

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PAYMENTS FOR
FACET JOINT INJECTION
SERVICES**



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OBJECTIVES

1. To determine the extent to which Medicare Part B payments for facet joint injections meet Medicare program requirements.
2. To determine what policies and safeguards exist to ensure that Medicare Part B payments for facet joint injections meet Medicare program requirements.

BACKGROUND

Medicare Part B payments for facet joint injections have increased from \$141 million in 2003 to \$307 million in 2006. Over the same period, the number of Medicare claims for facet joint injections increased by 76 percent.

Facet joints are joints in the spine that aid stability and allow the spine to bend and twist. Facet joint injections are a type of interventional pain management technique used to diagnose or treat back pain. Two primary codes, 64470 and 64475, are used to bill a single injection in the cervical/thoracic or lumbar/sacral areas of the spine, respectively. Each primary code has an associated add-on code for use when injections are provided at multiple spinal levels. Unilateral injections are performed on one side of the joint level, while bilateral injections are performed on the right and left side of the joint level. The Centers for Medicare & Medicaid Services (CMS) requires physicians to indicate a bilateral injection by using billing modifier 50. Physicians typically perform facet joint injections using radiological guidance to ensure correct needle placement and avoid nerve or other injury. Medicare Part B carriers are responsible for implementing program safeguards for these services.

We conducted a medical record review of a stratified random sample of 646 facet joint injection services performed in 2006. In addition, we interviewed staff from the 15 carriers that processed Medicare Part B claims in 2006 and reviewed their program safeguards for facet joint injections.

FINDINGS

Sixty-three percent of facet joint injection services allowed by Medicare in 2006 did not meet Medicare program requirements, resulting in approximately \$96 million in improper payments.

Medicare allowed an additional \$33 million in improper payments for

associated facility claims. Thirty-eight percent of facet joint injection services had a documentation error and 31 percent had a coding error. For services that had a coding error, just over 60 percent were overpaid because physicians incorrectly billed additional add-on codes to represent bilateral facet joint injections instead of using modifier 50. Eight percent of services had a medical necessity error. Fourteen percent of services had one or more overlapping errors.

Facet joint injection services provided in an office were more likely to have an error than those provided in an ambulatory surgical center or hospital outpatient department.

In 2006, most carriers had policies and safeguards for facet joint injection services but they identified limits to using these safeguards. Local coverage determinations (LCD) and claims processing edits are carriers' primary tools to protect Medicare payments for facet joint injections. Thirteen of fifteen carriers had LCDs for facet joint injections. Of carriers with LCDs, 10 had at least one active edit.

Carrier staff identified two complexities in creating frequency limits for facet joint injections. First, the lack of consensus in the medical community about appropriate frequency of injections is a barrier to creating frequency limits in LCDs. Second, frequency edits for facet joint injections are difficult to automate because many require information that is not currently available on Medicare claims.

RECOMMENDATIONS

Based on the results of our review, CMS should:

Strengthen program safeguards to prevent improper payment for facet joint injection services. CMS should assist carriers in developing ways to scrutinize physician claims for facet joint injection services provided in an office setting. CMS should also encourage carriers that require radiographic imaging guidance in their LCDs to implement automated edits for imaging guidance. Finally, CMS should direct carriers to revisit frequency limits in their LCDs and update them so that they are as effective as possible.

Clarify billing instructions for bilateral services. CMS should clarify billing instructions for bilateral services and recover funds if appropriate. Correct use of add-on codes and modifier 50 could result in cost savings.

Take appropriate action regarding the undocumented, medically unnecessary, and miscoded services identified in our sample. We have forwarded information on these services to CMS.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS described steps that it will take to address our recommendation to strengthen program safeguards for facet joint injection services. CMS agreed with our recommendations to clarify billing instructions for bilateral services and to take appropriate action on services paid in error in our sample.

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OBJECTIVES

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BACKGROUND

According to one source, chronic pain affects more adults in the United States than diabetes, heart disease, and cancer combined.¹ Treatment varies depending on the type of pain and can range from noninvasive to invasive procedures. Medicare paid over \$2 billion in 2006 for interventional pain management procedures.² Examples of interventional pain management procedures include: injections, nerve blocks, and spinal cord stimulation.

From 2003 to 2006, the number of Medicare claims for facet joint injections, an interventional pain management procedure, increased by 76 percent.³ Overall, payments for facet joint injections increased from \$141 million in 2003 to \$307 million in 2006.⁴ These payments represent both physician and facility payments. They account for approximately 15 percent of Medicare payments for interventional pain management services in 2006.

In addition to an increase in Medicare payments, a number of recent investigations by the Federal Bureau of Investigations (FBI) and the Office of Inspector General (OIG) have found inappropriate activity related to facet joint injections and other types of pain management. In one joint FBI-OIG case, an Ohio physician was convicted of multiple

¹ American Pain Foundation. "Pain Facts & Figures." (2007). Available online at <http://www.painfoundation.org/page.asp?file=Newsroom/PainFacts.htm>. Accessed on May 3, 2007.

² Estimate based on OIG analysis of interventional pain management procedure codes in the 2006 100-percent National Claims History (NCH) outpatient and physician/supplier files.

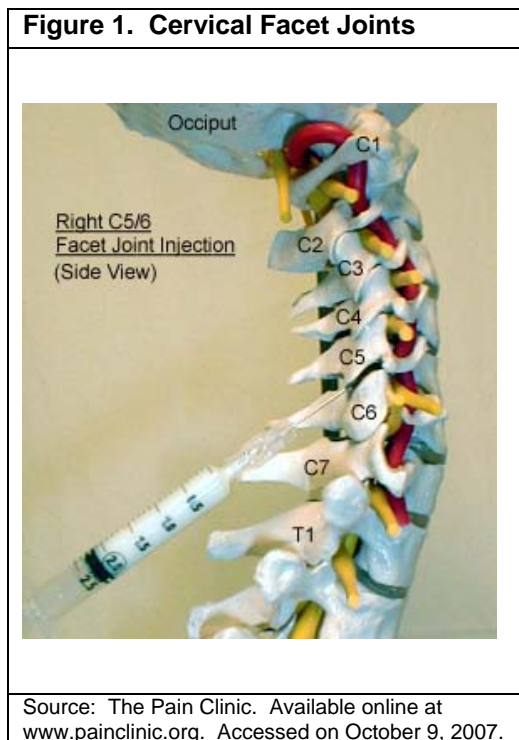
³ Estimate based on OIG analysis of facet joint injection procedure codes in the following Medicare claims files: (1) 2003 1-percent sample of NCH outpatient and physician/supplier files, and (2) 2006 100-percent NCH outpatient and physician/supplier files.

⁴ Ibid.

counts of health care fraud for interventional pain management procedures, including facet joint injections.⁵

Facet Joint Injections

Facet joints are joints in the spine that aid stability and allow the spine to bend and twist. Facet joints are located between each vertebra in the spinal column. See Figure 1 for an illustration of cervical facet joints. There are 25 levels of facet joints in the spine that are divided, from top to bottom, into cervical, thoracic, lumbar, and sacral regions.⁶ Each level has a pair of facet joints, one facet joint on the right and one on the left side of the spine.



Facet joint injections are a type of interventional technique used to diagnose or treat back pain. For some people with chronic pain due to a facet joint injury, injections of an anesthetic or steroid into a facet joint

⁵ U.S. Department of Justice, U.S. Attorney’s Office, Northern District of Ohio (June 9, 2006). Press release. Available online at http://www.usdoj.gov/usao/ohn/news/09June2006_2.html. Accessed on March 18, 2008.

⁶ The Pain Clinic. “Facet Joint Injections.” (n.d.) Available online at <http://www.painclinic.org/treatment-facetjointinjections.htm>. Accessed on March 19, 2008.

help reduce inflammation and relieve pain. Figure 1 shows a unilateral, single-level injection into the C5-C6 facet joint level. Unilateral injections are performed on one side of the joint level, while bilateral injections are performed on the right and left side of the joint level.

Frequency of injections. The frequency of facet joint injections varies for diagnostic and therapeutic injections. For a diagnostic injection, a physician injects a numbing medicine and/or a steroid into one or two suspect facet joints.⁷ The amount of immediate relief experienced by a patient will help confirm or reject the joint as the source of pain. For a therapeutic injection, a physician injects a numbing medicine and/or a steroid into one or more facet joints to reduce inflammation.⁸ Typically, a physician performs a diagnostic injection once, whereas therapeutic injections might be performed repeatedly for ongoing pain relief.

Radiographic guidance. Facet joint injections are typically performed using radiological guidance (radiographic guidance or live x-ray) to ensure correct needle placement and avoid nerve or other injury. Sometimes, a physician performs the procedure without radiological imaging, which is referred to as a “blind” injection. One study of these “blind” injections concluded that facet joint injections should not be performed without the aid of radiological imaging because of potential risk to the patient and lack of diagnostic accuracy.⁹

Setting and specialty. Facet joint injections may be performed in a variety of settings. In 2006, approximately 60 percent of facet joint injections were performed in an office setting, 20 percent in an ambulatory surgical center (ASC), and 20 percent in a hospital outpatient setting.¹⁰ In 2006, over 220,000 Medicare beneficiaries received a facet joint injection in one of these three settings.¹¹

Different physician specialties perform facet joint injections. In 2006, anesthesiologists, pain management specialists, and physiatrists

⁷ M. Boswell, et al. (2007). “A Systematic Review of Therapeutic Facet Joint Interventions in Chronic Spinal Pain.” *Pain Physician*, 10, pp. 229–253.

⁸ Ibid.

⁹ G. Purcell-Jones, et al. (1989). “Paravertebral Somatic Nerve Block: A Clinical, Radiographic, and Computed Tomographic Study in Chronic Pain Patients.” *Anesthesia & Analgesia*, 68(1), 32-9.

¹⁰ Estimate based on OIG analysis of facet joint injection procedure codes in the 2006 NCH Medicare Part B physician/supplier file for amounts greater than \$15 for ASC, office, and hospital outpatient department.

¹¹ Ibid.

performed approximately 64 percent of Medicare facet joint injections, while general practitioners, internal medicine physicians, and family practice physicians performed 19 percent. Other types of physicians performed the remaining 16 percent, including orthopedic surgeons, neurologists, and rheumatologists.¹²

Medicare Program Requirements for Facet Joint Injections

General provisions of the Social Security Act (the Act) govern Medicare reimbursement for all services, including facet joint injections. Section 1862(a)(1)(A) of the Act states that Medicare will cover only services considered to be reasonable and necessary.¹³ Reasonable and necessary items are those used in the diagnosis or treatment of illness or to improve the functioning of a malformed body part. Further, section 1833(e) of the Act states that payment is made only when a provider has furnished appropriate information about the service for the processing of the claim.¹⁴

Medicare requires that providers report services using uniform procedure codes.¹⁵ The Current Procedural Terminology (CPT) codes and descriptions for facet joint injections are listed in Table 1. Two primary codes, 64470 and 64475, are used for a single injection in the cervical/thoracic or lumbar/sacral areas of the spine, respectively. Each primary code has an associated add-on code for use when more than one injection is provided in an area. The add-on codes are 64472 (cervical/thoracic) and 64476 (lumbar/sacral).

Table 1: Facet Joint Injection CPT Codes and Descriptions	
CPT Code	Description
64470	Injection; Paravertebral facet joint or facet joint nerve; cervical/thoracic, single level
64472 (add-on)	Injection; Paravertebral facet joint or facet joint nerve; cervical/thoracic, each additional level
64475	Injection; Paravertebral facet joint or facet joint nerve; lumbar/sacral, single level
64476 (add-on)	Injection; Paravertebral facet joint or facet joint nerve; lumbar/sacral, each additional level

Source: American Medical Association CPT descriptions, 2006.

¹² OIG analysis of 2006 NCH Medicare Part B facet joint injection claims. Total does not sum to 100 percent because of rounding.

¹³ Social Security Act § 1862(a)(1)(A), 42 U.S.C. § 1395y.

¹⁴ Social Security Act § 1833(e), 42 U.S.C. § 1395l.

¹⁵ Section 1848(c)(5) of the Act required the Secretary of the Department of Health and Human Services to develop a uniform coding system for all physician services. The American Medical Association’s CPT is a numeric coding system for physicians’ services.

The “National Correct Coding Initiative Policy Manual” for Medicare Services (NCCI manual) outlines national correct coding guidelines for CPT codes.¹⁶ The NCCI manual states that providers should use the CPT codes that most comprehensively describe the services performed. The only specific references to facet joint injection codes in the NCCI manual relate to management of acute postoperative care. No guidance exists for facet joint injection codes outside of postoperative care.

The NCCI manual and the “Medicare Claims Processing Manual” require that physicians use modifiers to indicate when a service differs from the CPT definition. Modifiers are two-digit codes billed in conjunction with the CPT code. Up to two modifiers are allowed for each CPT code on a claim.

Medicare Part B Payments for Facet Joint Injections

Medicare reimburses physicians and facilities for facet joint injections according to the Medicare Physician Fee Schedule and Medicare Facility Payment Rates, respectively.¹⁷

Physician payments. The Medicare Physician Fee Schedule includes two types of fees, based on setting: those paid to physicians for services rendered in nonfacilities, such as their offices; and those paid to physicians for services rendered in facilities, such as ASCs and hospital outpatient departments. Physician fee schedule payments for office services are generally higher than physician fee schedule payments for facility services because they include payment for practice expenses such as building costs, salaries, and equipment. Fee schedule amounts are adjusted to account for geographic location. The base physician fee schedule rates for facet joint injections in 2006 are listed in Table 2.

Table 2: Medicare Physician Fee Schedule Base Rates, 2006		
CPT Code	Office	Facility
64470	\$349.04	\$101.19
64472 (add-on)	\$140.60	\$64.80
64475	\$318.72	\$81.10
64476 (add-on)	\$120.51	\$48.89

Source: Medicare Physician Fee Schedule, 2006.

¹⁶ Centers for Medicare & Medicaid Services (CMS) “NCCI Policy Manual for Part B Medicare Carriers,” Version 12.3, Introduction, pages viii–9 (October 1, 2006).

¹⁷ Section 1848(a)(1) of the Act established the physician fee schedule as the basis for Medicare reimbursement for all physician services beginning in January 1992.

Reimbursements for primary codes 64470 and 64475 are higher because they include presurgical and postsurgical expenses related to the procedure that the add-on codes, 64472 and 64476, do not.

Physician payments also vary based on modifiers billed with the CPT. For example, bilateral facet joint injections, which are performed on both the right and left side of a level, should be billed using modifier 50, which increases reimbursement to 150 percent of the base rate.¹⁸ If a physician performs multiple bilateral injections, modifier 50 should accompany each facet joint injection CPT code.

Facility payments. Medicare reimburses ASCs and hospital outpatient departments for their expenses separately from the payments made to physicians for rendering services in these settings. Medicare facility payment rates for ASCs and hospital outpatient departments are based on ASC payment groups and the outpatient prospective payment system, respectively. Facility payment rates are adjusted to account for geographic location. The base facility payment rates for facet joint injections in 2006 are listed in Table 3.

Table 3: Medicare Facility Base Payment Rates, 2006

CPT Code	ASC	Hospital Outpatient
64470	\$333	\$357.90
64472 (add-on)	\$333	\$321.42
64475	\$333	\$357.90
64476 (add-on)	\$333	\$321.42

Source: Ambulatory Surgical Center Approved Healthcare Common Procedural Coding System (HCPCS) Codes and Payment Rates, 2006, and Hospital Outpatient Prospective Payment Rates, 2006.

Claims Processing and Program Safeguards

CMS contracts with private organizations, called carriers, to process and pay Medicare Part B claims. In 2006, CMS contracted with 15 carriers to process Medicare Part B claims in the 50 States, the District of Columbia, and U.S. territories.

Carriers are also responsible for implementing program safeguards to reduce payment errors. To accomplish this, carriers create local coverage determinations (LCD), issue instructional articles, and

¹⁸ CMS “Medicare Claims Processing Manual,” Pub. No. 100-04, ch. 12, § 40.7.

implement claims processing edits. Carriers also analyze data, conduct provider education, and conduct medical reviews.

Local coverage determinations. Because no National Coverage Determination¹⁹ exists for facet joint injections, carriers may develop their own local coverage guidelines called LCDs. The LCDs describe whether services are reasonable and necessary and therefore covered by Medicare. They also provide additional guidance to physicians about specific services.

The LCDs vary by carrier and may result in different coverage in different parts of the country. They generally cover the following topics:

- indications and limitations of coverage and medical necessity,
- covered diagnosis codes supporting medical necessity,
- documentation requirements, and
- utilization guidelines.

Claims processing edits. Carriers may implement automated electronic edits to prevent improper payments.²⁰ These edits are coded system logic that automatically pay all or part of a claim, deny all or part of a claim, or suspend all or part of the claim for manual review. Carriers must have an LCD to implement their own local edits.

CMS requires carriers to evaluate local prepayment edits annually for effectiveness. CMS considers an edit effective when it has a reasonable rate of denial relative to suspensions, a reasonable dollar return on the cost of operation, or potential to avoid significant risk to beneficiaries.

Carriers also implement CMS-wide edits where appropriate. In 2007, CMS implemented Medically Unlikely Edits (MUE). CMS created MUEs to reduce the Medicare fee-for-service paid claims error rate.²¹ Carriers deny the entire service when the billed units of service exceed MUE criteria.²² CMS bases the MUE criteria on data for past periods, clinical judgment of CMS health care professionals, and comments from

¹⁹ National Coverage Determinations, issued by CMS, govern how Medicare will cover specific services, procedures, or technologies at a national level.

²⁰ CMS “Medicare Program Integrity Manual,” Pub. No. 100-08, ch. 3, § 3.5.

²¹ CMS “Medicare Claims Processing Manual,” Pub. 100-04, Quarterly Update to Medically Unlikely Edits, Version 2.1, transmittal 1265.

²² Ibid.

the health care community.²³ Currently, CMS has an active MUE for facet joint injection services establishing an upper limit for the number of services a physician can bill.²⁴

METHODOLOGY

To determine the extent to which facet joint injection services meet Medicare requirements, we: (1) conducted a medical record and coding review of a stratified random sample of allowed physician claims for Medicare Part B facet joint injection services in 2006, (2) reviewed CMS and carrier policies, and (3) conducted structured telephone interviews with carrier staff.

Sample Selection

The population from which we sampled consisted of all allowed physician services in the CMS NCH file for CPT codes 64470, 64472, 64475, and 64476 performed in 2006. We excluded services with allowed amounts less than \$15 to avoid performing a medical record review on low dollar claims.²⁵ The population consisted of approximately 1 million services and \$203 million in allowed physician payments. From this population, we selected a random sample of 660 physician line item claims²⁶ stratified by place of service and Medicare-allowed amount. See Appendix A for further detail on the sample selection, data collection, and data analysis.

Data Collection

After excluding 6 services from the 660 in our sample because of ongoing investigations by OIG, we requested, by mail, complete medical records from physicians for 654 sampled services. We classified providers for eight services as nonresponders.²⁷ Thus, we based our review on the remaining 646 line items. This represents a 99-percent response rate.

²³ CMS MUE Project. Available online at <http://www.cms.hhs.gov/MedicalReviewProcess/Downloads/MUECHARTER.pdf>. Accessed on February 20, 2008.

²⁴ To protect MUE effectiveness, CMS prohibits specific MUE limits from being published.

²⁵ These services represent less than 1 percent of the population.

²⁶ Multiple line items may be billed on a single claim. Hereinafter, line items will be referred to as services.

²⁷ A nonresponder is defined as a provider with whom no successful contact has been made after at least three written contacts and two phone calls.

We also reviewed 15 carrier LCDs for facet joint injections. We then conducted 15 structured telephone interviews with carrier staff regarding policies and safeguards for facet joint injection services. We conducted one interview per carrier with the carrier medical director and support staff. We conducted these interviews between October and December 2007.

Medical record review. We used a contractor to conduct the medical record review. The reviewers included five board-certified physicians with pain management and facet joint injection experience and one certified professional coder. One physician and the coder reviewed each of the medical records. The physician determined whether the service was adequately documented and medically necessary, while the coder determined the appropriate CPT code and modifier(s) for the service.

Data Analysis

We analyzed the results from the medical record review to determine the percentage of physician services that did not meet Medicare program requirements. We also calculated the projected physician dollars paid in error for these services. We then compared physician office error rates to facility (ASC and hospital outpatient) error rates. For our facility error rate, we combined ASC and hospital outpatient services, hereinafter referred to as facility. We did not compare ASC and hospital outpatient separately due to small sample sizes. Finally, when possible, we used the NCH files containing ASC and hospital outpatient department facility payments to match to the associated physician service. We projected the identified facility dollars paid in error.

We analyzed all carrier interviews and classified their responses. In particular, we counted the number and type of edits each carrier had in place in 2006. We also noted common themes in the interviews. Finally, we reviewed all carrier LCDs for facet joint injections and assessed their similarities and differences.

Comprehensive Error Rate Testing

CMS established the Comprehensive Error Rate Testing (CERT) to calculate the Medicare fee-for-service paid claims error rate. As of 2007, the CERT has not reported any specific information about facet joint injection services. This review was not designed to reproduce or to review CERT findings.

I N T R O D U C T I O N

Limitations

Because we did not stratify our sample by carrier, we were not able to calculate medical review error rates by carrier. Therefore, we were unable to assess whether carrier program safeguards had an impact on error rates.

Standards

Our review was conducted in accordance with the “Quality Standards for Inspections” issued by the President’s Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

► FINDINGS

Sixty-three percent of facet joint injection services allowed by Medicare in 2006 did not meet Medicare program requirements, resulting in approximately \$96 million in improper payments

Medicare allowed approximately \$96 million in improper payments to physicians for facet joint injection services in 2006. These improper payments represent

47 percent of the \$203 million physician payments for facet joint injections in 2006.

Medicare allowed an additional \$33 million in improper payments for associated facility claims. While the focus of this review is on physician claims, we also calculated facility claims that were submitted for the physician claims paid in error to provide additional context. The remaining analysis focuses on physician claims only.

Sixty-three percent of facet joint injection services did not meet Medicare requirements. Table 4 provides a breakdown of error rates and associated payments for physician claims by error type. Confidence intervals for projected error rates and payments are in Appendix B.

Table 4: Improperly Paid Medicare Facet Joint Injection Services Physician Claims, 2006				
Type of Error	Sample		Projected	
	Services	Allowed Amount	Services	Allowed Amount
Documentation	196	\$35,835	38%	\$81 million
Coding	173	\$11,670	31%	\$21 million
Medical Necessity	43	\$7,394	8%	\$17 million
(Overlapping Errors)	(71)	(\$12,247)	(14%)	(\$23 million)
Total	341	\$42,651*	63%	\$96 million

Source: OIG analysis of medical review results, 2008.

* Numbers do not sum to total because of rounding.

Thirty-eight percent of facet joint injection services had a documentation error

Medicare allowed approximately \$81 million for physician services that were either undocumented or insufficiently documented. Although some cases of missing documentation may be due to errors, others may represent services not rendered. Claims for services that lack sufficient

documentation to show that care was provided do not meet Medicare program requirements.²⁸

Twenty-seven percent of facet joint injection services were undocumented. Medicare allowed approximately \$59 million for undocumented facet joint injection services. For the majority of these services, physicians submitted no medical records for the sampled services. For the remaining services, a record was submitted but contained no documentation of the sampled services.

Eleven percent of facet joint injection services were insufficiently documented. Medicare allowed approximately \$22 million for insufficiently documented facet joint injections. The majority of records for these services were missing a description of the procedure that was billed. Others had a procedure note, but were missing details of the procedure, such as which levels and sides of the back were injected. In each case, the physician reviewer concluded there was insufficient documentation to support the service.

Thirty-one percent of facet joint injection services had a coding error Medicare allowed approximately \$21 million in overpayments, net of underpayments, to physicians for facet injection services that physicians billed with codes that did not accurately reflect the service described in the medical record. Approximately 79 percent of miscoded services affected payment; 82 percent were overpayments and 18 percent were underpayments. See Appendix B for the dollars associated with overpayments and underpayments.

Just over 60 percent of the overpaid services were instances in which the physician billed incorrectly for bilateral facet joint injections. Of the miscoded services that were overpaid, 61 percent were instances in which the physician incorrectly billed CPT add-on codes to represent bilateral facet joint injections instead of using modifier 50. Specifically, they billed multiple lines of CPT add-on codes 64472 or 64476 in addition to a primary code. Physicians should use add-on codes to represent additional levels of the back injected, not sides. As previously noted, the NCCI manual and “Medicare Claims Processing Manual” require that physicians use modifiers to indicate when they are billing for bilateral facet joint injection services. For example, a physician billing two add-on codes to represent a bilateral service receives

²⁸ Social Security Act § 1833(e); 42 U.S.C. § 13951(e).

200 percent of the base payment when he or she should receive 150 percent of the base payment. Billing add-on codes to represent bilateral injections results in a 50-percent higher net payment than Medicare should have allowed.

Physicians may have accidentally billed some of these miscoded services because of confusion about appropriate coding rules. Other miscoded services may have been intentionally exploited for higher payment. Additional investigation would be needed to distinguish accidental errors from potentially fraudulent activity.

All of the underpayments in our sample were for bilateral facet joint injections for which the provider only billed for unilateral services. All 29 of the underpaid services in our sample were bilateral facet joint injections for which the provider billed only for unilateral services, resulting in a 50-percent underpayment.²⁹

Eight percent of facet joint injection services had a medical necessity error

Medicare allowed approximately \$17 million to physicians for facet joint injection services that medical reviewers determined were medically unnecessary. In many instances, reviewers indicated that the record did not contain any patient history or physical exam to show that the treatment was medically indicated for the patient. In other instances, reviewers noted that the record was missing imaging studies to support the diagnosis and justify facet joint injections as the treatment.

Facet joint injection services provided in an office were more likely to have an error than those provided in a facility

Seventy-one percent of facet joint injection services provided in an office had some type of error, compared to 51 percent of facet joint injection services provided in a facility. See Table 5 on the following page for error rates by setting and error type.

²⁹ Statement is based only on the sample and not on a projection to the population.

F I N D I N G S

Table 5: Error Rate by Setting and Error Type for Medicare Facet Joint Injection Services—Physician Claims, 2006		
Type of Error	Office	Facility
Documentation*	49%	22%
Coding	30%	32%
Medical Necessity	10%	5%
Any Error*	71%**	51%

Source: OIG analysis of medical review results, 2008.

* Statistically significant at the 95-percent confidence level.

** Numbers do not sum to total because of overlapping errors.

In addition, certain physician specialties in our sample had high error rates in an office setting.³⁰ See Table 6 for physician specialty error rates in an office setting for our sample. For a complete list of specialty error rates in an office setting for our sample, see Appendix C.

Table 6: Physician Specialty Error Rate in an Office Setting for Sample				
Specialty**	Specialty Code	Any Error in Office*	Services in Office*	Percentage of Services With an Error in Office
General Practice	01	36	37	97%
Internal Medicine	11	13	15	87%
Family Practice	08	7	9	78%
Neurology	13	8	11	73%
Rheumatology	66	5	7	71%
Orthopedic Surgery	20	9	14	64%
Anesthesiology	05	30	48	63%
Pain Management	72	14	25	56%
Physical Medicine and Rehabilitation	25	8	15	53%

Source: OIG analysis of medical review results, 2008.

* Figures are based only on the sample and are not projected to the population.

** Only specialties with sample frequency equal to or greater than five are shown here.

³⁰ Statement is based only on the sample and not on projection to the population.

In 2006, most carriers had policies and safeguards for facet joint injection services but they identified limits to using these safeguards

The LCDs and claims processing edits are carriers’ primary tools to protect Medicare payments for facet joint injections. Carrier staff, however, identified limits to

using LCDs and edits to safeguard these services. Carrier staff reported minimal use of other safeguards for facet joint injections.

Almost all carriers had an LCD and at least one edit for facet joint injections

In 2006, 13 of 15 carriers had LCDs for facet joint injections. Of carriers with an LCD, 10 had at least one active edit. Table 7 illustrates the safeguards each carrier had in 2006 for facet joint injection services.

Table 7: Carrier Safeguards for Facet Joint Injection Services in 2006					
Carrier	LCD	Claims Processing Edits			
		Edits for Diagnosis	Edits for Frequency	Edits for Radiographic Guidance	Edits–Other
1	✓	✓			
2					
3	✓	✓	✓	✓	✓
4	✓				
5	✓	✓	✓		
6	✓	✓			
7	✓				
8	✓	✓	✓		✓
9	✓	✓			✓
10	✓				
11	✓	✓			
12	✓	✓			✓
13	✓	✓	✓		✓
14	✓	✓			✓
15					
Total	13	10	4	1	6

Source: OIG interviews and document review, 2007.

Local coverage determinations. Specific guidelines in LCDs varied by carrier. For example, 13 carriers considered facet joint injections to be medically necessary for patients with certain diagnosis codes; however, the number of acceptable diagnosis codes varied by carrier from 3 to 38.

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Despite the variation in acceptable diagnosis codes, some commonalities in the guidelines exist. Seven of the LCDs describe radiographic guidance as part of the standard of care for facet joint injections and require that providers use radiographic guidance for this service. In addition, six of the LCDs restrict providers from performing other interventional pain management procedures in the same anatomical region on the same day as a facet joint injection. Eight LCDs include frequency guidelines for diagnostic and therapeutic facet joint injections.

Claims processing edits. Ten carriers implemented automated electronic edits to enforce the guidelines established by their LCDs. Carriers most commonly used the diagnosis edit, which automatically checks to ensure that physicians bill an acceptable diagnosis code for facet joint injections. Four carriers used frequency edits, which deny or flag claims that exceed a limit for facet joint injections established by the LCD.

While half of the carriers require the use of radiographic guidance in their LCD, only one carrier in 2006 used an imaging edit to auto-deny facet joint injection claims billed without radiographic guidance. Carrier staff stated that the edit for radiographic guidance addresses two potential problems: (1) a facet joint injection billed without radiographic guidance indicates that it was not performed with guidance, which could put the patient at risk; and (2) without radiographic guidance, the procedure might have been a trigger point injection, a lower paying pain management service.

Several carriers also created unique claims processing edits. For example, one carrier created an edit to deny any facet joint injection service billed on the same day as another pain management service. Another carrier created an edit that automatically suspends all claims with add-on facet joint injection codes for manual review because of an identified issue with add-on codes being billed to represent bilateral services.

Other safeguards. Carrier staff did not report frequent use of other safeguards for facet joint injections, such as provider education and medical review. Carriers reported that their routine data analysis did not identify specific outliers in the data for these services. As a result, only three carriers conducted provider education and medical reviews for facet joint injections.

Carrier staff identified complexities to creating frequency limits for facet joint injections

Generally, carriers use LCDs and edits to protect the integrity of Medicare payments and control utilization for vulnerable services. Establishing frequency limits in LCDs and corresponding edits to enforce those limits is a common technique. However, carrier staff identified complexities that make frequency limits harder to implement for facet joint injections.

Staff at two-thirds of carriers identified barriers to implementing frequency limits for facet joint injections. First, one-third identified the lack of agreement in the medical community about appropriate frequency for facet joint injections as a barrier to creating LCDs. An additional one-third mentioned difficulty creating automated edits for facet joint injections.

Lack of consensus about appropriate frequency is a barrier to creating frequency limits in local coverage determinations. Carriers rely on clinical standards in the medical community to support specific guidelines in LCDs. However, the medical community has not yet established a body of evidence-based medicine to support frequency standards for facet joint injections. In the absence of clear standards in the medical community, carriers must search for consensus among physicians who perform the services. Reaching consensus is often challenging given that many different provider specialties perform facet joint injections and have varying opinions about the appropriate frequency.

Four carriers have successfully reached consensus on frequency limits and enforce those limits with automated edits. Staff at one carrier, however, reported that the limits were too high to identify potential problems.

Frequency edits for facet joint injections are difficult to automate. Carrier staff report that even if they were able to establish frequency limits in their LCD, automated prepay frequency edits are inherently difficult for facet joint injections. Many of the automated edits require information that is not currently available on Medicare claims.

Specifically, carriers are not able to establish frequency edits that rely on spinal level. Currently, the CPT and the claim do not distinguish spinal level. The CPT code indicates what region of the spine is injected, such as lumbar/sacral. However, the CPT code does not indicate which spinal level within that region was injected (such as

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C5-C6). Without this information on the claim, carriers cannot create specific frequency edits based on spinal level.

Claims do not have enough information for carriers to distinguish a diagnostic injection from a therapeutic injection, which affects the accuracy of frequency edits. Physicians generally do not perform diagnostic injections more than once, while therapeutic injections may be repeated multiple times. Even with a specific frequency standard in an LCD for each, carriers would have difficulty editing for these services because claims do not indicate whether the service is being performed for diagnostic or therapeutic purposes.

Sixty-three percent of Medicare facet joint injection services in 2006 did not meet program requirements, resulting in approximately \$96 million in improper payments to physicians and \$33 million to facilities. Although carriers have LCDs and claims processing edits for these services, they will likely continue to experience problems safeguarding these services until there is a comprehensive body of medical evidence and consensus in the medical community about facet joint injections.

Based on the results of our review, CMS should:

Strengthen Program Safeguards To Prevent Improper Payment for Facet Joint Injection Services

To strengthen program safeguards, CMS could:

Assist carriers in developing ways to scrutinize claims for facet joint injection services provided in an office setting. As error rates were significantly higher in an office setting than a facility, carriers may be able to identify problematic claims by examining place of service.

Encourage carriers that require radiographic imaging guidance in their LCDs to implement automated edits for imaging guidance. Carriers that require radiographic imaging in their LCDs should implement automated edits for imaging guidance if they have not already done so. The edit would auto-deny any facet joint injection claim submitted without imaging guidance by checking for the procedure code(s) associated with radiographic imaging guidance.

Direct carriers to revisit frequency limits in their LCDs for facet joint injections. Carriers should revisit the frequency limits in their LCDs and update them so that they are as effective as possible. Carriers that currently have frequency edits for facet joint injections could revisit quarterly claims data to determine edit effectiveness.

CMS bases current MUE limits for facet joint injections on previous billing patterns, which could be inflated because of inappropriate payments. These limits are not sufficient to identify inappropriate claims for facet joint injections.

Clarify Billing Instructions for Bilateral Services

CMS should clarify billing instructions for bilateral services and recover funds if appropriate. CMS should address the fact that some providers obtain higher reimbursement than allowed by billing add-on codes to represent bilateral service. CMS could accomplish this through a variety of mechanisms: educating providers, issuing program

memorandums, and encouraging carriers to flag add-on codes for additional review. Correct billing for bilateral services could result in cost savings.

Take Appropriate Action Regarding the Undocumented, Medically Unnecessary, and Miscoded Services Identified in Our Sample

We have forwarded information on these services to CMS.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS described steps that it will take to address our recommendation to strengthen program safeguards for facet joint injection services. CMS agreed with our recommendations to clarify billing instructions for bilateral services and to take appropriate action on services paid in error in our sample.

To strengthen program safeguards for facet joint injections, CMS plans to direct carriers to review claims data, particularly for services performed in office settings, and establish additional safeguards as necessary. CMS also plans to encourage carriers to consider automated edits for radiographic imaging where it is already required in their LCD. Finally, CMS expects that frequency limits will be addressed by the annual review of LCDs and by the Medicare Administrative Contractors (MAC) during contract consolidation.

We continue to recommend that CMS instruct MACs and remaining carriers specifically to revisit frequency limits for facet joint injections during annual reviews or during MAC consolidation. Without specific instruction by CMS, carrier annual reviews and MAC consolidation might not address the frequency recommendation in this report. Further, MAC reconciliation of LCDs could lead to less restrictive frequency limits. CMS comments describe how MACs reconcile varying frequency limits in LCDs and follow either the most clinically appropriate or the least restrictive requirement. However, without medical community consensus on the clinically appropriate frequency for facet joint injections, MACs may default to the least restrictive requirement which, in some cases, could be no limit. At the time of our study, 7 of 15 carriers did not have frequency limits in their LCDs.

To clarify billing instructions for bilateral services, CMS will issue a Medicare Learning Network Matters article to educate providers on the proper use of add-on codes and the bilateral modifier.

R E C O M M E N D A T I O N S

To address the services paid in error in our sample, CMS will review the claims data and direct Medicare contractors to review the claims and initiate appropriate recoveries of potential overpayments.

For the full text of CMS's comments, see Appendix D.

Detailed Methodology

Sample Selection

The population from which we sampled consisted of all the allowed physician services in the Centers for Medicare & Medicaid Services National Claims History (NCH) file for Current Procedural Terminology (CPT) codes 64470, 64472, 64475, and 64476 performed in 2006. We excluded services with allowed amounts less than \$15 to avoid performing a medical record review on low-dollar claims.³¹ The population consisted of 1,072,841 services that represented \$202,671,303 in allowed physician payments. We stratified the population based on place of service and Medicare-allowed amounts. The strata included services with low and high allowed amounts performed in physician offices, hospital outpatient departments, and ambulatory surgical centers (ASC). We took a stratified, simple random sample of 660 line items³² and excluded 6 services because of ongoing investigations by the Office of Inspector General (OIG). Our final sample included a total of 654 services. Table 8 shows the six strata and the number of services in each stratum.

Table 8: Population Count and Sample Size by Strata			
Stratum	Medicare-Allowed Amount	Number of Services in Population	Number of Services in Sample
1 – Office	Greater than \$300	242,806	108
2 – Office	Greater than \$15 and less than or equal to \$300	412,213	108
3 – Hospital Outpatient	Greater than \$100	50,916	109
4 – Hospital Outpatient	Greater than \$15 and less than or equal to \$100	170,891	110
5 – ASC	Greater than \$100	48,653	110
6 – ASC	Greater than \$15 and less than or equal to \$100	147,362	109
Total		1,072,841	654

Source: OIG sample stratification, 2008.

³¹ These services represent less than 1 percent of the population.

³² Hereinafter, line items will be referred to as services.

Data Collection

We used a contractor to conduct the medical record request and review. We requested, by mail, complete medical records and documentation from physicians for each of the 654 sampled services. We specified that physicians should include the following when available: initial patient evaluation and exam, test results, radiographic evidence of needle placement, and procedure notes. For additional context, we also requested that physicians furnish all documentation for services provided to the beneficiary 4 months before and 1 month after the sampled date of service.

We classified physicians for eight services as nonresponders. A nonresponder is a provider with whom no successful contact has been made after at least three written contacts and two phone calls. The final request letters were sent by certified mail. We based our review on the remaining 646 line items, corresponding to a 99-percent response rate.

Test review. To test our review instrument and ensure uniformity among the reviewers, we conducted a preliminary medical review of 12 services. These services were randomly sampled from the same population from which we drew our final sample using the same stratification.³³ We analyzed the results of the test review and presented them to the reviewers. Reviewers resolved inconsistencies in the results and suggested changes to the review instrument. Some of these changes were incorporated into the final review instrument.

Data Analysis

Calculation of improper physician payments. We calculated the total actual and projected dollars paid in error for these services. For services that were not medically necessary, insufficiently documented, or not documented, we counted the entire Medicare-allowed amount as improper and projected the amount paid in error. For services with a coding error, we determined if the error was a Medicare underpayment, overpayment, or had no effect on payment. We calculated the total net difference for all services with a coding error and projected it to the population of facet joint injection services in 2006. The only overpayments and underpayments included in the projection are cases for which we could calculate the exact amount overpaid or underpaid. We were able to calculate the exact

³³ This sample was drawn separately from the sample used for our review.

amount overpaid or underpaid for 137 of the 173 miscoded services. We were unable to calculate exact amounts for 36 services. Of the 36 services, 20 were for overpayments, 4 were for underpayments, and 12 were for services that had no effect or an unknown effect on payment. For services for which we could not determine the exact amount, we assumed there was no effect on payment. As a result, the projected overpayment is a conservative estimate.

Calculation of improper facility payments. In addition, we calculated and projected the facility payments associated with the services that did not meet Medicare program requirements. For ASC and outpatient claims, we used the NCH Part B file and hospital outpatient file, respectively, and matched facility claims to physician claims using the date of service, CPT, and beneficiary identification. We were able to match 88 percent of sampled services performed in a facility to their associated facility payments.³⁴ Finally, we projected the facility dollars associated with physician services paid in error.

³⁴ We matched 384 of the 485 sampled services in a facility. We were not able to match the remaining facility payments to physician payments for a number of reasons, including facilities failure to submit a service and incorrect coding of the place of service by the physician.

Confidence Intervals for Selected Estimates

Table 9: Estimates of All Errors		
Estimate Description	Point Estimate	95-Percent Confidence Interval
Percentage of services with any error	63.1%	59.0%–67.2%
Percentage of services with any documentation error	38.4%	33.8%–42.9%
Percentage of services with no documentation	27.5%	23.1%–31.8%
Percentage of services with insufficient documentation	10.9%	7.8%–14.1%
Percentage of services coded incorrectly	31.1%	26.7%–35.4%
Percentage of services that were not medically necessary	8.1%	5.4%–10.9%
Percentage of services with overlapping errors	14.0%	9.8%–18.2%

Source: Office of Inspector General (OIG) analysis of medical review results, 2008.

Table 10: Estimates of Improper Physician Payments Associated With All Errors		
Estimate Description	Point Estimate	95-Percent Confidence Interval
Amount allowed for services with any error	\$95,792,055	\$84,298,604–\$107,285,504
Amount allowed for services with any documentation error	\$80,733,041	\$69,246,854–\$92,219,228
Amount allowed for services with no documentation	\$58,587,140	\$47,833,250–\$69,341,030
Amount allowed for services with insufficient documentation	\$22,145,901	\$14,671,642–\$29,620,160
Amount allowed for services coded incorrectly	\$21,391,947	\$13,902,518–\$28,881,376
Amount allowed for services that were not medically necessary	\$16,648,373	\$9,919,301–\$23,377,445
Amount allowed for services with overlapping errors	\$22,981,307	\$12,657,976–\$33,304,637

Source: OIG analysis of medical review results, 2008.

Table 11: Estimate of Improper Facility Payments Associated With Any Error

Estimate Description	Point Estimate	95-Percent Confidence Interval
Amount allowed for services with any error	\$32,697,195	\$26,899,820–\$38,494,570

Source: OIG analysis of medical review results, 2008.

Table 12: Estimates of Miscoded Services

Estimate Description	Point Estimate	95-Percent Confidence Interval
Percentage of miscoded services that affected payment	79.0%	71.8%–86.1%
Percentage and amount allowed for services affecting payment that were overpaid	81.6%	74.6%–88.6%
	\$25,063,648	\$18,022,097–\$32,105,198
Percentage and amount allowed for services affecting payment that were underpaid	18.4%	11.4%–25.4%
	\$3,671,701	\$1,585,607–\$5,757,794
Percentage of overpaid services because of a bilateral billing error	61.2%	50.3%–72.1%

Source: OIG analysis of medical review results, 2008.

Table 13: Estimates of Errors and Improper Payments by Setting

Error Type	Setting	Point Estimate	95-Percent Confidence Interval
Any Documentation Error	Office	49.1%	42.1%–56.1%
	Facility	22.2%	17.8%–26.7%
Coded Incorrectly	Office	30.3%	23.8%–36.8%
	Facility	32.2%	27.2%–37.3%
Not Medically Necessary	Office	10.3%	5.9%–14.7%
	Facility	4.9%	2.7%–7.2%
Any Error	Office	71.2%	65.4%–77.1%
	Facility	50.8%	45.5%–56.1%

Source: OIG analysis of medical review results, 2008.

Specialty Error Rate in an Office Setting for Sample


Table 14: Physician Specialty Error Rate in an Office Setting for Sample

Specialty	Specialty Code	Any Error in Office*		Services in Office*		Percentage of Services With an Error in Office
		Sample Frequency	Sample Percentage	Sample Frequency	Sample Percentage	
Neurosurgery	14	3	2%	3	1%	100%
General Surgery	02	1	1%	1	0%	100%
Pathology	22	1	1%	1	0%	100%
Nurse Practitioner	50	1	1%	1	0%	100%
Emergency Room	93	1	1%	1	0%	100%
Physician Assistant	97	1	1%	1	0%	100%
General Practice	01	36	25%	37	18%	97%
Internal Medicine	11	13	9%	15	7%	87%
Family Practice	08	7	5%	9	4%	78%
Neurology	13	8	6%	11	5%	73%
Rheumatology	66	5	4%	7	3%	71%
Pediatric Medicine	37	2	1%	3	1%	67%
Orthopedic Surgery	20	9	6%	14	7%	64%
Anesthesiology	05	30	21%	48	23%	63%
Pain Management	72	14	10%	25	12%	56%
Physical Medicine and Rehabilitation	25	8	6%	15	7%	53%
Interventional Pain Management	09	2	1%	17	8%	12%
Diagnostic Radiology	30	0	0%	1	0%	0%

Source: Office of Inspector General analysis of medical review results, 2008.

* Figures are based only on the sample and are not projected to the population.

Agency Comments

	DEPARTMENT OF HEALTH & HUMAN SERVICES	Centers for Medicare & Medicaid Services
	200 Independence Avenue SW Washington, DC 20201	

DATE: AUG 29 2008

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Weems
Acting Administrator *[Signature]*

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Payments for Facet Joint Injection Services" (OEI-05-07-00200)

Thank you for the opportunity to review and respond to this OIG draft report. We appreciate the OIG's efforts to determine compliance with Medicare program requirements related to payments for facet joint injection services and their provision of recommendations to improve program safeguards for these services.

As the OIG notes, facet joint injection services refer to joints in the spine that aid stability and allow the spine to bend and twist. Facet joint injections are a type of interventional pain management technique used to diagnose or treat back pain. For some people with chronic pain due to a facet joint injury, injections of an anesthetic or steroid into a facet joint help reduce inflammation and relieve pain. Physicians (such as general practitioners, anesthesiologists, and others) most commonly provide these services in their offices, as well as in hospital outpatient settings and ambulatory surgical centers. In many cases, Center for Medicare & Medicaid Services' (CMS) contractors have identified facet joint injection services as a potential vulnerability in their jurisdictions and have instituted policies and edits to prevent paying for services inappropriately. It is in this context that we turn to the OIG's draft findings and recommendations.

OIG Recommendation

Strengthen Program Safeguards to Prevent Improper Payment for Facet Joint Injection Services

As part of this recommendation, the OIG presented 3 elements for CMS to consider:

- **OIG Element 1:** Assist carriers in developing ways to scrutinize claims for facet joint injection services provided in an office setting.

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CMS Response: The CMS will direct its contractors to review their claims data, particularly for services performed in office settings, and take appropriate action consistent with their individual prioritized strategy, which contractors use to best focus their resources. Contractors have the ability to establish prepayment edits, develop pre- and postpayment reviews, and educate suppliers if their data warrants any of these actions.

- **OIG Element 2:** Encourage carriers that require radiographic imaging guidance in their LCD's to implement automated edits for imaging guidance.

CMS Response: Chapter 13, Section 10, of the Program Integrity Manual (PIM) publication 100-08 found at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> states: "Contractors should apply LCDs to claims on either a prepayment or postpayment basis. If a contractor decides to enforce an LCD on a prepayment basis, the contractor shall design a medical review (MR) edit." CMS will encourage carriers to consider automated edits where they have required imaging guidance in their local coverage determinations (LCDs) when a contractor decides to enforce an LCD on a prepayment basis.

- **OIG Element 3:** Direct carriers to revisit frequency limits in their LCDs for facet joint injections.

CMS Response: Prior to the implementation of Medicare contracting reform, the fiscal intermediaries were responsible for developing any LCD policies for claims under Part A, as well as for Part B claims submitted by Part A providers, while carriers were responsible for developing LCDs for Part B claims by physicians, laboratories, and other non-institutional providers. CMS is currently in the process of transferring the claims processing functions performed by fiscal intermediaries and carriers to Medicare Administrative Contractors (MACs). CMS has instructed the MACs to reconcile the varying LCDs adopted by the outgoing contractors within their jurisdiction, so that the LCDs are the same throughout the MAC's jurisdiction. The MACs analyze all the LCDs and consolidate LCDs using either the least restrictive or most clinically appropriate LCD from the existing LCDs on a single topic (the MAC must follow the most clinically appropriate or least restrictive requirement as outlined in its Statement of Work). During consolidation, the MAC has the discretion to determine whether or not frequency limits should be considered as part of most clinically appropriate or least restrictive.

In addition, the MACs are required to follow Chapter 13 of the PIM, publication 100-08, found at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Chapter 13, Section 13.4 of the PIM states that contractors shall review and appropriately revise their LCDs annually. Most contractors include frequency and utilization data as well as clinical standards when reviewing LCDs for possible changes.

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OIG Recommendation

Clarify Billing Instructions for Bilateral Services

CMS should clarify billing instructions for bilateral services and recover funds if appropriate. CMS should address the fact that some providers obtain higher reimbursement than allowed by billing add on codes to represent bilateral service. CMS could accomplish this through a variety of mechanisms; educating providers, issuing program memorandums, and encouraging carriers to flag on codes for additional review. Correct billing for bilateral services could result in cost savings.

CMS Response

The CMS agrees with the OIG recommendation. Therefore, CMS will issue a change request with a Medicare Learning Network Matters article in the April 2009 release to educate providers on the proper use of add-on codes and the bilateral modifier when billing for more than one injection.

OIG Recommendation

Take Appropriate Action Regarding the Undocumented, Medically Unnecessary, and Miscoded Services Identified in Our Sample

We have forwarded information on these services to CMS.

CMS Response

The CMS agrees with the OIG recommendation. CMS is reviewing the claims data supplied by the OIG. CMS will direct the Medicare contractors to review the claims and to initiate appropriate recoveries of potential overpayments. CMS recovers the overpayments consistent with the Agency's policies and procedures.

The CMS would like to thank the OIG for its efforts and express our appreciation for the opportunity to review and comment on the draft report. We look forward to any additional insights that the OIG can provide so that CMS can strengthen its stewardship of the Medicare Trust Funds.



A C K N O W L E D G M E N T S

This report was prepared under the direction of Ann Maxwell, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Thomas Komaniecki, Deputy Regional Inspector General.

Laura Kordish served as the team leader for this study and Kelly Sullivan Waldhoff served as the lead analyst. Other principal Office of Evaluation and Inspections staff from the Chicago regional office who contributed to this report include Nicole Hrycyk; central office staff who contributed include Doris Jackson, Sandy Khoury, Megan Ruhnke, and Barbara Tedesco.