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: Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided (A-05-09-00054)

The attached final report provides the results of our review of evaluation and management services included in cardiovascular 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-05-09-00054 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

Daniel R. Levinson
Inspector General

May 2012
A-05-09-00054

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 423 codes for major cardiovascular global surgeries. CMS reimbursed physicians approximately $812 million for 403 of these CPT codes for surgeries performed during calendar year (CY) 2007.

CMS requested this review.

OBJECTIVE

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

SUMMARY OF RESULTS

Cardiovascular 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 98 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 (19 surgeries) or the surgery was 1 of multiple surgeries (79 surgeries). For the remaining 202 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 132 global surgery fees and provided more E&M services than were included in 70 global surgery fees. (For the 79 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 79 sampled surgeries as errors.)

Using our sample results, we estimated that Medicare paid a net $14.6 million for E&M services that were included in cardiovascular 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 cardiovascular 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 $14.6 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 cardiovascular 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.

Cardiovascular 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 423 codes for major cardiovascular global surgeries, such as coronary artery bypass grafting, insertion of a pulse generator, and mitral valve replacement. CMS reimbursed physicians approximately $812 million for 403 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 cardiovascular 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 $590 million made to physicians nationwide for 722,692 major cardiovascular 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 $222 million 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 cardiovascular global surgery fees. We did not determine the medical necessity of the surgeries or the related E&M services.

[3] There were no payments for the remaining 20 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 two 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.

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

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 722,692 major cardiovascular global surgeries totaling approximately $590 million and divided the sampling frame into 3 strata (Appendix A):

    - stratum 1 for the 5 CPT codes that represented 45.8 percent of the total payments in the sampling frame (code 33249 for electrode/insert pace-defibrillators, 33405 for aortic valve replacements, 33533 for coronary artery bypasses using single arterial grafts, 35301 for rechanneling of arteries, and 37620 for revisioning of major veins);

    - stratum 2 for the 170 CPT codes (excluding the 2 CPT codes in stratum 1) that included fewer than 7 E&M services in the global surgery fees; and

    - stratum 3 for the 213 CPT codes (excluding the 3 CPT codes in stratum 1) that included 7 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 $286,452 for 79 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 221 global surgeries examined for 65 CPT codes to estimate the Medicare reimbursement for E&M services that were included in

cardiovascular 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

Cardiovascular 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 98 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 (19 surgeries) or the surgery was 1 of multiple surgeries (79 surgeries). For the remaining 202 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 132 global surgery fees and provided more E&M services than were included in 70 global surgery fees.

Using our sample results, we estimated that Medicare paid a net $14.6 million for E&M services that were included in cardiovascular 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 79 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 79 sampled surgeries as errors.

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

For 202 of the 221 cardiovascular 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 1,507 E&M services were included in the global surgery fees for these 221 surgeries, but physicians provided 1,292 E&M services, a difference of 215 E&M services totaling a net $6,103.

Evaluation and Management Services Included in Cardiovascular 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]	91	695	475	220	$6,153
2	< 7	63	182	225	(43)	(1,083)
3	≥ 7	67	630	592	38	1,033
Total		**221**	**1,507**	**1,292**	**215**	**$6,103**

Using our sample results, we estimated that Medicare paid a net $14.6 million for E&M services that were included in cardiovascular global surgery fees but not provided during the global surgery periods in CY 2007 (Appendix B).

RELATIVE VALUE UNITS NOT REVIEWED

Cardiovascular 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 65 cardiovascular global surgery CPT codes that we examined. Specifically, CMS:

[6] Because the remaining 79 surgeries sampled were performed as 1 of multiple surgeries, we were unable to determine whether the E&M services 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 code 33249 has 3 E&M services included in the global fee; CPT code 35301 has 6 E&M services included; CPT code 33533 has 9 E&M services included; CPT code 33405 has 10 E&M services included; and CPT code 37620 has 11 E&M services included.

- had not reviewed the RVUs for 4 codes since the fee schedule was established in 1992,
- last reviewed the RVUs for 7 codes between 1993 through 1999,
- last reviewed the RVUs for 36 codes between 2000 through 2007,
- last reviewed the RVUs for 5 codes after 2007 (the year the sampled surgeries occurred), and
- had not reviewed the RVUs for 13 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 cardiovascular 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 $14.6 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 cardiovascular 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 cardiovascular global surgeries with dates of service in calendar year 2007.

SAMPLING FRAME

The sampling frame consisted of 722,692 major cardiovascular global surgeries with Medicare payments totaling $590,288,685. 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 cardiovascular 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]	276,229	$270,219,767
2	Surgeries (excluding those in stratum 1) with fewer than seven E&M services included in the fee	331,927	165,502,559
3	Surgeries (excluding those in stratum 1) with seven or more E&M services included in the fee	114,536	154,566,359
Total		**722,692**	**$590,288,685**

[1] CPT = Current Procedural Terminology. CPT code 33249 has 3 E&M services included in the global fee; CPT code 35301 has 6 E&M services included; CPT code 33533 has 9 E&M services included; CPT code 33405 has 10 E&M services included; and CPT code 37620 has 11 E&M services included.

SAMPLE SIZE

We selected a sample of 100 major cardiovascular 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 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 Cardiovascular 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	6	69	16	9	$6,153
2	< 7	100	6	24	33	37	-1,083
3	≥ 7	100	7	39	21	33	1,033
Total		**300**	**19**	**132**	**70**	**79**	**$6,103**

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

Stratum	Point Estimate	Limits Calculated for a 90-Percent Confidence Interval	
		Lower Limit	Upper Limit
1	$16,997,420	$9,223,486	$ 24,771,355
2	-3,596,363	-7,122,631	-70,095
3	1,182,619	-1,158,869	3,524,106
Overall	**$14,583,676**	**$5,814,886[3]**	**$23,352,465[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 33249 has 3 E&M services included in the global fee; CPT code 35301 has 6 E&M services included; CPT code 33533 has 9 E&M services included; CPT code 33405 has 10 E&M services included; and CPT code 37620 has 11 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 CARDIOVASCULAR SURGERIES EXAMINED

The 221 cardiovascular global surgeries examined had 65 CPT codes. The following tables identify the 65 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	Description	Last CMS Review
37620	Revision of major vein	Not reviewed
35301	Rechanneling of artery	1997
33249	Electrode/insert pace-defibrillator	2000
33405	Replacement of aortic valve	2007
33533	CABG[1] arterial, single	2007

Stratum 2

CPT Code	Description	Last CMS Review
33207	Insertion of heart pacemaker	Not reviewed
33213	Insertion of pulse generator	Not reviewed[2]
35903	Excision, graft, extremity	Not reviewed[2]
37607	Ligation of arteriovenous fistula	Not reviewed[2]
36833	Arteriovenous fistula revision	Not reviewed[3]
33282	Implant patient-activated heart recorder	Not reviewed[4]
33284	Remove patient-activated heart recorder	Not reviewed[4]
36819	Arteriovenous fuse, upper arm, basilic	Not reviewed[4]
34802	Endovascular abdominal aortic aneurysm repair using modular bifurcated prosthesis	Not reviewed[5]
36870	Percutaneous thrombectomy arteriovenous fistula	Not reviewed[5]
36818	Arteriovenous fuse, upper arm, cephalic	Not reviewed[6]

[1] Coronary artery bypass graft.

[2] CPT codes 33213, 35903, and 37607 were established in 1994.

[3] CPT code 36833 was established in 1999.

[4] CPT codes 33282, 33284, and 36819 were established in 2000.

[5] CPT codes 34802 and 36870 were established in 2001.

37215	Transcatheter stent, cervical carotid artery with distal embolic protection	Not reviewed[6]
37722	Ligate/strip long leg vein	Not reviewed[7]
33212	Insertion of pulse generator	1994
33222	Revise pocket, pacemaker	1994
36830	Artery-vein nonautograft	1997
36831	Open thrombect arteriovenous fistula	2001
36832	Arteriovenous fistula revision, open	2001
35226	Repair blood vessel lesion	2002
34825	Endovascular extend prosthesis, initial	2003
36821	Arteriovenous fusion direct any site	2009
36825	Artery-vein autograft	2010
37765	Phlebectomy veins—extremity—to 20	2011
37766	Phlebectomy veins—extremity—20+	2011

Stratum 3

CPT Code	Description	Last CMS Review
33025	Incision of heart sac	Not reviewed
33030	Partial removal of heart sac	Not reviewed
33496	Repair prosthetic valve clot	Not reviewed[8]
33971	Aortic circulation assist	1997
35656	Artery bypass graft	1997
36834	Repair arteriovenous aneurysm	1998
35082	Repair artery rupture, aorta	2002
35112	Repair artery rupture, spleen	2002
35151	Repair defect of artery	2002
35276	Repair blood vessel lesion	2002
35571	Artery bypass graft	2002
35621	Artery bypass graft	2002
35631	Artery bypass graft	2002
35661	Artery bypass graft	2002
35665	Artery bypass graft	2002
35666	Artery bypass graft	2002
35860	Explore limb vessels	2002

[6] CPT codes 36818 and 37215 were established in 2005.

[7] CPT code 37722 was established in 2006.

[8] CPT code 33496 was established in 1998.

CPT Code	Description	Last CMS Review
33406	Replacement of aortic valve	2007
33410	Replacement of aortic valve	2007
33426	Repair of mitral valve	2007
33427	Repair of mitral valve	2007
33430	Replacement of mitral valve	2007
33510	CABG, vein, single	2007
33511	CABG, vein, two	2007
33512	CABG, vein, three	2007
33513	CABG, vein, four	2007
33534	CABG, arterial, two	2007
33535	CABG, arterial, three	2007
34201	Removal of artery clot	2007
35081	Repair defect of artery	2007
35102	Repair defect of artery	2007
35556	Artery bypass graft	2007
35566	Artery bypass graft	2007
35583	Vein bypass graft	2007
35585	Vein bypass graft	2007
33411	Replacement of aortic valve	2011

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 0 2012

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Cardiovascular Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided (A-05-09-00054)

Thank you for the opportunity to review and comment on the OIG Draft Report entitled, "Cardiovascular 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 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 cardiovascular global surgery fees reflected the actual number of E&M services furnished in the global period in only 19 of the 300 global surgery periods reviewed. The OIG found that 79 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 202 global surgeries sampled, the OIG found that, in 132 instances, fewer E&M services were furnished than were accounted for in the global surgery payment, and in 70 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

since then 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 adjust the estimated number of E&M services within cardiovascular 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 $14.6 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 cardiovascular global surgeries may have changed. CMS plans to conduct further analysis before proposing any changes in the number of E&M services assigned to cardiovascular 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, in part, based 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 cardiovascular 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 the recommendation. CMS plans to conduct further analysis before proposing any changes in the number of E&M services assigned to cardiovascular 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.

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