

Report in Brief

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



Why OIG Did This Audit

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

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

How OIG Did This Audit

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

Medicare Improperly Paid Physicians for Spinal Facet-Joint Denervation Sessions

What OIG Found

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

What OIG Recommends and CMS Comments

We recommend that CMS: (1) direct the MACs to recover \$9.5 million in improper payments made to physicians for selected facet-joint denervation sessions; (2) instruct the MACs to, based upon the results of this audit, notify appropriate physicians (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the physicians can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and (3) assess the effectiveness of oversight mechanisms specific to preventing or detecting improper payments to physicians for facet-joint denervation sessions, and modify the oversight mechanisms based on that assessment. We also made two procedural recommendations to CMS (detailed in the report) to direct the MACs to review claims for denervation sessions after our audit period to recover any improper payments.

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