DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

May 1, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided (A-05-09-00053)

The attached final report provides the results of our review of evaluation and management services included in musculoskeletal global surgery fees for calendar year 2007. The Centers for Medicare & Medicaid Services requested this review.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-05-09-00053 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MUSCULOSKELETAL GLOBAL SURGERY FEES OFTEN DID NOT REFLECT THE NUMBER OF EVALUATION AND MANAGEMENT SERVICES PROVIDED

Daniel R. Levinson
Inspector General

May 2012
A-05-09-00053

Office of Inspector General

http://oig.hhs.gov

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Medicare program pays for physicians' services furnished on or after January 1, 1992, based on an established fee schedule that is updated annually. The fee schedule amounts are based on the resources, such as physician time and intensity of the work (measured in relative value units (RVU)), involved with furnishing services. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, must review the RVUs at least every 5 years and adjust them as it deems necessary to account for such developments as medical practice or coding changes, new data, or new procedures.

Included on the fee schedule are global surgery fees, which include payment for a surgical service and the related preoperative and postoperative evaluation and management (E&M) services provided during the global surgery period. The global period for major surgeries includes the day before the surgery, the day of the surgery, and the 90 days after the day of the surgery. In determining a global surgery fee, CMS estimates the number of E&M services that a physician provides to a typical beneficiary during the global surgery period. CMS compensates physicians for the surgical service and the related E&M services included in the fee regardless of the E&M services actually provided during the global surgery period.

The American Medical Association Current Procedural Terminology (CPT) identifies codes that physicians use to report medical services and procedures and claim reimbursement through the physician fee schedule. The CPT includes 1,355 codes for major musculoskeletal global surgeries. CMS reimbursed physicians approximately $1.5 billion for 1,331 of these CPT codes for surgeries performed during calendar year (CY) 2007.

CMS requested this review.

OBJECTIVE

Our objective was to determine whether musculoskeletal global surgery fees reflected the actual number of E&M services that physicians provided to beneficiaries during the global surgery periods.

SUMMARY OF RESULTS

Musculoskeletal global surgery fees often did not reflect the actual number of E&M services that physicians provided to beneficiaries during the global surgery periods. For 89 of the 300 global surgeries that we sampled, either the fees reflected the actual number of E&M services provided during the global surgery periods (24 surgeries) or the surgery was 1 of multiple surgeries (65 surgeries). For the remaining 211 global surgeries, the fees did not reflect the actual number of E&M services provided. Specifically, physicians provided fewer E&M services than were included in 165 global surgery fees and provided more E&M services than were included in 46 global surgery fees. (For the 65 sampled surgeries that were performed as 1 of multiple surgeries, we were unable to determine whether the E&M services that physicians provided were

related to the sampled surgeries or to 1 of the other surgeries performed on the same date of service. Therefore, we did not categorize these 65 sampled surgeries as errors.)

Using our sample results, we estimated that Medicare paid a net $49 million for E&M services that were included in musculoskeletal global surgery fees but not provided during the global surgery periods in CY 2007. The global surgery fees did not reflect the actual number of E&M services provided to beneficiaries because CMS had not reviewed or recently reviewed the RVUs for most of the CPT codes in our sample.

RECOMMENDATIONS

We recommend that CMS adjust the estimated number of E&M services within musculoskeletal global surgery fees to reflect the actual number of E&M services being provided to beneficiaries, which would have reduced payments in CY 2007 alone by an estimated $49 million, or use the results of this audit during the annual update of the physician fee schedule.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred, in part, with the recommendations but planned to conduct further analysis before proposing any changes in the number of E&M services assigned to musculoskeletal surgeries.

CMS's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

CMS noted that the savings from any change in payments associated with our first recommendation would be redistributed among other services under the physician fee schedule. While this is true, implementing our recommendation would more closely align payment rates with the cost of services provided.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance coverage to people aged 65, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

Physician Fee Schedule

Medicare Part B pays for physicians' services, including surgeries and evaluation and management (E&M) services,[1] provided to beneficiaries. Section 1848 of the Act (42 U.S.C. § 1395w-4) requires Medicare to pay for physicians' services furnished on or after January 1, 1992, based on an established fee schedule that CMS updates annually.[2] The fee schedule considers three major categories of costs required to provide physicians' services: physician work, practice expense, and malpractice insurance. Sections 1848(b) and (c) of the Act require that fee schedule amounts be based on the resources, such as physician time and intensity of the work, needed to furnish services. For each of the three categories of costs, CMS determines a relative value unit (RVU), which is a measure of the resources involved with furnishing a service, and uses the three RVUs to calculate the fee schedule amount for each physician service.

Section 1848(c)(2)(B) of the Act requires CMS to review the RVUs at least every 5 years and to adjust them as it deems necessary to account for such developments as medical practice or coding changes, new data, or new procedures.

Global Surgery Fees

CMS's *Medicare Claims Processing Manual,* Pub. No. 100-04 (the Manual), chapter 12, section 40, contains the national global surgery policy establishing a single, consistent payment across Medicare carrier jurisdictions nationwide for a surgery and related services when provided by the physician who performs the surgery. A global surgery is a group of clinically related services, including the surgical service and related preoperative and postoperative services, that are treated as a single unit for coding, billing, and reimbursement.

CMS determines each global surgery fee based on the RVUs for a typical beneficiary receiving the surgery and related E&M services during a global surgery period. The period for major surgeries includes the day before the surgery, the day of the surgery, and the 90 days after the day of the surgery. CMS estimates the number of E&M services that a typical beneficiary

[1] E&M services are nonsurgical services provided to diagnose and treat diseases or counsel and evaluate beneficiaries.

[2] Payment for physicians' services shall be the lesser of actual charges or the fee schedule amount.

receives during the global surgery period and includes reimbursement for that number of E&M services in the global surgery fee.

Musculoskeletal Global Surgeries

The American Medical Association Current Procedural Terminology (CPT) is a list of descriptive terms and codes that physicians use to report medical services and procedures and claim reimbursement through the physician fee schedule. The CPT includes 1,355 codes for major musculoskeletal global surgeries, such as knee arthroplasty, hand tendon repair, and lower leg amputation. CMS reimbursed physicians approximately $1.5 billion for 1,331 of these CPT codes for surgeries performed during calendar year (CY) 2007.[3]

CMS requested this review.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether musculoskeletal global surgery fees reflected the actual number of E&M services that physicians provided to beneficiaries during the global surgery periods.

Scope

Our review covered Medicare payments totaling approximately $1.3 billion made to physicians nationwide for 2,128,059 major musculoskeletal global surgeries and related E&M services provided during CY 2007. Our review included only those surgeries in which the number of E&M services provided to the typical beneficiary was known and the payment included compensation for E&M services related to the surgery.[4] We excluded Medicare payments totaling approximately $0.2 billion that did not meet those conditions.

We limited our review of internal controls to understanding CMS's policies and procedures for reimbursing physicians for global surgeries and establishing and updating global surgery fees. We limited our review of RVUs to determining the number of E&M services included in musculoskeletal global surgery fees. We did not determine the medical necessity of the surgeries or the related E&M services.

Our fieldwork included contacting the inpatient facilities and physician offices nationwide that performed the global surgeries and provided the E&M services.

[3] There were no payments for the remaining 24 CPT codes in CY 2007.

[4] CMS could not provide us with the number of E&M services included in the global surgery fee for 20 global surgery CPT codes; therefore, Medicare payments for these codes were excluded from our review. We also excluded any Medicare payments for global surgeries that did not include payment for E&M services, such as payments for assistant surgeons.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- discussed Medicare global surgery policy and procedures, including the establishment and update of global surgery fees, with CMS staff;

- identified a sampling frame of 2,128,059 major musculoskeletal global surgeries totaling approximately $1.3 billion and divided the sampling frame into 3 strata (Appendix A):

    - stratum 1 for the 5 CPT codes that represented 44.5 percent of the total payments in the sampling frame (code 22612 for lumbar spine fusions, 27130 for total hip arthroplasties, 27236 and 27245 for treating thigh fractures, and 27447 for total knee arthroplasties);

    - stratum 2 for the 750 CPT codes that included fewer than 6 E&M services in the global surgery fees; and

    - stratum 3 for the 544 CPT codes (excluding the 5 CPT codes in stratum 1) that included 6 or more E&M services in the global surgery fees;

- randomly selected 100 surgeries from each stratum for a total of 300 surgeries with payments totaling $215,537 for 119 CPT codes;

- obtained all paid claims related to the sampled surgeries and, for each surgery:

    - identified the name of the beneficiary, date of the surgery, applicable 92-day global surgery period, name of the physician who performed the surgery, and name of the facility where the surgery took place;

    - requested and received medical records from the performing physician and the facility where the surgery took place, identified the actual number of visits provided during the global surgery period, and counted each visit as an E&M service; and

    - determined the difference, if any, between the actual number of E&M services provided to the beneficiary and the number of E&M services included in the global surgery fee and determined the net dollar value of the difference;

- used the sample results of 235 global surgeries examined for 88 CPT codes to estimate the Medicare reimbursement for E&M services that were included in musculoskeletal

global surgery fees but not provided to beneficiaries during global surgery periods in CY 2007 (Appendix B);[5] and

- discussed the results of our review with CMS on September 14, 2011.

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

RESULTS OF AUDIT

Musculoskeletal global surgery fees often did not reflect the actual number of E&M services that physicians provided to beneficiaries during the global surgery periods. For 89 of the 300 global surgeries that we sampled, either the fees reflected the actual number of E&M services provided during the global surgery periods (24 surgeries) or the surgery was 1 of multiple surgeries (65 surgeries). For the remaining 211 global surgeries, the fees did not reflect the actual number of E&M services provided. Specifically, physicians provided fewer E&M services than were included in 165 global surgery fees and provided more E&M services than were included in 46 global surgery fees.

Using our sample results, we estimated that Medicare paid a net $49 million for E&M services that were included in musculoskeletal global surgery fees but not provided during the global surgery periods in CY 2007. The global surgery fees did not reflect the actual number of E&M services provided to beneficiaries because CMS had not reviewed or recently reviewed the RVUs for most of the CPT codes in our sample.

FEDERAL REQUIREMENTS

Chapter 12, section 40, of the Manual provides that the global surgery fee includes payment for the surgical service and preoperative and postoperative E&M services provided during the global surgery period. The global period for major surgeries includes the day before the surgery, the day of the surgery, and the 90 days after the day of the surgery. CMS compensates physicians for the surgical service and related E&M services included in the fee regardless of the E&M services actually provided during the global surgery period.

[5] We found that 65 of the 300 global surgeries that we sampled were performed as 1 of multiple surgeries. Chapter 12, section 40.6, of the Manual defines "multiple surgeries" as separate procedures performed by a physician on the same patient on the same day for which separate payment may be allowed. We were unable to determine whether the E&M services that physicians provided were related to the sampled surgeries or to one of the other surgeries performed on the same date of service. When evaluating our sample, we did not categorize these 65 sampled surgeries as errors.

EVALUATION AND MANAGEMENT SERVICES INCLUDED IN MUSCULOSKELETAL GLOBAL SURGERY FEES VERSUS SERVICES PROVIDED

For 211 of the 235 musculoskeletal global surgeries that we examined, the global surgery fees did not reflect the actual number of E&M services provided during the global surgery periods.[6] As shown in the following table, a total of 1,776 E&M services were included in the global surgery fees for these 235 surgeries, but physicians provided 1,427 E&M services, a difference of 349 E&M services totaling a net $9,883.

Evaluation and Management Services Included in Musculoskeletal Global Surgery Fees Versus Services Provided

Stratum	Number of E&M Services Included in Fees	Number of Sampled Global Surgeries Examined	Number of E&M Services Included in Sampled Surgeries' Fees	Actual Number of E&M Services Provided	Difference	Net Dollar Value of Difference[7]
1	Varies[8]	88	806	663	143	$4,065
2	< 6	71	256	246	10	171
3	≥ 6	76	714	518	196	5,647
Total		**235**	**1,776**	**1,427**	**349**	**$9,883**

Using our sample results, we estimated that Medicare paid a net $49 million for E&M services that were included in musculoskeletal global surgery fees but not provided during the global surgery periods in CY 2007 (Appendix B).

RELATIVE VALUE UNITS NOT REVIEWED

Musculoskeletal global surgery fees did not reflect the actual number of E&M services provided to beneficiaries because CMS had not reviewed or recently reviewed the RVUs for most of the 88 musculoskeletal global surgery CPT codes that we examined. Specifically, CMS:

[6] Because the remaining 65 surgeries sampled were performed as 1 of multiple surgeries, we were unable to determine whether the E&M services that physicians provided were related to the sampled surgeries or to 1 of the other surgeries performed on the same date of service. Therefore, we did not include them in this analysis and table.

[7] To calculate the net dollar value of the difference, we used 80 percent of the lowest fee schedule amount for an E&M service included in the global surgery fee. The 80 percent represented the Federal share for the E&M service, and the remaining 20 percent represented beneficiary coinsurance.

[8] CPT codes 27130, 27245, and 27447 have 9 E&M services included in the global fee, and CPT code 27236 has 10 E&M services included. CPT code 22612, which has 7 E&M services included, was in the sample but not examined as part of the 235 musculoskeletal global surgeries.

- had not reviewed the RVUs for 35 codes since the fee schedule was established in 1992,
- last reviewed the RVUs for 21 codes between 1993 through 1999,
- last reviewed the RVUs for 10 codes between 2000 through 2007,
- last reviewed the RVUs for 19 codes after 2007 (the year the sampled surgeries occurred), and
- had not reviewed the RVUs for 3 codes established after the 1992 fee schedule.

Appendix C contains details on these reviews.

RECOMMENDATIONS

We recommend that CMS adjust the estimated number of E&M services within musculoskeletal global surgery fees to reflect the actual number of E&M services being provided to beneficiaries, which would have reduced payments in CY 2007 alone by an estimated $49 million, or use the results of this audit during the annual update of the physician fee schedule.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS concurred, in part, with the recommendations but planned to conduct further analysis before proposing any changes in the number of E&M services assigned to musculoskeletal surgeries. CMS will assess whether these services should be reviewed under the potentially misvalued codes initiative.

CMS's comments are included in their entirety as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

CMS noted that the savings from any change in payments associated with our first recommendation would be redistributed among other services under the physician fee schedule. While this is true, implementing our recommendation would more closely align payment rates with the cost of services provided.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of paid Medicare major musculoskeletal global surgeries with dates of service in calendar year 2007.

SAMPLING FRAME

The sampling frame consisted of 2,128,059 major musculoskeletal global surgeries with Medicare payments totaling $1,270,925,894. We excluded surgeries and their payments in which the number of evaluation and management (E&M) services provided to the typical beneficiary was unknown and excluded payments that did not include compensation for E&M services related to the surgery, such as payments for assistant surgeons.

SAMPLE UNIT

The sample unit was a major musculoskeletal global surgery.

SAMPLE DESIGN

We used a stratified random sample.

Description of Stratified Sample

Stratum	Description	No. of Surgeries	Payments
1	Surgeries with the highest total payments for five specific CPT codes[1]	516,747	$566,017,963
2	Surgeries with fewer than six E&M services included in the fee	1,149,421	379,866,168
3	Surgeries (excluding those in stratum 1) with six or more E&M services included in the fee	461,891	325,041,763
Total		**2,128,059**	**$1,270,925,894**

[1] CPT = Current Procedural Terminology. CPT code 22612 has 7 E&M services included in the global fee; CPT codes 27130, 27245, and 27447 have 9 E&M services included; and CPT code 27236 has 10 E&M services included.

SAMPLE SIZE

We selected a sample of 100 major musculoskeletal global surgeries from each stratum, resulting in a total sample of 300 surgeries.

SOURCE OF RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services (OAS), statistical software to generate 100 random numbers for each stratum.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum. After generating 100 random numbers for each stratum, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total dollar amount of E&M services included in global surgery fees but not provided during the global surgery periods.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results: Evaluation and Management Services Included in Musculoskeletal Global Surgery Fees Versus Services Provided

Stratum	Number of E&M Services Included in Fees	Number of Sampled Surgeries	Number of Surgeries With Equal E&M Services Provided	Number of Surgeries With Fewer E&M Services Provided	Number of Surgeries With More E&M Services Provided	Number of Surgeries Performed as One of Multiple Surgeries	Net Dollar Value of Difference in Number of E&M Services[1]
1	Varies[2]	100	10	65	13	12	$4,065
2	< 6	100	8	38	25	29	171
3	≥ 6	100	6	62	8	24	5,647
Total		**300**	**24**	**165**	**46**	**65**	**$9,883**

Estimated Dollar Value of Evaluation and Management Services Included in Musculoskeletal Global Surgery Fees but Not Provided

Stratum	Point Estimate	Limits Calculated for a 90-Percent Confidence Interval	
		Lower Limit	Upper Limit
1	$21,005,352	$13,844,174	$28,166,530
2	1,963,326	-11,366,717	15,293,369
3	26,084,555	14,395,996	37,773,115
Overall	**$49,053,233**	**$30,111,621**[3]	**$67,994,846**[3]

[1] To calculate the net dollar value of the difference, we used 80 percent of the lowest fee schedule amount for an E&M service included in the global surgery fee. The 80 percent represented the Federal share for the E&M service, and the remaining 20 percent represented beneficiary coinsurance.

[2] CPT code 22612 has 7 E&M services included in the global fee; CPT codes 27130, 27245, and 27447 have 9 E&M services included; and CPT code 27236 has 10 E&M services included.

[3] The sum of the lower limits for the three strata is not mathematically equal to the overall lower limit. The same is true for the upper limits.

APPENDIX C: CURRENT PROCEDURAL TERMINOLOGY CODES AND DATES OF REVIEWS FOR SAMPLED MUSCULOSKELETAL SURGERIES EXAMINED

The 235 musculoskeletal global surgeries examined had 88 CPT codes. The following tables identify the 88 CPT codes by stratum and indicate the year in which the Centers for Medicare & Medicaid Services (CMS) last reviewed the relative value units for each code since establishing the fee schedule in 1992.

Stratum 1

CPT Code[1]	Description	Last CMS Review
27130	Total hip arthroplasty	2007
27236	Treat thigh fracture	2007
27447	Total knee arthroplasty	2007
27245	Treat thigh fracture	2009

Stratum 2

CPT Code	Description	Last CMS Review
23500	Treat clavicle fracture	Not reviewed
23600	Treat humerus fracture	Not reviewed
23650	Treat shoulder dislocation	Not reviewed
24650	Treat radius fracture	Not reviewed
25248	Remove forearm foreign body	Not reviewed
25565	Treat fracture radius & ulna	Not reviewed
25600	Treat fracture radius/ulna	Not reviewed
25630	Treat wrist bone fracture	Not reviewed
26410	Repair hand tendon	Not reviewed
26750	Treat finger fracture, each	Not reviewed
27301	Drain thigh/knee lesion	Not reviewed
27786	Treatment of ankle fracture	Not reviewed
27840	Treat ankle dislocation	Not reviewed
28080	Removal of foot lesion	Not reviewed
28290	Correction of bunion	Not reviewed
29826	Shoulder arthroscopy/surgery	Not reviewed
29880	Knee arthroscopy/surgery	Not reviewed
29881	Knee arthroscopy/surgery	Not reviewed
28289	Repair hallux rigidus	Not reviewed[2]
25605	Treat fracture radius/ulna	1993
22310	Treat spine fracture	1996
27266	Treat hip dislocation	1997

[1] CPT code 22612 was in the sample but not examined as part of the 235 musculoskeletal global surgeries.

[2] CPT code 28289 was established in 1999.

CPT Code	Description	Last CMS Review
28285	Repair of hammertoe	1997
28750	Fusion of big toe joint	1997
29876	Knee arthroscopy/surgery	1997
21335	Treatment of nose fracture	1998
21390	Treat eye socket fracture	1998
27193	Treat pelvic ring fracture	1998
28470	Treat metatarsal fracture	1998
21800	Treatment of rib fracture	2002
20680	Removal of support implant	2007
26160	Remove tendon sheath lesion	2007
26600	Treat metacarpal fracture	2007
28505	Treat big toe fracture	2008
28296	Correction of bunion	2009
21555	Remove lesion, neck/chest	2010
21556	Remove lesion, neck/chest	2010
21930	Remove lesion, back or flank	2010
24075	Remove arm/elbow lesion	2010
26115	Removal hand lesion subcut	2010

Stratum 3

CPT Code	Description	Last CMS Review
21627	Sternal debridement	Not reviewed
26990	Drainage of pelvis lesion	Not reviewed
27125	Partial hip replacement	Not reviewed
27132	Total hip arthroplasty	Not reviewed
27235	Treat thigh fracture	Not reviewed
27385	Repair of thigh muscle	Not reviewed
27446	Revision of knee joint	Not reviewed
27508	Treatment of thigh fracture	Not reviewed
27524	Treat kneecap fracture	Not reviewed
27530	Treat knee fracture	Not reviewed
27552	Treat knee dislocation	Not reviewed
27596	Amputation followup surgery	Not reviewed
27881	Amputation of lower leg	Not reviewed
27886	Amputation followup surgery	Not reviewed
27889	Amputation of foot at ankle	Not reviewed
28292	Correction of bunion	Not reviewed
28820	Amputation of toe	Not reviewed
24341	Repair arm tendon/muscle	Not reviewed[3]

[3] CPT code 24341 was established in 1997.

CPT Code	Description	Last CMS Review
25609	Treat fracture radial 3+ fragments	Not reviewed[4]
24515	Treat humerus fracture	1997
27134	Revise hip joint replacement	1997
27137	Revise hip joint replacement	1997
27486	Revise/replace knee joint	1997
27487	Revise/replace knee joint	1997
27488	Removal of knee prosthesis	1997
27506	Treatment of thigh fracture	1997
28293	Correction of bunion	1997
28715	Fusion of foot bones	1997
27503	Treatment of thigh fracture	1998
27507	Treatment of thigh fracture	1998
23472	Reconstruct shoulder joint	2002
27590	Amputate leg at thigh	2002
27880	Amputation of lower leg	2007
23615	Treat humerus fracture	2008
24579	Treat humerus fracture	2008
25575	Treat fracture radius/ulna	2008
27511	Treatment of thigh fracture	2008
27814	Treatment of ankle fracture	2008
27828	Treat lower leg fracture	2008
23410	Repair rotator cuff, acute	2009
23412	Repair rotator cuff, chronic	2009
27244	Treat thigh fracture	2009
23076	Removal of shoulder lesion	2010
27329	Remove tumor, thigh/knee	2010

[4] CPT code 25609 was established in 2007.

APPENDIX D: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: FEB 1 3 2012

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided" (A-05-09-00053)

Thank you for the opportunity to review and comment on the OIG Draft Report entitled, "Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided." The Centers for Medicare & Medicaid Services (CMS) appreciates the OIG's continuing effort to examine the number of post-operative evaluation and management (E&M) visits furnished during the global period for physician services.

For each global surgery, CMS establishes a uniform payment, which includes payment for all related services normally furnished by a surgeon during the global period. The global period may include 0, 10, or 90 days of post-operative care, depending on the procedure. Often the post-operative work, in the global surgery payment, includes post-operative E&M services. In order to set the payment amount for a global surgery, CMS estimates the number and level of post-operative E&M services that are typically furnished for a global surgical procedure, and includes the value of these E&M services in the payment rate. Payment rates for each global surgical procedure are based on the resources necessary to provide the typical surgery and follow up visits during the global period, not on the actual resources or the number of post-operative E&M services that are actually furnished for a particular case.

The OIG report presents findings from a review of 300 global surgeries. The OIG analysis showed that the musculoskeletal global surgery fees reflected the actual number of E&M services furnished in the global period in only 24 of the 300 global surgery periods reviewed. The OIG found that 65 surgeries were performed as one of multiple surgeries, and the OIG could not determine whether the E&M services were related to the sample surgery or another surgery. For the remaining 211 global surgeries sampled, the OIG found in 165 instances that fewer E&M services were furnished than were accounted for in the global surgery payment, and in 46 instances, more E&M services were furnished than were accounted for in the global surgery payment.

Medicare first applied the concept of global surgery fees on January 1, 1992, with the inception of the Resource Based Relative Value Scale. Various sources of information have been used to establish the number of E&M services typically furnished within a global period, with some from the late 1980s/early 1990s Harvard study that was used to establish the Physician Fee Schedule (PFS), some from the American Medical Association Relative Value Update Committee (AMA RUC) recommendations, and some from CMS.

OIG Recommendation

The OIG recommends that CMS should adjust the estimated number of E&M services within musculoskeletal global surgery fees to reflect the actual number of E&M services being provided to beneficiaries, which would have reduced payments in Calendar Year 2007 alone by an estimated $49 million.

CMS Response

The CMS appreciates the OIG recommendation and concurs, in part, with the recommendation. Global surgical payments are based on the typical work for that service, but allow for variations in the actual post-operative services that may result in more or less work than the typical. The OIG findings suggest that the typical post-operative work in musculoskeletal global surgeries may have changed. CMS plans to conduct further analysis before proposing any changes in the typical number of E&M services assigned to musculoskeletal surgeries. As part of our potentially misvalued codes initiative, we identify services that are potentially misvalued and usually suggest that the AMA RUC review these codes before proposing any changes through the annual PFS notice and comment rulemaking process. We establish payment rates based, in part, on our review of the AMA RUC-recommended values for those services. We will assess whether we believe the AMA RUC should review these codes under the potentially misvalued codes initiative.

The CMS notes that any change in payments resulting from our ongoing review of the number of E&M services included in the global period of both musculoskeletal surgeries and any other surgical services would be redistributed across all services paid under the PFS and would not result in savings to the Medicare program. Changes to the values of services under the PFS must be done in a budget neutral manner as required by the Medicare statute.

OIG Recommendation

The OIG recommends that CMS use the results of this audit during the annual update of the PFS.

CMS Response

The CMS appreciates the OIG recommendation on this issue and concurs, in part, with this recommendation. CMS plans to conduct further analysis before proposing any changes in the number of E&M services assigned to musculoskeletal surgeries. As noted above, we will

consider these services for inclusion in the potentially misvalued codes initiative. We will thoroughly analyze the OIG findings as we continue to identify and review potentially misvalued services.

CMS thanks the OIG for the opportunity to review and comment on this report.