DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of inspector General

Memorandum

Date MAR 31 1992

From Richard P. Kusserow
Inspector General

Subject Adjustments to the Medicare Fee Schedule Payments Based on Site of Service Differentials (A-05-92-00007)

To J. Michael Hudson
Acting Administrator
Health Care Financing Administration

Attached is a copy of our audit report summarizing the results of our review of the Health Care Financing Administration's (HCFA) methods for defining, and otherwise identifying, physician services that should be subject to payment limitations based on the site of service. Physician services identified for payment limitation were those services which were routinely performed (i.e., furnished over half of the time) in physicians' office settings. Payment for these services was reduced when the services were furnished in an outpatient hospital setting. This payment limitation extends to physician payments under the Medicare Physicians' Fee Schedule (MPFS), effective January 1, 1992, and is applied to the practice expense relative value unit of the fee schedule.

We believe that physician payments should continue to vary by site of service because practice expenses differ between office and non-office sites. At non-office sites, physicians do not incur certain practice expenses such as the cost of equipment, supplies, and nonphysician labor. In order to accurately reflect practice expense costs, HCFA should expand its definition of services routinely performed in physicians' offices to include an annual threshold factor, based solely on the volume of procedures. Because of their frequency, certain high-volume procedures should also be defined as routinely performed and should be subject to a payment limitation. In addition, we concluded that the payment limitation should be expanded beyond the outpatient hospital setting to include the inpatient hospital and skilled nursing facility (SNF) settings.

We recommended that HCFA expand the definition of services routinely performed in physicians' offices to include a high-volume criterion. Additionally, we recommended that the payment limitation should be expanded to include the

inpatient hospital and SNF settings. We estimate that our recommendations could result in annual program and beneficiary savings of approximately $170 million.

In commenting on our draft report, HCFA stated that it could not commit to implementing our recommendations at the time. Concerning a high-volume criterion, HCFA indicated that the change would not result in any savings since the fee schedule is to be budget neutral. With regard to expanding the payment limitation to other settings, HCFA believes that the payment differential will most likely be inherent in payments made under MPFS. The HCFA, however, plans to evaluate payment levels for appropriate physician services furnished outside the office setting. If warranted, HCFA will offer a legislative proposal in 1993 that will be in line with our recommendation to expand the payment limitation to other settings.

Since the MPFS regulations that pertain to budget neutrality address the amount of payments for physician services for the year 1992 only, we believe that savings can still be achieved in years after 1992 when budget neutrality is no longer a factor. Based on the significant cost savings potential, it is important that HCFA take the initiative to expand the payment limitations to include the inpatient hospital and the SNF settings. We do not agree that the payment differential will most likely be inherent in payments made under MPFS. The only distinction for site of service was made for selected procedures performed in outpatient departments.

If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at FTS 646-7104. We would appreciate receiving your comments within 60 days from the date of this memorandum.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ADJUSTMENTS TO THE MEDICARE FEE SCHEDULE PAYMENTS BASED ON SITE OF SERVICE DIFFERENTIALS

Richard P. Kusserow
INSPECTOR GENERAL

A-05-92-00007

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program and management problems, and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities, and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (01) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The 01 also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date MAR 31 1992

From Richard P. Kusserow
Inspector General

Subject Adjustments to the Medicare Fee Schedule Payments Based on Site of Service Differentials (A-05-92-00007)

To J. Michael Hudson
Acting Administrator
Health Care Financing Administration

This audit report summarizes the results of our review of the Health.Care Financing Administration's (HCFA) methods for defining, and otherwise identifying, physician services that should be subject to payment limitations based on the site of service. Physician services identified for payment limitation were those services which were routinely performed (i.e., furnished over half of the time) in physicians' office settings. Payment for these services was reduced when the services were furnished in an outpatient hospital setting. This payment limitation extends to physician payments under the Medicare Physicians' Fee Schedule (MPFS), effective January 1, 1992, and is applied to the practice expense relative value unit (RW) of the fee schedule.

We believe that payment should continue to vary by site of service because practice expenses differ between office and non-office sites. At non-office sites, physicians do not incur certain practice expenses such as the cost of equipment, supplies, and nonphysician labor. In order to accurately reflect practice expense costs, we concluded that HCFA should expand its definition of services routinely performed in physicians' offices to include an annual threshold factor, based solely on the volume of procedures. Because of their frequency, certain high-volume procedures should also be defined as routinely performed and should be subject to a payment limitation. In addition, we concluded that the payment limitation should be expanded beyond the outpatient hospital setting to include the inpatient hospital and skilled nursing facility (SNF) settings.

We recommended that HCFA add a high-volume criterion to the existing definition of services routinely performed in physicians' offices and use the revised definition to identify physician services subject to the payment limitation. We also recommended that the payment

limitation be expanded to include the inpatient hospital and SNF settings. We estimate that our recommendations could result in annual program and beneficiary savings of approximately $170 million. Our estimate was based on the use of a high-volume criterion of over 250,000 patient service occurrences performed annually in the office setting.

In commenting on our draft report, HCFA stated that it could not commit to implementing our recommendations at the time. Concerning a high-volume criterion, HCFA indicated that the change would not result in any savings since the fee schedule is to be budget neutral. With regard to expanding the payment limitation to other settings, HCFA believes that the payment differential will most likely be inherent in payments made under MPFS. The HCFA, however, plans to evaluate payment levels for appropriate physician services furnished outside the office setting. If warranted, HCFA will offer a legislative proposal in 1993 that will be in line with our recommendation to expand the payment limitation to other settings. The full text of HCFA's comments is included in the APPENDIX to this report.

Since the MPFS regulations that pertain to budget neutrality address the amount of payments for physician services for the year 1992 only, we believe that savings can still be achieved in years after 1992 when budget neutrality is no longer a factor. Based on the significant cost savings potential, it is important that HCFA take the initiative to expand the payment limitations to include the inpatient hospital and the SNF settings. We do not agree that the payment differential will most likely be inherent in payments made under MPFS. The only distinction for site of service was made for selected procedures performed in outpatient departments.

BACKGROUND

The Omnibus Budget Reconciliation Act of 1989 required major changes in Medicare physician payment rules. As of January 1, 1992, payment for all physician services is made under the Medicare fee schedule for physician services. Payments under the fee schedule are designed to reflect the resource inputs used by a physician to furnish a service. The fee schedule will include national uniform relative values for all physician services. The relative value of each service is the sum of the RVUs representing physician work, practice expenses, and malpractice costs.

While the relative value of the physician work component for each service remains constant, the practice expense component of the relative values may vary by site of service. Practice expense costs directly associated with furnishing a service may vary depending upon whether the service is performed in a physician's office or a facility such as a hospital, SNF, ambulatory surgical center, etc. For example, a physician may incur the costs of equipment, supplies, and personnel when performing a service in the office. However, these costs may be incurred by a facility when the service is performed in a nonoffice setting. As payment under the fee schedule is intended to reflect resource costs, payment should vary by site of service if practice expenses differ between office and nonoffice sites.

Prior to the implementation of the MPFS, Medicare rules limited payment for physician services based on site of service in one situation. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) authorized a payment limit for a service routinely performed in a physician's office if the service was furnished in an outpatient hospital setting. Implementing regulations established the payment limit at 60 percent of the prevailing charge. As a portion of the payment for a physician's service included practice expenses, the outpatient limit was applied to avoid paying both the physician and the hospital for the cost of practice expenses such as equipment, supplies, and personnel that were incurred by the hospital but not the physician.

To implement this requirement, HCFA defined in the Medicare Carriers Manual that "a service is considered routinely furnished in physicians' offices if over half of the volume of a service is done in an office setting." To further assist the carriers, HCFA developed a listing of procedure codes which, based on the Part B Medicare Annual Data (BMAD) system, were performed nationwide at least 50 percent of the time in physicians' offices.

In a prior audit report (A-05-89-00059), we recommended that HCFA seek legislative authority to expand the 60 percent limitation on specified types of outpatient services commonly furnished in a physician's office to additional settings (e.g., inpatient hospitals and SNFs) beyond those established by existing TEFRA regulations. The HCFA agreed to review site of service options concurrent with the implementation of MPFS.

SCOPE

Our audit was made in accordance with Government Auditing Standards. The objective of our review was to evaluate HCFA's methods for defining, and otherwise identifying, physician services that should be subject to payment limitations based on site of service. Our conclusions regarding the volume of Medicare services and charges for the various procedure codes were based solely on data taken from HCFA's BMAD system. Our analysis of BMAD data was primarily limited to statistics gathered for Calendar Year (CY) 1987. For calculations involving potential savings, we also used BMAD data for CY 1989. We did not, however, review the input to the BMAD data files or the internal controls in place over the maintenance of the BMAD system. The field work for our audit was performed during Fiscal Year 1991.

RESULTS OF AUDIT

Physicians' practice expenses can be divided into two categories, direct and indirect costs. Direct costs are those that can be directly identified with the delivery of a service, such as the cost of nonphysician labor or the medical supplies used. Indirect costs, such as rent and utilities, are those that cannot be readily identified with a particular service.

An underlying premise of MPFS is that payment under the fee schedule is intended to reflect resource costs. Therefore, payment should vary by site of service if practice expenses differ between office and nonoffice settings. Many services are provided in both office and nonoffice settings. When these services are provided in an office setting, practice expenses include both direct and indirect costs. However, when the same services are provided in nonoffice settings, only indirect costs are incurred.

To more accurately reflect practice expenses incurred outside the office setting, we determined that HCFA's criterion for identifying services subject to a payment limitation should be expanded. Currently, services which are routinely performed (over half of the volume) in an office setting are subject to a payment limitation. This definition excludes certain high-volume procedures. We believe that expanding the criterion to include high-volume procedures enhances the premise of limiting payments for

services routinely performed in an office setting. Significant program savings can be realized if HCFA would include procedures furnished in office settings on a high-volume basis as additional criteria for identifying services subject to the limitation. Savings would dramatically increase if HCFA expanded the payment limitation beyond the outpatient hospital setting to include services in other provider settings, primarily inpatient hospital and SNF settings.

Identification of Procedure Codes

In November 1990, HCFA distributed to the carriers a listing of 282 procedure codes which, based on national 1987 BMAD data, were performed at least 50 percent of the time in physicians' offices or clinics. To determine the reasonableness of this listing for use in identifying procedures to be subjected to payment reduction, we further analyzed the 1987 BMAD data. We noted that many of the procedures appearing on HCFA's listing met the 50 percent criterion but were not frequently performed. Conversely, several procedures that were frequently performed in physicians' offices did not appear on HCFA's listing.

For example, procedure code 69433 "Tympanostomy" was performed only 17,405 times nationwide under Medicare during CY 1987. Of the 17,405 occurrences, 15,868 (91 percent) were performed in physicians' offices. Therefore, this procedure code was one of the 282 codes on HCFA's listing. By comparison, procedure code 90620 "Comprehensive Consultation" was performed 1,079,702 times in physicians' offices and did not appear on HCFA's listing since the in-office occurrences represented only 22 percent of its total volume. This single procedure code was performed more frequently in physicians' offices than was the combined total of 62 procedures on HCFA's listing. We also noted that 37 of the 282 procedure codes on HCFA's listing were performed less than 20,000 times in physicians' office settings. One of the codes was only performed 1,545 times.

The HCFA's use of the 50 percent criterion for defining routinely performed does result in the identification of procedures that are predominantly performed in the office setting. We believe, however, that a more accurate definition of routinely performed should also include the frequency of the procedures as a factor. This could be accomplished by adjusting HCFA's definition of routinely

performed in physicians' offices to add an annual threshold factor, based solely on the volume of procedures.

while we are not recommending a specific volume level as an annual threshold, we did screen the CY 1987 BMAD data for high-volume procedure codes. If a threshold volume of 250,000 occurrences in the office setting was used as a screening factor, 8 additional procedure codes would be identified that did not meet HCFA's current 50 percent criterion. These eight procedures include five consultation procedures and three psychotherapy procedures. For these 8 procedure codes, we obtained CY 1989 data from the BMAD system, which indicated frequencies of in-office services during CY 1989 ranging from 339,563 occurrences to 1,344,886 occurrences. The percentage of in-office services to total services for the eight codes ranged from about 24 percent to about 48 percent. The CY 1989 statistics are included as EXHIBIT A.

Calculation of Potential Savings

Under MPFS, the practice expense RW is reduced by 50 percent when an office-based service subject to the limitation is performed in an outpatient hospital setting. Payment is made at the lower of the actual charges or the reduced fee schedule amount. The 50 percent limit is applied only to the practice expense RW and not to the entire payment. The 50 percent reduction allows for nonphysician personnel costs and certain office expenses of the physician's practice. Since practice expense costs represent, on average, about 41 percent of total physician revenues, reducing the practice expense RW by 50 percent reduces the overall payment by about 21 percent.

Using a 21 percent reduction to allowed CY 1989 charges in the outpatient hospital setting for the eight procedure codes, we estimated annual savings to be about $6.9 million. However, in accordance with our prior audit recommendation, if HCFA expanded the payment limitation beyond the outpatient hospital setting to include services in other provider settings (primarily inpatient hospital and SNF settings), savings would dramatically increase. Based on 21 percent of allowed CY 1989 charges in the outpatient, inpatient, and SNF settings for the eight

procedures, we estimated total annual savings to be over $170 million ($136 million for Medicare and $34 million for beneficiaries), as follows:

Setting	Potential Annual Savinus
Outpatient	$ 6,935,000
Inpatient	160,562,000
SNF	2,510,000
Total	$ 1 7

Details of the above calculations are presented as EXHIBIT B.

CONCLUSIONS AND RECOMMENDATIONS

Under MPFS, payment for services should more accurately reflect the variation in practice expenses between office and nonoffice settings. We recommended that HCFA expand the definition of services routinely performed in physicians' offices to include a high-volume criterion. Additionally, we recommended that the payment limitation be expanded to include the inpatient hospital and SNF settings.

HCFA COMMENTS

In commenting on our draft report, HCFA stated that it could not commit to implementing our recommendations at this time. Concerning a high-volume criterion, HCFA indicated that, although this change was proposed in the Notice of Proposed Rule Making on the physicians' fee schedule, the change would not result in any savings since the fee schedule is to be budget neutral.

With regard to expanding the payment limitation to other settings, HCFA stated that a consensus reached at an April 13, 1990 resolution meeting, held to discuss this previously recommended action, should still apply. The HCFA believes that the payment differential will most likely be inherent in payments made under MPFS. After the

1992 implementation of MPFS, HCFA plans to evaluate payment levels for appropriate physician services furnished outside the office setting. If warranted, HCFA will offer a legislative proposal in 1993 that will be in line with our recommendation.

OIG RESPONSE

The addition of a high-volume criterion to the definition of "services routinely performed in physicians' offices" was not accomplished through the final MPFS regulations, published in the Federal Register on November 25, 1991. Our recommendation is consequently still valid. The provisions of the final MPFS regulations that pertain to budget neutrality address the amount of payments for physician services for the year 1992 only. Therefore, we believe that savings can still be achieved in years after 1992 when budget neutrality is no longer a factor.

Concerning our recommendation to expand the payment limitation to include the inpatient hospital and SNF settings, we do not believe that actions should be further delayed. The audit resolution meeting, referred to by HCFA, was held at a time when the development of MPFS regulations was in its infancy. Although, at that time, HCFA anticipated that our recommended change would be made through MPFS, the final MPFS regulations indicate otherwise. From our review of the regulations, we do not believe that this issue will be completely resolved through the implementation of MPFS. Based on the significant cost savings potential, especially in years after the 1992 "neutrality year," it is important that HCFA take the initiative to expand the payment limitations to include the inpatient hospital and the SNF settings.

EXHIBITS

EXHIBIT A

Number of Total Services and In-Office Services for Selected High-Volume-Procedure Codes for Calendar Year 1989

Code	Procedure Description	Number of Services		Percent
		Total	In-Office	In-Office
90600	Initial Consultation (limited)	877,102	354,780	40.45
90605	Initial Consultation (intermediate)	1,043,890	354,982	34.01
90610	Initial Consultation (extensive)	1,254,377	423,696	33.78
90620	Initial Consultation (comprehensive)	5,658,927	1,344,886	23.76
90630	Initial Consultation (complex)	1,423,335	339,563	23.86
90841	Psychotherapy (unspecified time)	1,051,550	433,326	41.21
90843	Psychotherapy (20 to 30 minutes)	2,189,139	1,053,172	48.11
90844	Psychotherapy (45 to 50 minutes)	2.386.813	1,137,669	47.67
	Total (number of services)	15,885,133	5,442,074	

EXHIBIT B

Calculation of Estimated Annual Cost Savings for Selected High-Volume Procedures Based on TEFRA Limitation for the Outpatient, Inpatient, and SNF Settings

(Calendar Year 1989 Data)

Procedure Code	Allowed Charges			
	Outpatient	Inpatient	SNF	Total
Consultations:				
90600	$ 2,305,176	$ 21,979,078	$ 1,369,503	$ 25,653,757
90605	3,643,627	34,926,678	436,587	39,006,892
90610	3,963,524	54,676,013	729,700	59,369,237
90620	13,173,293	394,263,476	3,794,012	411,230,781
90630	4'344,388	129,081,973	1,693,851	135,120,212
Psychotherapy:				
90841	543,767	22,010,575	933,147	23,487,489
90843	2,019,511	35,802,679	1,527,516	39,349,706
90844	3.030.898	71,842,066	1,466,110	76,339,074
Total	$33,024,184	$764,582,538	$11,950,426	$809,557,148
Times Factor'	x .21	x .21	x .21	x .21
Savings	$6,935,000	$160,562,000	$2,510,000	$170,007,000
Savings Allocation:				
80% Medicare	$5,548,000	$128,450,000	$2,008,000	$136,006,000
20% Bene.	1.387.000	32.112.000	502,000	34,001,000
Total	$6,935,000	$160,562,000	$2.510.000	$170,007,000

'Based on 21 percent of allowed charges. See page 6 of report for discussion.

APPENDIX - HCFA Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Memorandum

Date SEP 23 1991

From Administrator
Health Care Financing Administration

Subject OIG Draft Report - "Adjustments to the Medicare Fee Schedule Payments Based on Site of Service Differentials," (A-05-91-00006)

To Inspector General
Office of the Secretary

We have reviewed the subject final report which summarizes OIG's review of HCFA's methods for defining and otherwise identifying physician services that should be subject to payment limitations based on the site of service.

The report recommends that HCFA expand the definition of services routinely performed in physicians* offices to include an annual threshold factor based solely on the volume of procedures. It also recommends that the payment limitation be expanded to include inpatient hospital and skilled nursing facility settings. OIG believes that these recommendations could result in annual program and beneficiary savings of approximately $170 million.

We cannot commit to implementing either of these recommendations at this time. With regard to the first recommendation, the high-volume criterion has been proposed as a possible change to the definition of services routinely performed in physicians' offices in the Notice of Proposed Rulemaking on the physician fee schedule. Although we will consider making the change in light of comments received, implementation would not result in any savings since the physician fee schedule is to be budget neutral. Any changes occurring from this action would, at best, result in a redistribution of payment among procedures.

As the report notes, the second recommendation to expand the payment limitation to other settings was also contained in a previous audit (A-05-89-00059) and a final management decision had been reached. At the resolution meeting held on April 13, 1990, to discuss this previous recommendation, OIG and HCFA reached the following consensus:

HCFA agrees with the principle of differential by place of service for procedures that are furnished in physicians' offices more than 50 percent of the time. However, as physician payment reform will most likely make a distinction in payment based on site of service, HCFA would first want to see if we could achieve similar results within the parameters of this reform. After the 1992 implementation of physician payment reform, HCFA will evaluate payment levels for appropriate physician services furnished outside the office setting. If physician payment reform has failed to make the appropriate distinction based on site of service, HCFA will offer a legislative proposal in 1993 that will be in line with OIG's recommendation.

We believe that. under the present circumstances, this mutually agreed to position still remains valid.

Thank you for the opportunity to review and comment on this report. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.