would reimburse physicians for a maximum of 5 facet-joint injection sessions per rolling 12-month period in the cervical/thoracic or lumbar spines. The remaining MAC jurisdiction did not have a coverage limitation for the number of reimbursable facet-joint injection sessions in its previous LCD.

Physicians are required to comply with current Medicare billing requirements and are responsible for keeping up-to-date on those requirements. However, physicians and billing staff may not have been aware of updated requirements posted on the MACs' websites. In addition, physicians and billing staff may not have been aware of training sessions and existing education materials if they did not monitor information sent via the MACs' email lists.

CONCLUSION

Medicare improperly paid physicians for 66 of the 120 facet-joint intervention sessions in our sample. In addition, physicians incorrectly billed for therapeutic facet-joint injections instead of diagnostic facet-joint injections for 33 of the 43 sampled sessions. These deficiencies occurred because the MACs' education of physicians and billing staff varied across jurisdictions and was not always sufficient to ensure compliance with Medicare requirements and guidance. Although the MACs are not required to be consistent in the education that they provide, CMS and the MACs could help reduce the number of incorrectly billed facet-joint interventions by working together to develop collaborative training programs across all of the MAC jurisdictions.

Meeting Medicare Guidance Is Important for Medicare Beneficiary Quality of Care

If physicians do not follow LCA guidance for billing diagnostic facet-joint injections with modifier KX, beneficiaries may not receive all of the facet-joint injection sessions they are entitled to, which may impact their quality of care. Not following the guidance may also result in beneficiaries having to pay for sessions out of pocket because Medicare reimburses physicians for only four therapeutic facet-joint injection sessions per beneficiary for each covered spinal region during a rolling 12-month period, as stated in the MACs' LCDs.

In addition, before the MACs issued their updated LCAs, the LCAs did not instruct physicians to use modifier KX for diagnostic facet-joint injections to differentiate these claim lines from those for therapeutic facet-joint injections. It is critical for physicians to indicate whether the facet-joint injections administered were diagnostic or therapeutic because Medicare requirements in the MACs' updated LCDs state that the MACs will reimburse physicians for up to four diagnostic and up to four therapeutic facet-joint injection sessions per beneficiary for each covered spinal region during a rolling 12-month period. To further minimize incorrect billing for the type of facet-joint injection administered, CMS should encourage the MACs to develop solutions, such as developing additional education specific to billing diagnostic facet-joint injections with modifier KX or updating guidance on how each type of injection should be billed.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- direct the MACs to recover $18,084 in improper payments made to physicians for the 66 sampled sessions for facet-joint interventions;

- 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

- encourage the MACs to: (1) develop collaborative training programs to be used for all of the MAC jurisdictions and that are specific to Medicare requirements for facet-joint interventions, which could have saved an estimated $29,566,172 for our audit period; and (2) develop solutions to prevent the incorrect billing of diagnostic facet-joint injections as therapeutic facet-joint injections, such as developing additional education specific to billing injections with modifier KX or updating guidance on how each type of injection should be billed.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our recommendations and described actions that it had taken or 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 notifying the MACs of this audit so that they may determine whether additional education on proper billing and Medicare requirements for facet-joint interventions is necessary. CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, appear in their entirety as Appendix F.

In its written comments, CMS also provided additional information, which is summarized below. Our response follows.

CMS Comments

CMS stated that we relied solely on claim information for this study, did not conduct medical reviews to determine whether services were medically necessary, and did not contact any of the physicians who administered the facet-joint interventions.

Regarding our first recommendation, CMS stated that it "recognizes the possibility that multiple physicians could have fulfilled the billing requirements for the facet-joint interventions for the

same beneficiary without knowledge of the specific billing of another physician." CMS also stated: "These physicians may not be liable because they could be found without fault under section 1870(b) of the Social Security Act."

Office of Inspector General Response

Regarding CMS's statement that we relied solely on claim information, we did contact physicians to obtain beneficiaries' medical records and to obtain written responses to questions about the provided services. Although we did not use medical review to determine whether facet-joint interventions were medically necessary, we reviewed the medical records and written responses to our questions to evaluate compliance with selected Medicare billing requirements and guidance. Additionally, we shared our findings with the medical review staff at the seven MACs to confirm that the MACs agreed with our determinations of sessions that did not comply with Medicare requirements.

Regarding CMS's statement about the "without fault" provision, based on a review of medical records, our audit findings only identified individual providers' failures to meet documentation and other requirements that are not impacted by what other providers bill. Specifically, this audit did not review frequency limitations that might be exceeded based on services billed by multiple providers. Therefore, we do not believe that the "without fault" provision would apply to overpayments identified by this audit.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered Medicare Part B payments of $62,210,136 for 425,843 claim lines for facet-joint interventions, which we grouped into 218,421 sessions, with dates of service from August 1 through October 31, 2021.[37] We selected for review a stratified random sample of 120 of these sessions, for which Medicare paid $35,892.[38] For each session, we reviewed beneficiaries' medical records to evaluate compliance with selected Medicare billing requirements and guidance, but we did not use medical review to determine whether facet-joint interventions were medically necessary. However, we shared our findings with the medical review staff at the seven MACs to confirm that the MACs agreed with our determinations of sessions that did not comply with Medicare requirements.

We assessed CMS's and the MACs' internal controls and compliance with laws and regulations necessary to satisfy our objective. In particular, we assessed relevant policies (e.g., LCDs), system edits, and provider education.

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 February 2022 to January 2023, which included contacting CMS in Baltimore, Maryland; the 7 MACs; and the physicians who performed the facet-joint interventions for the 120 sampled sessions.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance, as well as the MACs' LCDs and LCAs related to facet-joint interventions;

- interviewed staff at CMS and the MACs regarding the types of provider education they had provided specific to reimbursing physicians for facet-joint interventions;

[37] A session consisted of all Medicare Part B claim lines for facet-joint interventions for a single date of service for a Medicare beneficiary.

[38] Each of the 120 sampled sessions had a covered diagnosis related to the cervical/thoracic or lumbar spines, and therefore the LCD requirements and LCA guidance for facet-joint interventions applied to each session. In addition, we verified that none of the 120 sessions included facet-joint interventions performed on the sacral spine.

- used CMS's NCH file to identify claim lines for facet-joint interventions (billed using CPT[39] codes 64490 through 64495 for facet-joint injections and 64633 through 64636 for facet-joint denervation) with dates of service during our audit period;

- grouped the claim lines into sessions by Health Insurance Claim (HIC) number (i.e., the beneficiary's identification number) and date of service;

- selected a stratified random sample of 120 sessions and:

    - obtained from physicians supporting documentation for each sampled session,

    - determined whether the physicians complied with Medicare requirements and guidance for billing facet-joint interventions,

    - shared our findings with the medical review staff at the MACs to confirm that the MACs agreed with our determinations of sampled sessions that did not comply with Medicare requirements or guidance,[40]

    - calculated the improper payment for each sampled session that did not comply with Medicare requirements, and

    - estimated the potential cost savings if the sampled sessions had been billed in accordance with Medicare requirements; and

- discussed the results of our audit with CMS officials.

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

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

[39] **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2020–2021 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.**

[40] We used information provided by the medical review staff to identify additional documentation in the medical records that supported our findings, and we revised our determinations as appropriate.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Improperly Paid Physicians for Spinal Facet-Joint Denervation Sessions	A-09-21-03002	12/3/2021
Noridian Healthcare Solutions, LLC, Made Improper Medicare Payments of $4 Million to Physicians in Jurisdiction E for Spinal Facet-Joint Injections	A-09-20-03010	2/19/2021
Medicare Improperly Paid Physicians for More Than Five Spinal Facet-Joint Injection Sessions During a Rolling 12-Month Period	A-09-20-03003	10/9/2020

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 218,421 sessions totaling $62,210,136. The frame consisted of 425,843 Medicare Part B paid claim lines for facet-joint interventions billed by physicians with dates of service during our audit period, which we grouped into sessions by each beneficiary's HIC number and date of service.[41]

SAMPLE UNIT

The sample unit was a facet-joint intervention session.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample, consisting of four strata. Each session appeared only once in the sampling frame and in only one stratum. We selected 120 sample units for review. See Table 1 for the details of each stratum.

Table 1: Facet-Joint Intervention Sessions by Stratum

Stratum	Session Type	Frame Size (No. of Sessions)	Value of Frame	Sample Size
1	Facet-joint intervention sessions for which during the same session: (1) both facet-joint injections and denervation were administered, (2) facet-joint denervation was administered to both the cervical/thoracic and lumbar spines, or (3) facet-joint injections were administered to both the cervical/thoracic and lumbar spines	1,107	$387,301	30
2	Facet-joint denervation sessions not included in stratum 1	75,638	31,136,953	30
3	Diagnostic facet-joint injection sessions not included in stratum 1	26,379	5,955,347	30
4	Therapeutic facet-joint injection sessions not included in stratum 1	115,297	24,730,535	30
Total		**218,421**	**$62,210,136**	**120**

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

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE UNITS

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

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the total amount of payments that MACs made to physicians for facet-joint interventions that did not comply with Medicare requirements. We calculated the point estimate and the corresponding two-sided 90-percent confidence interval using the empirical likelihood option.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size (No. of Sessions)	Value of Frame	Sample Size	Value of Sample	No. of Sessions in Sample That Did Not Comply With Requirements	Net Value of Improper Payments in Sample
1	1,107	$387,301	30	$9,979	22	$6,577
2	75,638	31,136,953	30	11,427	15	5,511
3	26,379	5,955,347	30	7,219	12	2,569
4	115,297	24,730,535	30	7,267	17	3,427
Total	**218,421**	**$62,210,136**	**120**	**$35,892**	**66**	**$18,084**

Table 3: Estimated Net Value of Improper Payments in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)

Point estimate	$29,566,172
Lower limit	22,681,395
Upper limit	37,063,384

APPENDIX E: MEDICARE REQUIREMENTS RELATED TO FACET-JOINT INTERVENTIONS

Requirements Related to the Number of Facet-Joint Levels or Facet Joints

Medicare requires a uniform procedure coding system for all physicians' services' (the Act § 1848(c)(5)). Physicians are required to use CPT[42] codes when billing Medicare for physicians' services (45 CFR §§ 162.1000(a) and 162.1002(c)(1) and (a)(5)).

For facet-joint injections, two primary CPT codes, 64490 and 64493, are used for a single injection to a facet-joint level in the cervical/thoracic spine and lumbar/sacral spine, respectively. Each primary CPT code has associated add-on codes for use when injections are administered to the second and third levels of the spine: 64491 and 64492 for the cervical/thoracic spine and 64494 and 64495 for the lumbar/sacral spine. For CPT codes 64490 and 64493, a unit of service is a single facet-joint level; for CPT codes 64491 and 64494, a unit of service is a second facet-joint level from the same session; and for CPT codes 64492 and 64495, a unit of service is a third and any additional facet-joint levels from the same session. (AMA, *CPT 2021*.)

For facet-joint denervation, two primary CPT codes, 64633 and 64635, are used for a single facet joint in the cervical/thoracic spine and lumbar/sacral spine, respectively. Each primary CPT code has associated add-on codes for use when additional facet joints are included in the denervation session: 64634 for the cervical/thoracic spine and 64636 for the lumbar/sacral 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. (AMA, *CPT 2021*.)

Physician payments vary based on modifiers billed with the CPT codes. For example, facet-joint interventions performed on the left and right sides of a level should be billed using modifier 50, which increases the reimbursement to 150 percent of the base rate (CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 12, § 40.7.B; *National Correct Coding Initiative Policy Manual*, chapter I, § V.3.a.ii, and chapter VIII, § H.9).

Limitation-of-Coverage Requirements

The MACs' LCDs for facet-joint interventions contain the following limitation-of-coverage requirements:[43]

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[42] **The five character codes and descriptions included in this document are obtained from Current Procedural Terminology (CPT®), copyright 2020–2021 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.**

[43] LCDs L33930 for JN, L34892 for JH and JL, L35936 for J6 and JK, L38765 for JJ and JM, L38773 for J15, L38801 for JE, L38803 for JF, and L38841 for J5 and J8. These LCDs contain the limitation-of-coverage requirements and all of the requirements for facet-joint interventions that follow in this appendix.

- Facet-joint interventions (both diagnostic and therapeutic) are limited to one spinal region per session.

- One to two levels, either unilateral or bilateral, are allowed per facet-joint intervention session per spinal region. The need for a three- or four-level procedure bilaterally may be considered under unique circumstances and with sufficient documentation of medical necessity.

- Diagnostic facet-joint injections at the same level as a previously successful facet-joint denervation procedure are not considered reasonable and necessary.

- Facet-joint interventions with definitive clinical and/or imaging findings pointing to a specific diagnosis other than facet-joint syndrome are not considered reasonable and necessary.

- Facet-joint interventions performed after anterior lumbar interbody fusion are not considered reasonable and necessary.

- Nonthermal modalities for facet-joint denervation—including chemical, low-grade thermal energy (less than 80 degrees Celsius), laser neurolysis, and cryoablation—are not considered reasonable and necessary.[44]

Requirements Related to Indications of Pain

The MACs' LCDs for facet-joint interventions contain the following requirements related to indications of beneficiary pain:

- The beneficiary has moderate to severe chronic neck or low back pain, predominantly axial, that causes a functional deficit measured on a pain or disability scale.[45]

- There is no nonfacet pathology per a clinical assessment or radiology study that could explain the source of the beneficiary's pain, including but not limited to a fracture, a tumor, an infection, or a significant deformity.

[44] Nonthermal modalities are treatments that do not involve heat. Laser neurolysis is the application of a laser to peripheral nerves, which are used to send messages from the brain and spinal cord to the rest of the body. Cryoablation is a procedure in which an extremely cold liquid or an instrument called a cryoprobe is used to freeze and destroy abnormal tissue.

[45] A pain assessment must be performed and documented at baseline after each diagnostic procedure using the same pain scale for each assessment. A disability scale must also be obtained at baseline to be used for functional assessment if the beneficiary qualifies for treatment.

- The beneficiary's pain must be present for a minimum of 3 months with documented failure to respond to noninvasive conservative management as tolerated.

- The absence of untreated radiculopathy or neurogenic claudication (except for radiculopathy caused by a facet-joint cyst).[46]

Requirements for Facet-Joint Denervation

The MACs' LCDs for facet-joint interventions contain the following requirements related to facet-joint denervation:

- The beneficiary has had at least two medically reasonable and necessary diagnostic facet-joint injections in which each one provided a consistent minimum of 80-percent sustained relief of primary pain, with the duration of relief being consistent with the agent used.

- Repeat facet-joint denervation at the same anatomic site is considered medically reasonable and necessary provided the patient had a minimum of consistent 50-percent improvement in pain for at least 6 months or at least 50-percent consistent improvement in the ability to perform previously painful movements and ADLs as compared with the baseline measurement using the same scale.

Requirements for Diagnostic Facet-Joint Injections

The MACs' LCDs for facet-joint interventions contain the following requirements for diagnostic facet-joint injections:

- A second confirmatory diagnostic facet-joint injection can be performed if, after the first diagnostic facet-joint injection, there was a consistent positive response of at least 80-percent relief of primary pain, with the duration of relief being consistent with the agent used.

- A second diagnostic facet-joint injection may only be performed a minimum of two weeks after the initial diagnostic procedure (clinical circumstances that necessitate an exception to the 2-week duration may be considered on an individual basis and must be clearly documented in the beneficiary's medical records).

- Intra-articular facet blocks are considered reasonable and necessary as a diagnostic test only if medial branch blocks cannot be performed because of specific documented anatomic restrictions or there is an indication to proceed with therapeutic intra-articular injections.

[46] Neurogenic claudication is leg pain or weakness with walking because of a problem at a nerve.

Requirements for Therapeutic Facet-Joint Injections

The MACs' LCDs for facet-joint interventions contain the following requirements for therapeutic facet-joint injections:

- The beneficiary has had two medically reasonable and necessary diagnostic facet-joint injections in which each one provided a consistent minimum of 80-percent relief of primary pain, with the duration of relief being consistent with the agent used.

- There is documentation of why the beneficiary is not a candidate for facet-joint denervation (e.g., the beneficiary has established spinal pseudarthrosis or an implanted electrical device).

- Subsequent therapeutic facet-joint injections at the same anatomic site result in at least consistent 50-percent pain relief for at least 3 months from the prior therapeutic procedure or at least 50-percent consistent improvement in the ability to perform previously painful movements and ADLs as compared with the baseline measurement using the same scale.

Frequency Limitations

The MACs' LCDs for facet-joint interventions have the following frequency limitations for diagnostic and therapeutic facet-joint injections:

- For each covered spinal region, no more than four diagnostic joint sessions will be reimbursed per rolling 12-month period, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure.

- For each covered spinal region, no more than four therapeutic facet joint sessions will be reimbursed per rolling 12-month period.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: February 06, 2023

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

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

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Improperly Paid Physicians an Estimated $30 Million for Spinal Facet-Joint Interventions (A-09-22-03006)

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 serves the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes. CMS takes the health and safety of individuals with Medicare seriously, and is committed to providing them with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments.

CMS contracts with Medicare Administrative Contractors (MACs) which serve as the primary operational contact between the Medicare Fee-For-Service (FFS) program and the health care providers and suppliers enrolled in the program. The MACs perform many activities including processing Medicare FFS claims, educating providers and suppliers about Medicare FFS billing requirements, and reducing the number of improper payments for claims that do not comply with Medicare's coverage, coding, payment, and billing policies. Additionally, 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.

Facet joints are joints in the spine that aid stability and allow the spine to bend and twist. Facet joint interventions are used to diagnose or treat back pain. While CMS does not have a national policy to limit coverage of facet joint interventions, all 12 MACs have instituted LCDs to limit the number of sessions of facet joint interventions covered by Medicare. These coverage limitations are intended to address inappropriate billing for pain management tied to overuse of spinal facet joint interventions. 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.

In addition to the MACs' efforts to administer Medicare FFS claims, CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system and prepayment and post payment medical reviews. For example, the Recovery Audit Contractors have had an approved complex review of medical necessity and documentation requirements for facet joint interventions since 2018.[1] As part of the program integrity strategy, CMS recovers identified overpayments in accordance with relevant law and agency policies and procedures.

Furthermore, CMS continues to focus on reducing unnecessary increases in the volume of covered hospital outpatient department services by requiring prior authorization for certain services in this setting. In the Calendar Year 2023 Outpatient Prospective Payment System final rule with comment period, CMS added Facet Joint Interventions to the list of services that require prior authorization.[2] CMS believes that prior authorization can be an effective mechanism to ensure individuals with Medicare receive medically necessary care while protecting the Medicare Trust Funds from unnecessary increases in volume, by reducing improper payments, without adding new documentation requirements for providers or suppliers. The implementation date for prior authorization for the Facet Joint Interventions service category in the hospital outpatient department setting is currently scheduled for July 1, 2023.

While CMS appreciates the OIG's work in this area, CMS notes that OIG relied solely on claim information for this study. OIG did not conduct medical reviews to determine whether services were medically necessary. OIG also did not contact any of the physicians who administered the facet joint interventions.

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

OIG Recommendation 1

The OIG recommends that the Centers for Medicare & Medicaid Services direct the MACs to recover the $18,084 in improper payments made to physicians for the 66 sampled sessions for facet-joint interventions.

CMS Response

CMS concurs with this recommendation. CMS will direct the MACs to recover the identified overpayments consistent with relevant law and the agency's policies and procedures.

However, CMS recognizes the possibility that multiple physicians could have fulfilled the billing requirements for the facet joint interventions for the same beneficiary without knowledge of the specific billing of another physician. These physicians may not be liable because they could be found without fault under section 1870(b) of the Social Security Act. However, multiple physicians who are members of the same medical practice and submit facet joint interventions that exceed the limit for the same beneficiary will not be without fault.

[1] Additional information regarding this review is available at: https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/approved-rac-topics-items/0095-facet-injections.

[2] Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; COVID-19 (87 FR 71748) (Nov. 23 2022). Accessed at: https://www.govinfo.gov/content/pkg/FR-2022-11-23/pdf/2022-23918.pdf

OIG Recommendation 2

The OIG recommends that the Centers for Medicare & Medicaid Services 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 3

The OIG recommends that the Centers for Medicare & Medicaid Services encourage the MACs to: (1) develop collaborative training programs to be used for all of the MAC jurisdictions, and (2) develop solutions to prevent the incorrect billing of diagnostic facet-joint injections as therapeutic facet-joint injections, such as developing additional education specific to billing injections with modifier KX or updating guidance on how each type of injection should be billed.

CMS Response

CMS concurs with the recommendation. As discussed above, CMS has added Facet Joint Interventions to the list of services that require prior authorization beginning July 1, 2023, which we believe will help reduce improper payments for these services in the hospital outpatient department setting. CMS has instructed the MACs to provide education for providers regarding the prior authorization process for facet joint interventions in the hospital outpatient department setting.[3]

Additionally, CMS will notify the MACs of this audit so that they may determine whether additional education on proper billing and Medicare requirements for facet joint interventions is necessary.

[3]Change Request 13016: Provider Education for Prior Authorization Process for Facet Joint Interventions in the Hospital Outpatient Department Setting (12/21/22) Accessed at: https://www.cms.gov/files/document/r11753otn.pdf