Department of Health and Human Services
Office of Inspector General
Office of Audit Services

July 2025 | A-09-23-03013

Medicare Could Have Saved an Estimated $17.7 Million if CMS's Oversight Had Prevented At-Risk Payments for Anesthesia Administered During Spinal Pain Management Procedures

REPORT HIGHLIGHTS

July 2025 | A-09-23-03013

Medicare Could Have Saved an Estimated $17.7 Million if CMS's Oversight Had Prevented At-Risk Payments for Anesthesia Administered During Spinal Pain Management Procedures

Why OIG Did This Audit

- In rare circumstances, Medicare Part B covers the cost of anesthesia administered during certain spinal pain management (SPM) procedures (e.g., facet-joint injections).
- A prior OIG audit of a Medicare Administrative Contractor (MAC) found that the MAC paid physicians for anesthesia administered during 27 of 100 sampled facet-joint injection sessions for which the physicians did not document the need for anesthesia to be administered.
- For this nationwide audit, we identified Medicare Part B payments to physicians for anesthesia administered during selected SPM procedures that were at risk for noncompliance with Medicare requirements.

What OIG Found

Medicare Part B paid physicians $45.7 million for anesthesia administered during selected SPM procedures that were at risk for noncompliance with Medicare requirements. Specifically, Medicare paid for anesthesia that may not have been administered in only rare circumstances.

- Anesthesia was administered during approximately 18 percent of 3.9 million sessions associated with selected SPM procedures, and CMS and the MACs denied payment for anesthesia less than 1 percent of the time that it was billed for these procedures.
- For 20 of 28 sessions in our nonstatistical sample, the enrollees' medical records did not document a rare circumstance in which administering anesthesia was reasonable or necessary for the specific SPM procedure.

Medicare made at-risk payments for anesthesia administered during selected SPM procedures because CMS and MAC oversight was not adequate. If oversight had been adequate, Medicare could have saved an estimated $17.7 million from May 2, 2021, through August 31, 2023. (We calculated this amount using the MACs' expectations of how often anesthesia would be reimbursed for selected SPM procedures, i.e., only in rare circumstances.)

What OIG Recommends

We made four recommendations to CMS, including that CMS direct the MACs to review potentially improper claims for anesthesia administered during selected SPM procedures to determine whether payments for anesthesia complied with Medicare requirements and collaborate with the MACs to develop or update system edits that would lower the risk of improper Medicare payments. The full recommendations are in the report.

CMS did not concur with our first recommendation. CMS concurred with the remaining recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

In rare circumstances when considered medically reasonable and necessary, Medicare Part B covers the cost of anesthesia administered during certain spinal pain management (SPM) procedures (e.g., facet-joint injections).[1, 2] A prior Office of Inspector General (OIG) audit of a Medicare Administrative Contractor (MAC) found that the MAC paid physicians for anesthesia administered during 27 of 100 sampled facet-joint injection sessions for which the physicians did not document the need for anesthesia to be administered.[3, 4] These results may indicate that MACs may be improperly paying physicians nationwide for anesthesia administered during other types of SPM procedures. Therefore, we conducted this nationwide audit of payments for anesthesia administered to Medicare enrollees during facet-joint injections, facet-joint denervation, epidural steroid injections, and sacroiliac joint injections (which we refer to collectively as "selected SPM procedures").[5]

OBJECTIVE

Our objective was to identify Medicare Part B payments to physicians for anesthesia administered during selected SPM procedures that were at risk for noncompliance with Medicare requirements.

BACKGROUND

Medicare Part B

Medicare Part B provides supplementary medical insurance, including coverage for the cost of anesthesia administered during selected SPM procedures when it is medically reasonable and necessary. The Centers for Medicare & Medicaid Services (CMS) administers Part B and

[1] The term "rare circumstances" refers to the limited circumstances in which anesthesia would be allowable during these procedures (e.g., rare, unique circumstances in which medical necessity for sedation is unequivocal, and in exceptional and unique cases).

[2] Facet joints in the spine aid stability and allow the spine to bend and twist. For some people with chronic neck and back pain due to a facet-joint injury or arthritis, facet-joint injections can help reduce inflammation and relieve pain.

[3] A session consists of all Medicare Part B claim lines for certain SPM procedures (e.g., facet-joint injections) for a single date of service for a Medicare enrollee.

[4] OIG, *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), page 12, Feb. 19, 2021.

[5] See the section "Spinal Pain Management Procedures Covered by Medicare" for background information on the selected SPM procedures.

contracts with MACs to, among other things, determine reimbursement amounts and pay claims, conduct audits, safeguard against fraud and abuse, establish local coverage determinations (LCDs), and educate providers about Medicare billing requirements.[6] 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.[7]

Spinal Pain Management Procedures Covered by Medicare

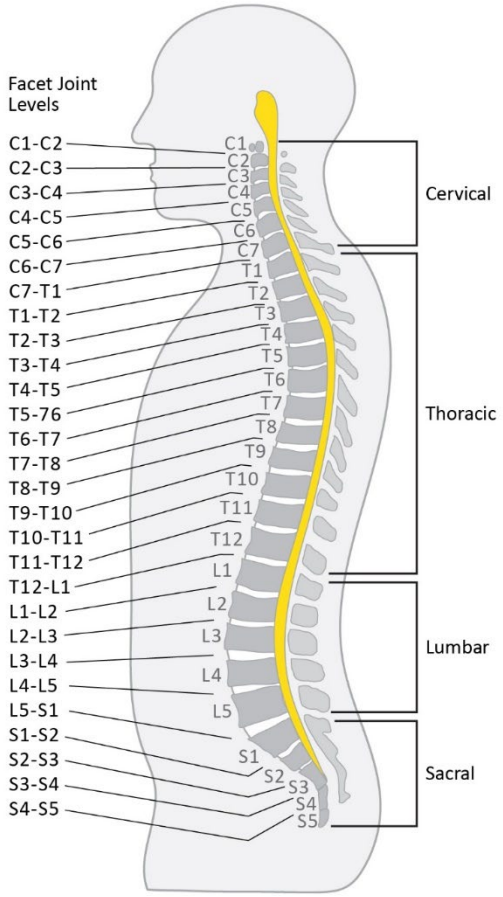
Medicare covers various types of SPM procedures, including facet-joint injections, facet-joint denervation (also known as radiofrequency ablation), epidural steroid injections, and sacroiliac joint injections; the requirements are outlined in LCDs. (Facet-joint injections and facet-joint denervation are also known as facet-joint interventions.)

Facet-Joint Injections and Facet-Joint Denervation

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

For some people with chronic neck and back pain due to a facet-joint injury or arthritis, facet-joint injections can help reduce inflammation and relieve pain. Facet-joint injections can be either diagnostic or therapeutic, depending on an enrollee'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 an enrollee is not a candidate for facet-joint denervation). The goal of facet-joint denervation is to reduce neck or back pain for more than 6 months. The goal of therapeutic facet-joint injections is to provide pain relief for at least 3 months.

Figure 1: Spinal Regions and Facet-Joint Levels

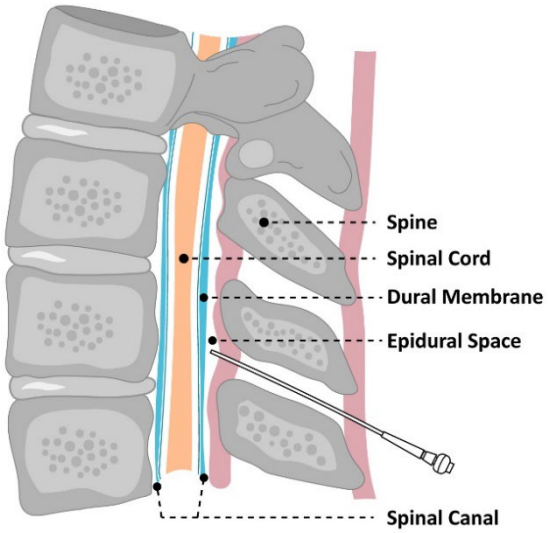


[6] An LCD is a decision by a MAC whether to cover a particular item or service on a contractor-wide basis in accordance with 1862(a)(1)(A) of the Social Security Act.

[7] Physicians who perform selected SPM procedures and administer anesthesia include those who specialize in interventional pain management or anesthesiology.

Epidural Steroid Injections

Figure 2: Epidural Space

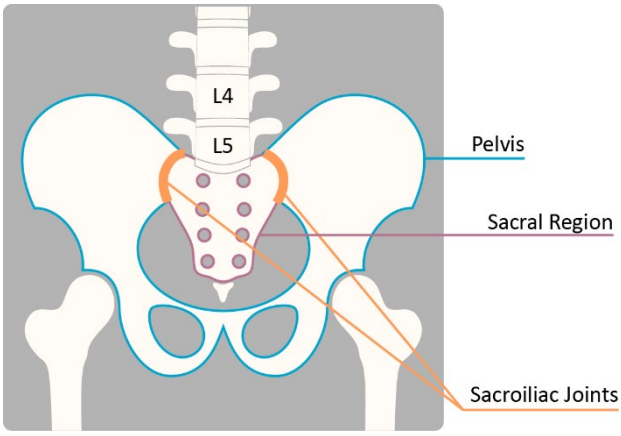


The epidural space lies outside the dural membrane but inside the spinal canal. (See Figure 2.) The spinal nerve roots, which stimulate movement and feeling throughout the spinal canal, can be affected by a number of irritations and inflammations and can become a significant and disabling source of pain.

Physicians generally administer epidural steroid injections to treat pain arising from irritated and inflamed spinal nerve roots, with pain relief expected to last at least 3 months. Physicians administer these injections in the cervical, thoracic, lumbar, or sacral regions of the spine, using one of three distinct techniques, each of which involves introducing a needle into the epidural space.

Sacroiliac Joint Injections

Figure 3: Pelvis and Sacroiliac Joints



Sacroiliac joints are the joints that connect the lower spine to the pelvis. (See Figure 3.) These joints provide a range of functions, including supporting upper-body weight, walking, spinal and thigh movements, and changes in posture or position, such as changing from lying to standing and from standing to sitting. The sacroiliac joints can become painful because of various conditions, including sacroiliac-joint dysfunction, which is a condition caused by excessive or insufficient movement of the sacroiliac joint (usually from injury, pregnancy, or osteoarthritis).

Sacroiliac joint injections are used to improve spinal motion and provide pain relief. A diagnostic sacroiliac joint injection is administered to confirm whether the sacroiliac joint is the source of lower back pain. If an enrollee experiences significant pain relief immediately after the injection, it strongly indicates that the sacroiliac joint is the source of the pain. A therapeutic sacroiliac joint injection is administered after the sacroiliac joint is determined to be the source of pain, with pain relief expected to last at least 3 months.

Types of Anesthesia Administered During Selected SPM Procedures Covered by Medicare

In rare circumstances when considered medically reasonable and necessary, Medicare Part B covers the cost of the following types of anesthesia administered during selected SPM procedures: moderate sedation, general anesthesia, and monitored anesthesia care.

- *Moderate sedation* is a drug-induced depression of consciousness during which an enrollee responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain the enrollee's airway, and spontaneous ventilation is adequate.

- *General anesthesia* is a drug-induced loss of consciousness during which an enrollee is not arousable, even by painful stimulation. The ability to independently maintain breathing is often impaired. The enrollee often requires assistance in maintaining an open airway that allows for adequate airflow and proper oxygenation of the lungs. Positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function.

- *Monitored anesthesia care* is a specific anesthesia service for a diagnostic or therapeutic procedure. Indications for monitored anesthesia care include the need for deeper levels of analgesia (i.e., the inability to feel pain) and sedation than can be provided by moderate sedation. Monitored anesthesia care falls between moderate sedation and general anesthesia.

Physician Submission of Medicare Claims for SPM Procedures and Anesthesia

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

To receive Medicare payment for a selected SPM procedure or for anesthesia, a physician submits a claim and uses Current Procedural Terminology (CPT®) codes on the claim to indicate the type of SPM procedure that was performed (e.g., CPT code 64490[8, 9] for a facet-joint injection) or the type of anesthesia that was administered (e.g., CPT code 01937 for general anesthesia). Modifier QS may be billed with a general anesthesia CPT code to indicate that

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monitored anesthesia care was administered.[10, 11, 12] Table 1 shows the 10 CPT codes used to bill for selected SPM procedures and the 10 CPT codes used to bill for the 3 types of anesthesia, as well as the modifier for monitored anesthesia care.

Table 1: CPT Codes for Selected SPM Procedures and Three Types of Anesthesia

	CPT Codes
Selected SPM Procedure	
Facet-joint injections	64490 and 64493
Facet-joint denervation	64633 and 64635
Epidural steroid injections	62321, 62323, 64479, and 64483
Sacroiliac joint injections	27096 and 64451
Type of Anesthesia	
Moderate sedation	99152, 99153, 99156, and 99157
General anesthesia	01937, 01938, 01939, 01940, 01991, and 01992
Monitored anesthesia care	01937, 01938, 01939, 01940, 01991, and 01992 (with QS modifier)

CMS and MAC Oversight of Medicare Part B Payments for Anesthesia Administered During Selected SPM Procedures

CMS and MACs perform various types of oversight for preventing and detecting improper payments for anesthesia administered during selected SPM procedures.

CMS's National Correct Coding Initiative Procedure-to-Procedure Edits

CMS developed the National Correct Coding Initiative (NCCI) program to promote national correct coding of Medicare Part B claims. The purpose of NCCI procedure-to-procedure (PTP) edits is to prevent improper payments when incorrect combinations of CPT codes are reported for services administered to an enrollee on the same date of service by the same physician.[13]

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

[11] *The responsibility for the content of any "National Correct Coding Policy" included in this product is with the Centers for Medicare and Medicaid Services and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any use, nonuse or interpretation of information contained in this product.*

[12] 56 Fed. Reg. 59502, 59563 (Nov. 25, 1991); *Medicare Claims Processing Manual,* chapter 12, §§ 50 and 140.3.

[13] An edit is programming within the standard claims processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, takes action on the claims, such as paying them in full, paying them in part, or suspending them for manual review.

NCCI PTP edits are automated prepayment edits, which the MACs implement within their claims processing systems.

Before our audit period, CMS developed edits based on a few combinations of CPT codes for anesthesia and selected SPM procedures that Medicare would not pay for; those NCCI PTP edits were still in effect during our audit period. For example, Medicare will not pay for CPT code 01991 (general anesthesia) when billed on the same date of service as CPT code 62321 (epidural steroid injections) for the same enrollee if the same physician performed the services.[14]

MACs' Oversight of Medicare Payments

MACs oversee payments that are made for anesthesia administered during selected SPM procedures to identify instances in which anesthesia claims do not meet Medicare requirements and should not be paid. Besides implementing NCCI PTP edits developed by CMS, the extent of oversight varies by MAC. Oversight may include monitoring claims daily for potential aberrant patterns in physician billing and implementing local system edits that suspend payment for anesthesia that is billed on the same date of service as a selected SPM procedure.

MACs' Local Coverage Determinations

MACs develop and implement LCDs specific to services within their jurisdictions. LCDs may vary by MAC and result in differing coverage in different jurisdictions. Generally, the MACs' LCDs for selected SPM procedures state that the use of moderate sedation, general anesthesia, and monitored anesthesia care is usually unnecessary or rarely indicated for these procedures. However, individual consideration may be given in rare cases in which documentation clearly established the need for such anesthesia.

All seven MACs have the same LCD requirements for anesthesia administered during facet-joint injections, facet-joint denervation, and epidural steroid injections. Effective March 19, 2023, five of the seven MACs have LCD requirements that are specific to anesthesia administered during sacroiliac joint injection procedures. The remaining two MACs, First Coast Service Options, Inc. (First Coast), and Novitas Solutions, Inc. (Novitas), have no LCD requirements for anesthesia administered during sacroiliac joint injection procedures.[15]

[14] CMS's NCCI PTP edits are available to the public at https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits. Accessed on Apr. 16, 2025.

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

MACs' Education of Physicians and Their Billing Staff

MACs provide education to physicians and billing staff in MAC jurisdictions to make them aware of the LCD requirements for anesthesia administered during selected SPM procedures. The extent of education varies by MAC and may include conducting webinars and posting on MAC websites supplemental articles that detail Medicare coverage of anesthesia during these procedures.

HOW WE CONDUCTED THIS AUDIT

Medicare Part B paid for 3.9 million sessions associated with selected SPM procedures that had dates of service from May 2, 2021, through August 31, 2023 (audit period).[16] During our audit period, physicians billed for anesthesia administered during 698,448 of these sessions. Medicare paid $46.2 million for anesthesia administered during 695,267 sessions.[17] Medicare denied payments for anesthesia administered during the remaining 3,181 sessions.

Of the 695,267 sessions, we analyzed the claims data for anesthesia administered during 689,004 sessions associated with facet-joint interventions, epidural steroid injections, and sacroiliac joint injections for which there were applicable LCD requirements to determine whether the number of instances in which the MACs paid for anesthesia administered during these sessions was consistent with how often the MACs would consider the administration of anesthesia for SPM procedures to be medically reasonable or necessary (i.e., administered in rare circumstances). We also analyzed the claims data for payments denied by CMS's and the MACs' system edits for anesthesia administered during 3,181 sessions associated with selected SPM procedures to assess whether the frequency of those payment denials may have indicated that anesthesia was administered in rare circumstances.

To test provider compliance with Medicare requirements for anesthesia administered during selected SPM procedures, we selected a nonstatistical sample of 28 sessions associated with selected SPM procedures and submitted supporting documentation for these sessions to an independent medical review contractor to determine whether the anesthesia was medically necessary.[18] The results of the contractor's review could not be used for an estimate of

[16] For facet-joint interventions, epidural steroid injections, and sacroiliac joint injections, the beginning dates of service were May 2, 2021, June 19, 2022, and Mar. 19, 2023, respectively, when all LCDs for each selected SPM procedure were in effect. (First Coast and Novitas did not have LCD requirements for anesthesia administered during sacroiliac joint injections.)

[17] Medicare paid for 689,004 sessions associated with facet-joint interventions, epidural steroid injections, and sacroiliac joint injections (for which there were applicable LCD requirements) and 6,263 sessions associated with sacroiliac joint injections (for which there were not applicable LCD requirements).

[18] For the 28 sessions, we selected 7 sessions for each type of SPM procedure (i.e., facet-joint injections, facet-joint denervation, epidural steroid injections, and sacroiliac joint injections) in which 1 of the 3 types of anesthesia was administered. These sessions included moderate sedation (11 sessions), monitored anesthesia care (10 sessions), and general anesthesia (7 sessions).

improper payments because we used a nonstatistical sample. In addition, we reviewed information provided by the physicians that billed for anesthesia for the 28 sampled sessions to determine: (1) their awareness of the MACs' LCD requirements and MACs' education activities and (2) their reasoning for administering anesthesia during these sessions.

For the 689,004 sessions in which anesthesia was administered in association with facet-joint interventions, epidural steroid injections, and sacroiliac joint injections for which there were applicable LCD requirements, we calculated the potential savings for administration of anesthesia by using the MACs' expectations of how often anesthesia would be reimbursed for these procedures (because anesthesia should be paid for in only rare circumstances).[19] See Appendix B for our calculation methodology.

Finally, we analyzed the claims data for anesthesia administered during 6,263 sessions associated with sacroiliac joint injections paid for dates of service from March 19 through August 31, 2023, by the 2 MACs without LCD requirements during our audit period to compare: (1) the number of sessions for which these 2 MACs paid for anesthesia for this procedure and (2) the number of sessions for which the 5 MACs with LCD requirements paid for anesthesia for this procedure.

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

Appendix A contains the details of our audit scope and methodology.

FINDINGS

Medicare Part B made payments of $45.7 million to physicians for 689,004 sessions in which anesthesia was administered during selected SPM procedures that were at risk for noncompliance with Medicare requirements.[20] Specifically, Medicare paid for anesthesia that may not have been administered in only rare circumstances as required by the MACs' LCDs. We found the following:

- For 689,004 (approximately 18 percent) of 3.9 million sessions associated with selected SPM procedures paid for during our audit period, anesthesia was also administered.[21]

[19] We obtained from five MACs the expected percentages of sessions in which each type of anesthesia would be administered for each type of selected SPM procedure.

[20] The amount that Medicare paid that was at risk for noncompliance with Medicare requirements was $45,729,441.

[21] We did not include in our analysis 6,263 sacroiliac joint injection sessions with payments totaling $426,621.

In addition, CMS and the MACs denied payment for anesthesia less than 1 percent of the time that it was billed for these procedures.

- For 20 of the 28 nonstatistically sampled sessions reviewed by an independent medical review contractor, the enrollees' medical records did not document a rare circumstance in which administering anesthesia was reasonable or necessary for the specific SPM procedure.

Medicare made at-risk payments for anesthesia administered during selected SPM procedures because CMS and MAC oversight was not adequate.[22] Specifically, CMS's and the MACs' system edits were not designed to prevent all at-risk payments for anesthesia administered during selected SPM procedures, and the MACs' education materials did not include sufficient detail about when anesthesia would be considered medically necessary for an SPM procedure. If CMS and MAC oversight had been adequate, Medicare could have saved an estimated $17.7 million for our audit period.[23] (See Appendix B for details on our calculation of the estimate.)

In addition, the 2 MACs that did not have LCDs during our audit period that specified that Medicare payments for anesthesia administered during sacroiliac joint injection sessions should be made in only rare circumstances paid physicians $426,621 for the administration of anesthesia associated with 6,263 sacroiliac joint injection sessions for dates of service from March 19 through August 31, 2023.[24] This number of sessions was 47 percent of all sacroiliac injections for which the administration of anesthesia was paid during this timeframe.

MEDICARE REQUIREMENTS

The MACs' LCDs for SPM procedures state that anesthesia administered during these procedures is generally not medically reasonable and necessary and that payment will be made in only rare circumstances. The LCDs state the following for these procedures:

- **Facet-Joint Injections and Facet-Joint Denervation:** General anesthesia is considered not medically reasonable and necessary for facet-joint interventions. Neither conscious sedation nor monitored anesthesia care is routinely necessary for intra-articular facet-joint injections or medial branch blocks, and neither is routinely considered medically

[22] "At-risk" payments were payments for anesthesia administered during selected SPM sessions that were at risk for noncompliance with Medicare requirements.

[23] The amount that Medicare could have saved for our audit period was an estimated $17,688,110.

[24] Because the five other MACs' LCDs that restricted use of anesthesia during sacroiliac joint injection sessions to rare circumstances were not effective until March 19, 2023, we limited our review of sacroiliac joint injection sessions for the remaining two MACs to claims with dates of service from March 19 through Aug. 31, 2023, the end of our audit period.

reasonable and necessary.[25] Individual consideration may be given on appeal for payment in rare, unique circumstances if the medical necessity of sedation is unequivocal and clearly documented in the medical record.[26]

- **Epidural Steroid Injections:** Use of moderate sedation, general anesthesia, or monitored anesthesia care is usually unnecessary or rarely indicated for epidural steroid injections and is therefore not considered medically reasonable and necessary. Even in patients with a needle phobia and anxiety, typically oral medications used to reduce anxiety suffice. In exceptional and unique cases, documentation must clearly establish the need for such sedation in the specific enrollee.[27]

- **Sacroiliac Joint Injections:** Use of moderate sedation, general anesthesia, or monitored anesthesia care is usually unnecessary and rarely indicated for sacroiliac joint injections and is therefore not considered medically reasonable and necessary. Even in patients with a needle phobia and anxiety, typically oral medications used to reduce anxiety suffice.[28]

MEDICARE PAYMENTS FOR ANESTHESIA ADMINISTERED DURING SELECTED SPINAL PAIN MANAGEMENT PROCEDURES WERE AT RISK FOR NONCOMPLIANCE WITH MEDICARE REQUIREMENTS

Anesthesia During Selected SPM Procedures May Not Have Been Administered in Only Rare Circumstances

Medicare paid for anesthesia that may not have been administered during selected SPM procedures in only rare circumstances. For 3.9 million sessions associated with selected SPM procedures paid for during our audit period, Medicare paid $45.7 million for anesthesia administered during 689,004 of these sessions (18 percent of the total 3.9 million sessions). Five of the seven MACs stated they would not consider this percentage to be consistent with the administration of anesthesia in only rare circumstances.[29]

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[25] Intra-articular facet-joint injections and medial branch blocks are types of facet-joint injections. An intra-articular facet-joint injection is an injection of local anesthetic and possibly a corticosteroid into the facet-joint capsule. A medial-branch block is the placement of local anesthetic and possibly a corticosteroid near the medial branch nerve, which supplies sensory innervation to a specific facet joint.

[26] LCDs L33930, L34892, L35936, L38001, L38003, L38765, L38773, and L38841.

[27] LCDs L33906, L36920, L38994, L39015, L39036, L39054, L39240, and L39242.

[28] LCDs L39383, L39402, L39455, L39462, L39464, and L39475. First Coast and Novitas did not have LCDs during our audit period for anesthesia administered during sacroiliac joint injections.

[29] The remaining two MACs stated that they were unable to specify a percentage for how often they expected the administration of anesthesia to be required during SPM procedures.

In addition, MACs denied payments for anesthesia for 3,181 sessions, or less than 1 percent of the 692,185 sessions for which physicians billed for anesthesia in MAC jurisdictions in which MACs had LCD requirements specific to anesthesia associated with selected SPM procedures (consisting of 689,004 sessions for which MACs paid for anesthesia and the 3,181 sessions for which payments were denied). The low rate of denial for anesthesia may indicate that payments were allowed for anesthesia that was not administered in only rare circumstances. See Table 2 for a comparison of the total number of sessions for which physicians billed for anesthesia with the number of sessions for which MACs denied payment for anesthesia.

Table 2: Comparison of the Total Number of Sessions in Which Physicians Billed for Anesthesia With the Number of Sessions for Which MACs Denied Payment for Anesthesia

SPM Procedure	Total No. of Sessions for Which Physicians Billed for Anesthesia	No. of Sessions for Which MACs Paid for Anesthesia	No. of Sessions for Which MACs Denied Payment for Anesthesia	Percentage of Billed Sessions for Which MACs Denied Payment for Anesthesia
Facet-joint denervation	253,924	253,143	781	0.3%
Facet-joint injections	207,154	206,702	452	0.2%
Epidural steroid injections	223,864	221,956	1,908	0.9%
Sacroiliac joint injections*	7,243	7,203	40	0.6%
Total	**692,185**	**689,004**	**3,181**	**0.5%**

* The number of sessions in which anesthesia was administered during sessions associated with sacroiliac joint injections did not include the 6,263 sessions paid for by the 2 MACs without LCD requirements.

Anesthesia Administered During 20 Sampled Sessions Associated With SPM Procedures Was Not Reasonable or Necessary

For 20 of 28 nonstatistically sampled sessions associated with selected SPM procedures in which anesthesia was administered, physicians did not document in the enrollees' medical records a rare circumstance in which administering anesthesia was reasonable or necessary.[30] For example, a physician administered moderate sedation to an enrollee during an epidural steroid injection session. The enrollee's medical records provided by the physician stated that

[30] For seven of the eight sessions in which anesthesia was determined to be reasonable or necessary, the independent medical review contractor stated that it could not determine whether anesthesia was necessary because the LCDs did not specifically address anesthesia for facet-joint denervation. The MACs added clarifying language to their LCDs (effective for dates of service starting in July or August 2024) specific to anesthesia administered during facet-joint denervation procedures. The medical review contractor stated that if this clarifying language had been in the LCDs in effect during our audit period, the contractor would have determined that the anesthesia administered during these seven sessions was not reasonable or necessary.

this type of anesthesia was administered because of the enrollee's anxiety, which is not a medically necessary indication according to the LCD. The medical records also did not have evidence of failed oral sedation, which could have necessitated moderate sedation.

Of the $2,021 that Medicare paid for anesthesia administered during these 28 sampled sessions, Medicare improperly paid $1,491 for the 20 sessions in which anesthesia was not reasonable or necessary.

CMS and MAC Oversight Was Not Adequate To Prevent or Detect At-Risk Payments for Anesthesia Administered During Selected SPM Procedures

CMS and the MACs conducted oversight activities to prevent and detect improper payments for anesthesia administered during selected SPM procedures. However, these oversight activities were not adequate to prevent or detect payments for anesthesia that were at risk for noncompliance with Medicare requirements.

CMS's and MACs' System Edits and Other Oversight Activities Were Insufficient

Before our audit period, CMS developed a limited number of NCCI PTP edits that would deny payment for anesthesia when billed by the same physician on the same date of service as an SPM procedure for the same enrollee. Specifically, these edits were designed to deny 4 of the 10 CPT codes for anesthesia procedures when they were billed by the same physician along with most (but not all) of the 10 CPT codes for selected SPM procedures for the same date of service for the same enrollee.[31] However, during our audit period, there were no NCCI PTP edits to deny the remaining six selected anesthesia CPT codes when they were billed by the same physician along with any of the selected SPM procedure CPT codes on the same date of service for the same enrollee. Such edits would have prevented payment for 273,935 of the 689,004 sessions. In addition, the existing edits did not prevent payment for the administration of anesthesia when it was billed by different physicians on the same date of service for the same enrollee. Edits designed to deny payment for anesthesia billed by a different physician on the same date as an SPM procedure for the same enrollee could have prevented payment for the administration of anesthesia associated with the remaining 415,069 sessions.

In addition to the NCCI PTP edits that CMS implemented, six of seven MACs implemented local system edits during our audit period specific to anesthesia administered during selected SPM procedures. However, these edits did not cover all of the CPT codes for the selected SPM and anesthesia procedures when those codes were billed on the same date of service for the same enrollee. We also found that the edits for anesthesia CPT codes differed among the MACs. For example, one MAC's edits were designed to deny payments for three anesthesia CPT codes and another MAC's edits were designed to deny payments for six anesthesia CPT codes when billed with any of the four CPT codes for epidural steroid injections.

[31] The four anesthesia CPT codes were 01991, 01992, 99156, and 99157.

Additional oversight activities that the MACs performed were also insufficient to prevent and detect at-risk payments for anesthesia administered during selected SPM procedures. For example, the MACs stated that they monitored claims for potential aberrant patterns in physician billing during our audit period. However, the MACs either did not review any billing specific to anesthesia administered during selected SPM procedures or reviewed a limited number of these instances.

MACs' Education of Physicians Was Insufficient To Ensure That Physicians Understood Medicare Requirements for Administering Anesthesia During Selected SPM Procedures

The MACs' education of physicians specific to anesthesia administered during selected SPM procedures did not include sufficient detail about when anesthesia would be considered medically necessary for an SPM procedure. Specifically, the types of education provided during our audit period varied among the MACs: some MACs referred physicians to the LCDs and hosted webinars, and one MAC posted an article and YouTube video about anesthesia administered during selected SPM procedures. However, besides restating the LCD requirements, the education did not go into much detail about when anesthesia for these procedures would be considered medically necessary. The only two examples provided of when anesthesia would generally not be needed were in the LCDs for epidural steroid injections and sacroiliac joint injections (in cases of needle phobia and anxiety). The LCDs for facet-joint injections and facet-joint denervation did not include any medical conditions that would not constitute a rare circumstance in which anesthesia would be administered.

We identified guidance published after our audit period by insurance carriers other than Medicare that specified medical conditions and procedures in which anesthesia would be considered allowable for selected SPM procedures. See Table 3 for another insurance carrier's published guidance outlining medical conditions that may constitute rare circumstances for which that insurance carrier would cover administered anesthesia during these procedures.

Table 3: Medical Conditions in Another Insurance Carrier's Guidance That May Constitute Rare Circumstances

Moderate Sedation
• Severe anxiety under active medical management with psychotropic medication and/or cognitive therapy
• Other severe psychiatric condition(s)
• Severe cognitive impairment that would risk endangering the individual's safety during the planned procedure
Monitored Anesthesia Care or General Anesthesia
• American Society of Anesthesiologists Physical Status III or above*
• Severe cardiac disease and/or pulmonary disease
• Documented sleep apnea

- Morbid obesity
- Chronic renal failure
- Chronic liver disease
- Older than 70 years old
- Severe anxiety under active medical management with psychotropic medication and/or cognitive therapy
- Other severe psychiatric condition(s)
- Severe cognitive impairment(s) that would risk endangering the individual's safety during the planned procedure
- Spasticity or movement disorder (e.g., cerebral palsy, brain injury)
- Individuals at risk of airway obstruction due to anatomical variation (e.g., neck tumor, jaw abnormality)
- Anticipated tolerance or physical dependence to sedatives or monitored sedation (e.g., chronic opioid use)
- History of active illicit drug or alcohol abuse

[*] The American Society of Anesthesiologists Physical Status Classification System is used to assess and communicate a patient's pre-anesthesia medical comorbidities (i.e., a disease or medical condition that is simultaneously present with another or others in a patient). There are six status levels, ranging from a normal, healthy patient (status I) to a declared brain-dead patient whose organs are being removed for donor purposes (status VI). A patient at status III is considered to have a severe systemic disease (e.g., morbid obesity).

Some of the physicians associated with the 28 sessions in our nonstatistical sample stated that they would prefer that LCD requirements list examples of rare circumstances in which anesthesia may be considered allowable, similar to the guidance from other insurance carriers.

Furthermore, although the MACs provided education to physicians in their jurisdictions, 13 of the 28 physicians that administered anesthesia for the sampled sessions associated with selected SPM procedures stated that they were not aware that their MACs had provided any guidance on this topic. The 28 physicians also provided various suggestions of how MACs could further provide education on administering anesthesia during selected SPM procedures, including: (1) in-person and on-demand online training; (2) emailing physicians with anesthesia guidelines, changes in requirements, and examples of when anesthesia would be covered for these procedures; (3) posting on the MACs' websites examples of when anesthesia would and would not be covered for these procedures; and (4) mailing fliers to physicians that describe how they can access training on this topic.[32]

Medicare Could Have Saved an Estimated $17.7 Million if CMS and MAC Oversight Had Been Adequate

If CMS and MAC oversight had been adequate to prevent or detect at-risk payments for anesthesia administered during selected SPM procedures, Medicare could have saved an estimated $17.7 million for our audit period. We calculated this amount based on the MACs'

[32] We did not confirm whether MACs already provide this type of education.

expectations of how often anesthesia would be reimbursed for these procedures (i.e., in only rare circumstances). See Appendix B for details on how we calculated the estimated amount.

TWO MACs WITHOUT LOCAL COVERAGE DETERMINATIONS FOR ANESTHESIA ADMINISTERED DURING SACROILIAC JOINT INJECTION PROCEDURES ACCOUNTED FOR ALMOST HALF OF PAID SESSIONS IN WHICH ANESTHESIA WAS ADMINISTERED

For dates of service from March 19 through August 31, 2023, 2 of the 7 MACs (First Coast and Novitas) paid physicians $426,621 for anesthesia administered during 6,263 sacroiliac joint injection sessions, or approximately 47 percent of the 13,466 total sessions nationwide in which anesthesia was administered for this type of procedure. These two MACs did not have LCDs during our audit period that specified that Medicare payments for anesthesia administered during sacroiliac joint injection sessions should be made in only rare circumstances because, according to the two MACs, they had higher priority issues to address at the time.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- direct the MACs or other CMS contractors to review potentially improper claims for anesthesia administered during selected SPM procedures that had dates of service during our audit period to determine whether payments for administration of anesthesia complied with Medicare requirements;

- collaborate with the MACs to develop or update system edits that would lower the risk of improper Medicare payments for anesthesia administered during selected SPM procedures, which could have saved an estimated $17,688,110 during our audit period;

- collaborate with the MACs to develop additional physician education specific to anesthesia administered during selected SPM procedures, and consider the suggestions provided by the physicians for the 28 sessions in our nonstatistical sample; and

- share the results of this audit with all of the MACs to show that: (1) for the SPM procedures for which LCDs are in place, MACs paid physicians for anesthesia administered during selected SPM procedures that were at risk for noncompliance with Medicare requirements and (2) for sacroiliac joint injections for which two MACs do not have LCDs in place, these two MACs paid for almost half of the sessions nationwide in which anesthesia was administered during these procedures.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our second, third, and fourth recommendations, and described actions that it had taken or planned to take to address these

recommendations. However, CMS did not concur with our first recommendation. After reviewing CMS's comments, we maintain that our first recommendation is valid.

CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included as Appendix C. The following sections summarize CMS's comments and our response.

CMS COMMENTS

- Regarding our first recommendation, CMS stated that it contracts with various types of contractors in its effort to fight improper payments and promote provider compliance in the Medicare program. CMS also stated that the MACs have been instructed to target their efforts to those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources. In addition, CMS stated it will notify the MACs of this audit so that they may take our findings and recommendation into consideration as they prioritize services and items for medical review.

- Regarding our second recommendation, CMS stated that it will explore opportunities to develop or update system edits that would lower the risk of improper Medicare payments for anesthesia administered during selected SPM procedures.

- Regarding our third recommendation, CMS stated that CMS and the MACs are continuously educating physicians on Medicare requirements. CMS also noted that education must be consistent with existing Medicare requirements.

- Regarding our fourth recommendation, CMS stated that it will notify the MACs of this audit consistent with this recommendation.

OIG RESPONSE

After reviewing CMS's comments, we maintain that our first recommendation is valid and continue to recommend that CMS take action to review potentially improper claims for anesthesia administered during selected SPM procedures that had dates of service during our audit period. However, we revised this recommendation by adding "other CMS contractors" to review potentially improper claims in order to capture the various types of contractors CMS uses to fight improper payments. Our audit found that Medicare made at-risk payments for anesthesia administered during selected SPM procedures. Specifically, we calculated that of the $45.7 million that was paid to physicians for selected SPM procedures, $17.7 million was paid to physicians for anesthesia that may not have been administered in only rare circumstances as required by Medicare. By implementing this recommendation, CMS may lower the financial risk to the Medicare program.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Medicare Part B paid for 3,853,173 sessions associated with selected SPM procedures that had dates of service from May 2, 2021, through August 31, 2023. During this period, physicians billed for anesthesia administered during 698,448 of these sessions. Medicare paid $46,156,062 for anesthesia administered during 695,267 sessions.[33] Medicare denied payments for anesthesia administered during the remaining 3,181 sessions.

Of the 695,267 sessions, we analyzed the claims data for anesthesia administered during 689,004 sessions associated with facet-joint interventions, epidural steroid injections, and sacroiliac joint injections for which there were applicable LCD requirements to determine whether the number of instances in which the MACs paid for anesthesia administered during these sessions was consistent with how often the MACs would consider the administration of anesthesia for SPM procedures to be medically reasonable or necessary (i.e., administered in rare circumstances). We also analyzed the claims data for payments denied by CMS's and the MACs' system edits for anesthesia administered during 3,181 sessions associated with selected SPM procedures to assess whether the frequency of those payment denials may have indicated that anesthesia was administered in rare circumstances.

From the sampling frame of 695,267 sessions, we selected a nonstatistical sample of 28 sessions to test provider compliance with Medicare requirements for anesthesia administered during selected SPM procedures. Specifically, we selected one session paid by each of the seven MACs with LCD requirements in place for anesthesia associated with each of the four selected SPM procedures in place during our audit period.[34] We submitted supporting documentation for these sessions to an independent medical review contractor to determine whether the anesthesia was medically necessary. The results of our nonstatistical sample cannot be generalized to the population of Medicare payments for anesthesia administered during selected SPM procedures during our audit period.

For the 689,004 sessions in which anesthesia was administered in association with facet-joint interventions, epidural steroid injections, and sacroiliac joint injections for which there were applicable LCD requirements, we calculated the potential savings for administration of

[33] Medicare paid for 689,004 sessions associated with facet-joint interventions, epidural steroid injections, and sacroiliac joint injections (for which there were applicable LCD requirements) and 6,263 sessions associated with sacroiliac joint injections (for which there were not applicable LCD requirements).

[34] For the 28 sessions, we selected 7 sessions for each type of SPM procedure in which 1 of the 3 types of anesthesia was administered: moderate sedation (11 sessions), monitored anesthesia care (10 sessions), and general anesthesia (7 sessions). For the seven sessions for sacroiliac joint injections, we selected two sessions that were not paid by First Coast or Novitas because these MACs did not have LCD requirements specific to anesthesia administered during sacroiliac joint injections during our audit period.

anesthesia by using the MACs' expectations of how often anesthesia would be reimbursed for these procedures (because anesthesia should be paid for in only rare circumstances).

Finally, we analyzed the claims data for anesthesia administered during 6,263 sessions associated with sacroiliac joint injections paid for by the two MACs without LCD requirements during our audit period.

We did not perform an overall assessment of the internal control structures of CMS and the MACs. Rather, we limited our review to those controls that were significant to our objective. Specifically, we assessed CMS's and the MACs' oversight activities to identify and monitor potentially at-risk payments made to physicians for anesthesia administered during selected SPM procedures. We also assessed guidance provided by the MACs to physicians specific to administering anesthesia during these procedures.

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 data.

We conducted our audit from September 2023 through May 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed staff at CMS and the 7 MACs regarding the types of internal controls, system edits, and provider education materials specific to anesthesia administered during selected SPM procedures;
- used CMS's NCH file to identify the following with dates of service during our audit period:
    - paid sessions associated with selected SPM procedures (i.e., facet-joint injections and denervation, epidural steroid injections, and sacroiliac joint injections),
    - paid anesthesia administered for an enrollee on the same date of service as the selected SPM procedures, and
    - paid sessions associated with the selected SPM procedures for which CMS's and the MACs' system edits denied payment for anesthesia;
- performed various analyses of the data obtained from the NCH file, including identifying the number of instances in which anesthesia was administered during the selected SPM

procedures and how often the MACs denied payment for anesthesia administered during selected SPM procedures;

- selected a nonstatistical sample of 28 sessions associated with SPM procedures in which anesthesia was administered;

- obtained from physicians the medical records for the 28 sampled sessions and:

    - used an independent medical review contractor to determine whether each sampled session complied with selected billing requirements, which included determining whether the administration of anesthesia during selected SPM procedures was medically necessary, and

    - asked the physicians to identify: (1) their awareness of the MACs' LCD requirements and MACs' education activities for anesthesia administered during SPM procedures and whether they needed more information and (2) their reasoning for administering anesthesia during these sessions;

- calculated the estimated amount that Medicare Part B could have saved for our audit period if Medicare had paid physicians for anesthesia administered during the selected SPM procedures based on the MACs' expectations of how often anesthesia would be reimbursed for these procedures (Appendix B);

- analyzed the claims data for anesthesia administered during sacroiliac joint injections paid for by the 2 MACs without LCD requirements during our audit period to compare: (1) the number of sessions for which these 2 MACs paid for anesthesia for this procedure and (2) the number of sessions for which the remaining 5 MACs with LCD requirements paid for anesthesia for this procedure; 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.

APPENDIX B: CALCULATION OF ESTIMATED MEDICARE PART B SAVINGS

To calculate the estimated amount that Medicare Part B could have saved for our audit period, we calculated the paid amount that exceeded the expected amount for the MACs with LCD requirements in place during our audit period for anesthesia administered during sessions associated with selected SPM procedures by: (1) subtracting the expected number of sessions from the number of paid sessions during our audit period in which anesthesia was administered and (2) multiplying the resulting number by the average dollar amount paid for anesthesia per session. We calculated the expected number of sessions by multiplying: (1) the number of paid sessions for each selected SPM procedure during our audit period in which anesthesia was or was not administered by (2) the percentages in general that the MACs gave us for how often they expected the administration of anesthesia to be required during each type of SPM procedure (expected percentages).[35] See Table 4 for those expected percentages.

Table 4: Expected Percentages That the MACs Provided to Us for Administration of Anesthesia for Each Selected SPM Procedure

Selected SPM Procedure	Expected Percentage for Administration of Moderate Sedation and Monitored Anesthesia Care	Expected Percentage for Administration of General Anesthesia
Facet-joint injections	5 percent	0.01 percent
Facet-joint denervation	20 percent	0.01 percent
Epidural steroid injections	5 percent	0.01 percent
Sacroiliac joint injections	5 percent	0.01 percent

For example, the potential savings for moderate sedation administered during facet-joint injections was calculated as follows:

- The MACs paid $1,604,799 for moderate sedation administered during 72,988 facet-joint injection sessions for our audit period. On average, physicians received $21.99 per session in which moderate sedation was administered during facet-joint injection sessions ($1,604,799/72,988).

- The MACs expected that 5 percent of all facet-joint injection sessions would require moderate sedation.

[35] Of the seven MACs, two stated they were unable to define an expected percentage of administration of anesthesia for each selected SPM procedure.

- During our audit period, the MACs paid for a total of 1,359,583 facet-joint injection sessions, regardless of whether anesthesia was administered. Therefore, the MACs expected that 67,979 of these sessions would require moderate sedation (1,359,583 × 5%).

- The number of sessions during our audit period in which moderate sedation was administered for facet-joint injection sessions exceeded the MACs' expected number of sessions in which moderate sedation would be administered by 5,009 (72,988 – 67,979). The calculated payment amount for potential savings for moderate sedation for these 5,009 excessive sessions totaled $110,148 (5,009 × $21.99).

Our calculation assumes that the MACs' expected percentages of sessions in which each type of anesthesia would be administered for each type of selected SPM procedure are reasonable. The MACs' LCDs generally stated that anesthesia was considered allowable in rare circumstances for these procedures. In addition, according to the MACs, the expected percentages are based on statements from subject matter experts during various meetings that the MACs held when developing the LCDs.

Table 5 shows our estimate of potential savings if Medicare had paid physicians for anesthesia administered during selected SPM procedures based on MACs' expectations of how often anesthesia would be reimbursed for these procedures.

Table 5: Potential Savings if Medicare Had Paid Physicians for Anesthesia Administered During Selected SPM Procedures Based on MACs' Expectations of How Often Anesthesia Would Be Reimbursed for These Procedures

	Moderate Sedation	Monitored Anesthesia Care	General Anesthesia	Total
No. of Paid Facet-Joint Injection Sessions With and Without Anesthesia				1,359,583
No. of sessions with anesthesia	72,988	84,928	48,786	206,702
Amount paid for anesthesia	$1,604,799	$8,047,440	$4,752,377	$14,404,616
No. of expected sessions for type of anesthesia	67,979	67,979	136	136,094
No. of sessions that exceeded MACs' expected no. of sessions	5,009	16,949	48,650	70,608
Calculated payment amount for anesthesia for potentially excessive sessions	$110,148	$1,606,087	$4,738,997	$6,455,232
No. of Paid Facet-Joint Denervation Sessions With and Without Anesthesia				727,806
No. of sessions with anesthesia	130,658	77,769	44,716	253,143
Amount paid for anesthesia	$3,099,551	$7,715,548	$4,495,930	$15,311,029

	Moderate Sedation	Monitored Anesthesia Care	General Anesthesia	Total
No. of expected sessions for type of anesthesia	145,561	145,561	73	291,195
No. of sessions that exceeded MACs' expected no. of sessions	0	0	44,643	44,643
Calculated payment amount for anesthesia for potentially excessive sessions	$0	$0	$4,488,407	$4,488,407
No. of Paid Epidural Steroid Injection Sessions With and Without Anesthesia				1,623,800
No. of sessions with anesthesia	68,908	101,862	51,186	221,956
Amount paid for anesthesia	$1,359,070	$9,442,020	$4,745,252	$15,546,342
No. of expected sessions for type of anesthesia	81,190	81,190	162	162,542
No. of sessions that exceeded MACs' expected no. of sessions	0	20,672	51,024	71,696
Calculated payment amount for anesthesia for potentially excessive sessions	$0	$1,916,088	$4,730,435	$6,646,523
No. of Paid Sacroiliac Joint Injection Sessions With and Without Anesthesia				93,197
No. of sessions with anesthesia	2,927	3,272	1,004	7,203
Amount paid for anesthesia	$57,705	$310,916	$98,833	$467,454
No. of expected sessions for type of anesthesia	4,660	4,660	9	9,329
No. of sessions that exceeded MACs' expected no. of sessions	0	0	995	995
Calculated payment amount for anesthesia for potentially excessive sessions	$0	$0	$97,948	$97,948
Total Calculated Payment Amount for Potential Savings for Anesthesia That Exceeded MACs' Expected No. of Sessions				**$17,688,110**

APPENDIX C: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: June 23, 2025

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

FROM: Dr. Mehmet Oz DR
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Could Have Saved an Estimated $17.7 Million if CMS's Oversight Had Prevented At-Risk Payments for Anesthesia Administered During Spinal Pain Management Procedures (A-09-23-03013)

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 recognizes the importance of continuing to provide Medicare beneficiaries with access to medically necessary services and, at the same time, working to protect the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and post-payment reviews. As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures.

Additionally, CMS has taken action to educate health care providers on the proper billing of Medicare services. As stated in the OIG's report, the Medicare Administrative Contractors (MACs) provided education to physicians and billing staff to make them aware of the local coverage determination (LCD) requirements for anesthesia administered during selected spinal pain management (SPM) procedures. The formats for providing education varied amongst the MACs but included hosting webinars, posting a YouTube video, and publishing articles on their websites. It is important to note that education must be based on existing Medicare requirements, and comparisons to education or guidance published by other insurance carriers may not be appropriate.

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

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services direct the MACs to review potentially improper claims for anesthesia administered during select SPM procedures that had dates of service during our audit period to determine whether payments for administration of anesthesia complied with Medicare requirements.

CMS Response
CMS does not concur with this recommendation. CMS contracts with various types of contractors in its effort to fight improper payments and promote provider compliance in the

Medicare FFS program. The MACs have been instructed to target their efforts to those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources. Consistent with the recommendation below, CMS will notify the MACs of this audit so that they may take the OIG's findings and recommendation into consideration as they prioritize services and items for medical review.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services collaborate with the MACs to develop or update system edits that would lower the risk of improper Medicare payments for anesthesia administered during selected SPM procedures.

CMS Response

CMS concurs with this recommendation. CMS will explore opportunities to develop or update system edits that would lower the risk of improper Medicare payments for anesthesia administered during selected SPM procedures. Consistent with the recommendation below, CMS will notify the MACs of this audit so that they may take the OIG's findings and recommendation into consideration.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services collaborate with the MACs to develop additional physician education specific to anesthesia administered during selected SPM procedures, and consider the suggestions provided by the physicians for the 28 sessions in our nonstatistical sample.

CMS Response

CMS concurs with this recommendation. CMS and the MACs are continuously educating physicians on Medicare requirements. Consistent with the recommendation below, CMS will notify the MACs of this audit so that they may take the OIG's findings and recommendation into consideration. It is important to note that education must be consistent with existing Medicare requirements.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services share the results of this audit with all of the MACs to show that: (1) for the SPM procedures for which LCDs are in place, MACs paid physicians for anesthesia administered during selected SPM procedures that were at risk for noncompliance with Medicare requirements and (2) for sacroiliac joint injections for which two MACs do not have LCDs in place, these two MACs paid for almost half of the sessions nationwide in which anesthesia was administered during these procedures.

CMS Response

CMS concurs with this recommendation. CMS will notify the MACs of this audit consistent with this recommendation.

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