ITINERANT SURGERY

OFFICE OF INSPECTOR GENERAL

OFFICE OF ANALYSIS AND INSPECTIONS

APRIL 1989

OFFICE OF INSPECTOR GENERAL

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This study was conducted to determine quality of care issues related to itinerant surgery and if Medicare made overpayments to itinerant surgeons for services not provided.

The report was prepared under the direction of Don McLaughlin, the Regional Inspector General of Region VII, Office of Analysis and Inspections. Participating in this project were the following people:

Kansas City

Tim Dold *(Project Leader)*
Phil O'Hare
Deborah Walden
James Wolf
Alicia Smith

Headquarters

Barry Steeley
Kitty Ahern
Mary Hogan

ITINERANT SURGERY

Richard P. Kusserow
INSPECTOR GENERAL

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EXECUTIVE SUMMARY

OBJECTIVES

This inspection report focuses on issues involving itinerant surgery. The overall objective of the inspection was to determine:

- the extent of itinerant surgery in rural hospitals;
- the extent to which quality of care is affected by itinerant surgery; and
- the extent to which itinerant surgeons bill global fees that include postoperative care they did not provide.

BACKGROUND

Itinerant surgery is defined in this inspection as the practice by a physician (normally residing in another city) of traveling to small rural hospitals to perform surgery. The surgeon typically is not available for follow-up care, having traveled to another rural hospital or returned to his or her home base all in the same day. The American College of Surgeons will and have excluded physicians from fellowship for performing itinerant surgery. However, medical opinions vary greatly regarding the necessity and ethics of itinerant surgery and its effect on the quality of patient care.

METHODOLOGY

A random sample of 72 hospitals was selected from the universe of 1,328 rural hospitals with 50 beds or fewer. We then determined which of the sample hospitals used the services of itinerant surgeons. Medicare beneficiaries' admission records in the 20 hospitals which utilized itinerant surgeons, during October 1, 1985 through September 30, 1986, were screened for the 12 most frequently reported surgical diagnosis related groups (DRGs) in rural hospitals. All surgeries in those DRGs at the sample hospitals were selected for review. Contact with the hospitals determined if local or itinerant surgeons had performed the surgeries in question.

Reimbursement was analyzed by comparing documentation in the medical records to the billing and payment information from Medicare payment histories. The medical records were then reviewed by a medical review contractor to assess quality of care. Contacts were made with several organizations, including the American College of Surgeons, the American Medical Association, the American Academy of Family Physicians, peer review organizations (PROs), and State medical licensure boards, to obtain their views on itinerant surgery.

FINDINGS

Some Rural Hospitals Make Extensive Use Of Itinerant Surgery

- Twenty-eight percent (20 of 72) of the sampled rural hospitals utilized itinerant surgeons. Itinerant surgeons performed 73 percent (177 of 242) of the sample cases which were selected from the 12 most common surgeries in the sampled rural facilities.

Many Rural Hospitals See Itinerant Surgery As A Cost-effective Means Of Providing Needed Surgery Which Might Not Otherwise Be Available In Some Rural Areas

Nevertheless, There Is A Higher-than-average Risk Of Poor Quality Care In Itinerant Surgery

- Physicians under contract to the Office of Inspector General (OIG) identified 29 cases (16.3 percent) with adverse outcomes. In 10 of these cases, the adverse outcome was aggravated by itinerant surgery.

- Contract physicians found that 123 (70 percent) of the cases reviewed were elective surgeries. Further, 8 percent of those elective surgeries were found to be contraindicated.

- Contract physicians identified 41 cases in which a surgical note was not present before anesthesia. In 10 cases where notes were present, the notes were not adequate. The review also identified 29 cases where the preoperative workup was not adequate.

- The overall rate of poor quality care in this study was determined to be 26.6 percent. In comparison, the National DRG Validation Study completed by the OIG found a 3.3 percent rate of poor quality care in surgical cases in small rural hospitals.

Medicare Pays Many Itinerant Surgeons For Postoperative Care Which Is Not Performed

- Review of medical records and payment histories found that, in 113 of 177 (63.8 percent) of the records reviewed, the itinerant surgeons did not provide postoperative care. However, they billed the Medicare program a global fee which included this care.

RECOMMENDATIONS

To Improve The Quality Of Care In Itinerant Surgery Cases

- Rural physicians and hospital administrators should develop and monitor implementation of procedures to ensure adequacy of:

  - preoperative workups;
  - the patient's opportunity to seek a second opinion;
  - postoperative plans of care; and
  - postoperative communication between the attending physician and the itinerant surgeon.

- The Health Care Financing Administration (HCFA) should require that PROs review procedures performed by itinerant surgeons to determine if the quality of patient care is affected when preoperative or postoperative care is not provided by the itinerant surgeon. Particular attention should be paid to adverse outcomes related to itinerant surgery.

To Recover And Reduce Overpayments For Postoperative Care Billed, But Not Performed By, Itinerant Surgeons

- The HCFA should instruct Medicare carriers to recover overpayments from itinerant surgeons identified in this study who billed a global fee but did not provide postoperative care.

- The HCFA should instruct all carriers to use procedure code modifier "54" to eliminate Medicare overpayments in cases where itinerant surgeons provided surgery only. The HCFA should instruct all carriers to educate surgeons regarding the use of the "54" modifier.

- The HCFA should develop guidelines regarding the percentage allocation of global fees for surgery and postoperative care. These guidelines would provide criteria for consistent claims adjudication, and should be disseminated nationwide.

AGENCY COMMENTS

The HCFA comments reflect general agreement with the findings and recommendations in this report. The OIG is pleased that HCFA is taking action to implement the majority of these recommendations. However, HCFA did not agree with the recommendation that PROs should review itinerant surgery procedures because such a review would require a new review procedure, and itinerant surgeons cannot be identified from non-itinerant surgeons. Although we

recognize the efforts expended by PROs, we believe that a review of itinerant surgeries should not require an extensive revision of procedures since the scope of work currently includes rural hospitals, and local PROs should be aware of itinerant surgeons in their service area.

HEALTH ORGANIZATION COMMENTS

The OIG issued the draft report to six health organizations for comments, of which two (the American Hospital Association and the American Academy of Family Physicians) responded. In general, both organizations were in agreement with the majority of the report recommendations. However, these organizations also shared a concern that the conclusions in the report were reached from a small sample of surgical cases. The sampling process, as in all inspections, is approved by OIG statistical staff to ensure accuracy and consistency of the inspection process. The findings from this study were based on the analysis of data drawn from valid random samples.

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INTRODUCTION

OBJECTIVES

This national inspection focuses on issues involving the quality of care related to inpatient itinerant surgery, and on Medicare program overpayments to itinerant surgeons for postoperative services not provided. The overall objective of the inspection was to determine:

- the frequency of itinerant surgery;
- the extent to which a physician other than the itinerant surgeon provides preoperative and/or postoperative care;
- the extent to which the quality of care is affected by the surgeon's absence;
- if itinerant surgeons are billing global fees which include postoperative care they did not provide;
- Medicare carrier procedures and policies regarding global fees; and
- the amount of Medicare program overpayments resulting from payments of global fees billed by itinerant surgeons for services not provided.

BACKGROUND

Itinerant surgery is defined in this inspection as the practice by a physician (normally residing in another city) of travelling to small rural hospitals to perform surgery. The surgeon typically is not available for follow-up care, having traveled to another rural hospital or returned to his or her home base all in the same day. In most of these cases, preoperative and postoperative care is performed by the patient's local attending physician rather than the itinerant surgeon.

Itinerant surgery occurs in small rural hospitals for several reasons. A hospital may not have a local surgeon, yet surgical patients prefer to be hospitalized in their local hospital. Where there is a local surgeon, he or she is usually a general surgeon. A surgical specialist (e.g. urologist or orthopedist) may be required for other than general surgery. This specialist would typically be an itinerant surgeon, even if resident in a rural area, since small hospitals cannot support a specialist on a full-time basis.

Usually, an attending physician admits a patient and is responsible for the care the patient receives. When surgery is required, a surgeon consults with the attending physician, examines the patient, performs the surgery, and provides surgical aftercare, such as ordering antibiotics, fluid replacement, and the type and frequency of dressing changes.

As mentioned above, some small rural hospitals do not have a patient population large enough to support general and/or specialized surgeons, so surgery is often performed by an itinerant surgeon. Whether an itinerant surgeon performs all or part of the preoperative or postoperative care, or shares that care with the attending physician, depends on the surgeon and can vary from case to case. This practice raises concerns regarding the quality of care rural Medicare patients receive and whether Medicare payments to itinerant surgeons cover services not provided.

Medical opinions vary greatly regarding the necessity and ethics of itinerant surgery and its effect on the quality of patient care. Medical journals have included articles about itinerant surgery which question whether surgery should be performed by an itinerant surgeon if the operation carries with it a significant risk; or whether itinerant surgery is ethical because a surgeon abandons the patient's postoperative care and turns it over to another physician.

Several organizations contacted during the course of this inspection, including the American College of Surgeons (ACS), have written guidelines and/or set a policy regarding itinerant surgery. The ACS prohibits its members from performing itinerant surgery. Their bylaws state that it is unethical to turn over the postoperative care of a patient to another physician who is not as well qualified to undertake it. A finding that itinerant surgery was performed may lead to a member's expulsion by the ACS Board of Regents. In one specific case, the ACS excluded a physician from fellowship because he performed itinerant surgery.

On the other hand, a representative of the American Medical Association stated that itinerant surgery is an "accepted and necessary" practice. A representative of the American Academy of Family Physicians stated that itinerant surgery can represent quality medical care if the following criteria are met:

- The surgeon is competent to provide surgery;
- the surgeon and the attending physician enter into a defined agreement regarding the provision of aftercare;
- services are provided in a competent hospital; and
- there is adequate postoperative communication between the surgeon and the attending physician.

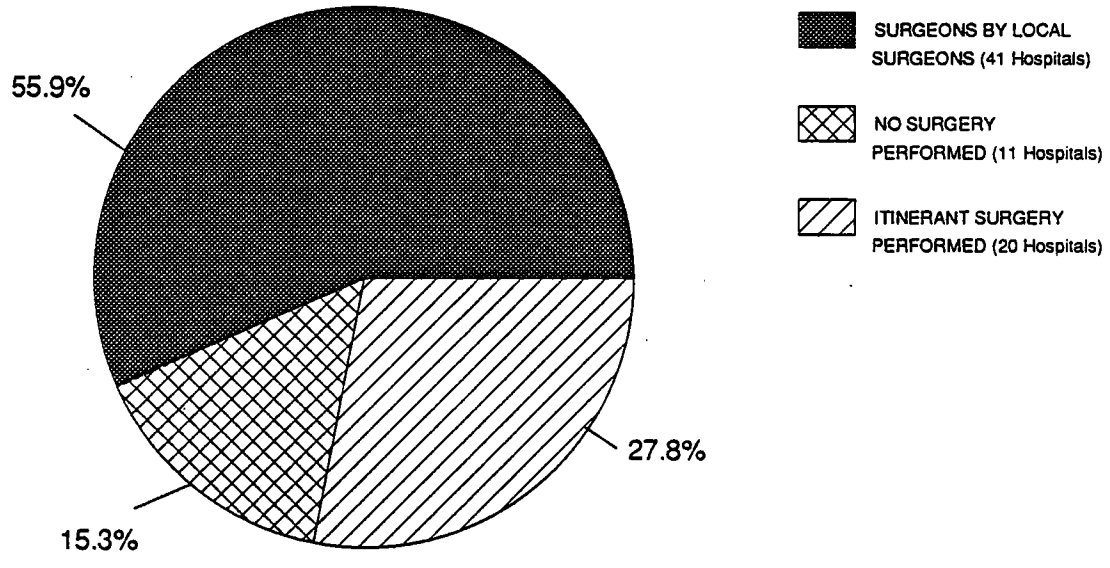
Surgical procedure codes used by physicians in billing for medical/surgical procedures are listed in the *Physicians' Current Procedural Terminology* (CPT) Manual and are similar to the Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS). The HCPCS codes for surgery provide a "global allowance" for surgical procedures and uncomplicated postoperative care. In instances when only a portion of the global service is performed (i.e., surgery only), a procedure code with a two-digit modifier provides the means by which the physician can indicate when the scope of a surgical procedure has been altered. The

CPT modifier "54," used with the procedure code, indicates that the surgeon performed only the surgery and did not provide postoperative care. The HCFA guidelines require that all carriers be able to accept claims billed with a five-digit HCPCS code and up to two modifiers. However, carriers may elect not to use the modifiers for pricing or profiling purposes. Medicare program overpayments may result when surgeons do not provide postoperative care and submit bills using a procedure code without a modifier. Overpayments may also result with proper billings using modifiers for surgery only if the carrier payment system does not recognize the modifier and pays for a global service.

METHODOLOGY

The inspection methodology was completed in the following steps. (See appendix I for outline.) First, a random sample of 72 hospitals was selected from the universe of 1,328 rural hospitals of 50 beds or fewer which were located in areas outside Metropolitan Statistical Areas as defined by the Census Bureau. Second, the hospitals in the sample were contacted to determine if itinerant surgeries were performed in those facilities. In 11 of the 72 hospitals (15 percent), no surgery was performed. Forty-one hospitals (57 percent) used only local staff surgeons. Itinerant surgeries were performed in the remaining 20 hospitals (28 percent) located in 14 States.

Figure 1
72 SAMPLED RURAL HOSPITALS



Third, Medicare beneficiaries' admission records in the 20 hospitals, during the period October 1, 1985 through September 30, 1986, were screened for the following 12 most frequently reported surgical diagnosis related groups (DRGs) in rural hospitals:

DRG	Description
5	Extra Cranial Vascular Procedures
39	Lens Procedures
148	Major Small and Large Bowel Procedures
154	Stomach, Esophageal, Duodenal Procedures
157	Anal Procedures
161	Inguinal and Femoral Hernia Repair
197	Total Cholecystectomy
209	Major Joint Procedures
210	Hip and Femur (Except Major Joint) Procedures
257	Total Mastectomy, Malignancy
310	Transurethral Procedures
336	Transurethral Prostatectomy

A total of 243 surgical admissions of Medicare beneficiaries in the 20 hospitals was selected initially as the sample for this inspection. One hospital was dropped from the inspection because it had only one identified admission in that hospital and in that particular Medicare carrier's area.

Fourth, the review team identified, through discussions with hospital staff and review of medical records, that 177 of the remaining 242 surgeries were performed by itinerant surgeons. We found that over half of these surgeries were performed by itinerant surgeons in the surgical specialties of ophthalmology, urology, and orthopedics. The remaining 65 surgeries were performed by local attending physicians (30 cases) or by local surgeons (35 cases).

The Office of Inspector General (OIG) contracted with the Forensic Medical Advisory Service of Rockville, Maryland, to perform a quality of care review of the 177 sampled itinerant surgery records. The OIG specified that the contractor provide medical review and written assessment of the quality of care of services provided to patients treated by itinerant surgeons identified in the sample.

The 177 medical records were examined to determine if they reflected problems related to an acceptable quality of care, and the extent of preoperative and postoperative services provided by the itinerant surgeon. The scope of review did not include a review of patient visits, if any, to the surgeon's office after the hospital discharge. Quality of care could involve various aspects of surgery and include quality of the surgery, complications following surgery, and the provision of preoperative and/or postoperative care by the surgeon, as documented in the medical record.

Since the 177 medical records included several types of surgery, the contractor used board-certified physician reviewers who included general surgeons and also specialty surgeons who

reviewed cases in their respective specialties. The physician reviewers, using professional judgment, completed a narrative summary and an abstraction of data elements on each of the 177 cases. A list of the data elements is included as appendix II.

Beneficiary payment histories for the 177 itinerant surgery admissions were obtained from Medicare carriers. The HCFA guidelines provide for payment of a global fee to the surgeon for the surgical procedure and postoperative care unless postoperative care is not provided. Medicare program overpayments were calculated for cases in which it was determined that the surgeon provided no postoperative care, yet billed the Medicare program a global fee. The respective carrier guidelines were used in calculating Medicare program overpayments. The carriers varied in the number of postoperative days included in the global fee; however, the most frequent period was 14 days. See appendix III for details.

Discussions were held with itinerant surgeons, attending physicians, hospital administrators, surgeons' billing offices, State medical boards, and peer review organizations (PROs) in the States where on-site hospital visits were made. Several health organizations were contacted to obtain views regarding itinerant surgery as it relates to quality of care.

FINDINGS

Some Rural Hospitals Make Extensive Use Of Itinerant Surgery

Twenty-eight percent (20 of 72) of the sampled rural hospitals utilized an itinerant surgeon. Itinerant surgeons performed 73 percent of the sample cases (177 of 242) covering the 12 most common surgeries in the sampled rural facilities. The 177 surgeries were performed by 43 itinerant surgeons.

ITINERANT SURGERY SAMPLE

Hospital	*No. of Beds*	*Total Cases*	*Surgery Performed by*		*No. of Itinerant Surgeons*
			Local Surgeon	*Itinerant Surgeon*	
A	49	46	12	34	3
B	42	8	7	1	1
C	33	9	0	9	2
D	26	17	0	17	4
E	34	2	2	0	0
F	32	15	7	8	5
G	35	14	9	5	2
H	31	11	0	11	3
I	20	5	3	2	1
J	23	3	0	3	2
K	30	14	0	14	1
L	46	28	0	28	8
M	25	12	9	3	2
N	20	9	0	9	1
O	25	3	0	3	1
P	35	1	0	1	1
Q	49	30	12	18	5
R	31	1	1	0	0
S	35	14	3	11	1
TOTALS		**242**	**65**	**177**	**43**

During interviews with 11 of the 43 itinerant surgeons, we found that 5 of the 11 were from cities with a population greater than 50,000 and were specialists (such as orthopedic surgeons). Six of the 11 itinerant surgeons were from small cities (less than 25,000 population) or towns similar in size to the towns where itinerant surgery occurred, and were usually general surgeons.

Many Rural Hospitals See Itinerant Surgery As A Cost-effective Means Of Providing Needed Surgery Which Might Not Otherwise Be Available In Some Rural Areas

The practice of itinerant surgery in a rural hospital is perceived to have a beneficial impact on the hospital, the community, local physicians, and patients.

Rural Medicare patients feel they can benefit from itinerant surgery. By having surgery at the local hospital, the patient is not subjected to the trauma of going to an unfamiliar hospital and the associated problem of transportation to the hospital for the patient, his or her family and friends.

The local attending physician also benefits from itinerant surgery. Because his or her patients are able to have surgery at the local hospital rather than transferring to another hospital, the attending physician can provide daily medical care which, in many cases, could not be done if the patient had to be sent to another city for surgical care.

From the rural hospital's point of view, itinerant surgery enables the hospital to keep surgical patients, thereby improving occupancy and hospital income. Since many rural hospitals are the primary employer in the community, itinerant surgery can also indirectly effect the employment of community residents.

We interviewed itinerant surgeons, attending physicians, and hospital administrators from rural communities. Some of their opinions regarding itinerant surgery follow:

- Itinerant surgery is vital to the survival of rural hospitals and rural communities who fear that referring patients to larger hospitals means losing them forever;

- without itinerant surgery, the quality of rural medicine would suffer;

- itinerant surgery performed locally costs less, while maintaining the same quality as surgeries performed in larger hospitals; and

- surgery performed locally allows patients to remain close to their friends and family, eliminating the social and economic problems associated with transferring to a hospital outside the community.

In summary, itinerant surgery provides a needed service to local physicians, the rural hospitals, patients, and residents of rural communities.

Nevertheless, There Is A Higher-than-average Risk Of Poor Quality Care In Itinerant Surgery

Contract physicians identified problems related to the quality of care associated with itinerant surgery. The following types of problems were identified within the sample of cases:

- There were adverse outcomes related to a number of the surgeries, some of which were also aggravated by itinerant surgery.

- Preoperative work-ups were inadequate.

- Surgical follow-up was not performed.

Discussion of the more significant quality of care issues follows.

Adverse Outcomes Aggravated by Itinerant Surgery

The review determined that 29 of the 177 cases (16.3 percent) had adverse outcomes that were related to surgery performed by itinerant surgeons. In 10 of those cases, the physician reviewers determined that the adverse outcomes were not only related to the surgery, but were also aggravated by itinerant surgery. The contract physicians defined "aggravated by itinerant surgery" to mean that the adverse outcomes were made worse because the surgery was performed by an itinerant surgeon who did not provide sufficient medical care before and/or after surgery. The following are examples of these cases, as described by the physician reviewers:

- An 84-year-old woman had a breast mass biopsied under general anesthesia despite multiple medical problems contraindicating general anesthesia. The surgeon's preoperative note for the biopsy did not mention her medical problems. She subsequently suffered severe postanesthetic complications. Despite these complications, and despite the fact that the biopsy was in essence a segmental mastectomy (partial breast removal), the surgeon elected to perform a second surgery--a modified radical mastectomy--again under general anesthesia. The patient developed respiratory distress and ultimately cardiac arrest from which she expired on the third postoperative day. The surgeon did not see the patient after either surgery, and, indeed, may not have been aware of her near-demise following the biopsy. Both the use of general anesthesia and radical surgery in this high-risk patient were contraindicated.

- At discharge 7 days after a cholecystectomy (gallbladder removal), a 68-year-old man continued to have bile drainage from a drain left in place. The surgeon did not see the patient postoperatively, despite the continuing bilious drainage, which could have represented injury to the liver bed, the common bile duct, or the cystic duct during surgery. The postoperative management was grossly unsatisfactory, since this complication required surgical rather than medical management.

- A 73-year-old man had a hernia repair under local anesthesia. There was no indication that he was seen postoperatively by the surgeon or the attending physician, and he was discharged with the wound still bleeding. He was readmitted by a third physician 2 days postoperatively with hemorrhage in the area of the hernia, cellulitis, and jaundice. This represents unacceptable postoperative care, with complications aggravated by the surgeon's inattendance.

In 5 of these 10 cases, the itinerant surgeon did not provide postoperative care. In the 5 remaining cases, only limited postoperative care was provided. In all 10 cases, postoperative care, when present, was provided by the patient's attending physician.

Other Adverse Outcomes Related to Surgery

The review also found that the remaining 19 cases with adverse outcomes were related to the surgery performed by the itinerant surgeons. In 15 of these cases, the surgeon either did not provide postoperative care or provided only limited postoperative care. The physician reviewers cited examples of adverse outcomes related to surgery:

- In three cases, patients had urinary incontinence following resections of the prostate. In none of these cases was the patient seen by the surgeon postoperatively, although the postoperative complication was related to the surgery.

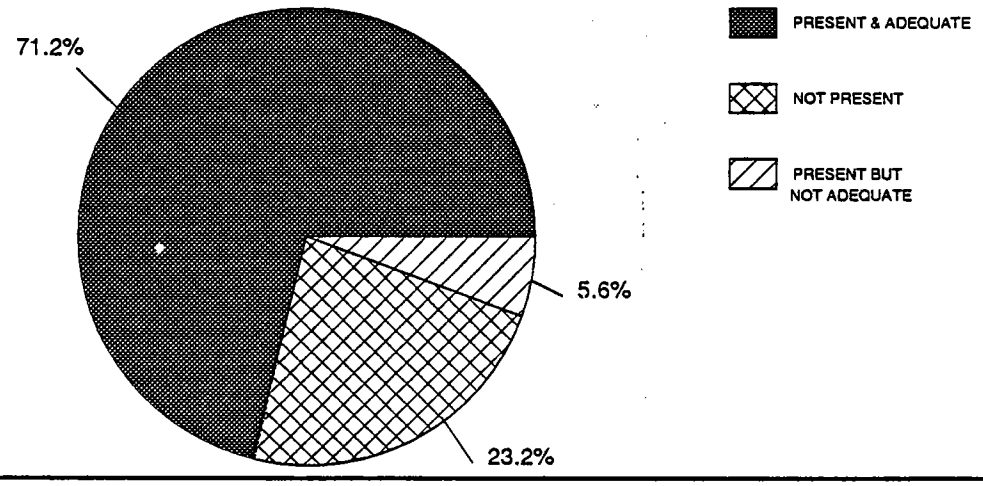
- The preoperative workup on an 84-year-old woman admitted with abdominal pain was inadequate. As a result, the surgeon operated for suspected perforated diverticulitis. When he did not find it, he closed the incision, made another, and removed a noninflamed gallbladder. It was inappropriate to remove the gallbladder unnecessarily in a high-risk patient. The surgeon failed to either diagnose or treat the acute perforated ulcer that caused the admission.

Inadequate Surgical Notes Before Anesthesia

In 41 cases, a surgical note was not present before anesthesia was administered to the patient. The medical review contractor stated that the lack of a surgical note before anesthesia suggests that the patient had not been seen and evaluated by the itinerant surgeon prior to the administration of anesthesia.

In the remaining 136 cases, a surgical note before anesthesia was documented in the medical records. However, in 10 of the 136 cases, the surgical notes before anesthesia were not adequate. In these cases, the surgical notes did not adequately describe an evaluation of the patient prior to surgery or explain the indications for surgery.

Figure 2
SURGICAL NOTES BEFORE ANESTHESIA
UNIVERSE OF 177 ITINERANT SURGERY CASES



Inadequate Preoperative Workups

The preoperative workup prior to surgery, as reflected in the medical records, was not adequate in 29 cases. In these cases, the evaluations of the patient by the attending physician and the itinerant surgeon were both considered. Some of the most common deficiencies reported were a lack of documentation that certain exams and certain laboratory and radiological tests were performed. Also, there was insufficient evaluation of a patient's prior medical history to make a diagnosis.

Contraindicated Surgery

Analysis of data from the physician reviewers found that 123 of the 177 itinerant surgeries (70 percent) were elective surgeries. The reviewers also found that in 10 of those 123 surgical cases (8 percent), the elective surgery was contraindicated. These 10 surgeries were performed by itinerant surgeons in the surgical specialties of urology, ophthalmology, and general surgery. Three of these surgical cases were among those with adverse outcomes described above.

Overall Quality Of Care Was Significantly Worse In These Cases Than In A Random Sample Of Surgical Cases In Small Rural Hospitals

As discussed above, this study identified a 16.3 percent rate of adverse outcomes directly related to itinerant surgery. These outcomes were not necessarily indicative of the overall quality of care rendered during the hospital stay. In some instances, the adverse outcome could have been that the patient was known to be a very poor surgical risk who wanted to undergo surgery in any case. On the other hand, cases with poor quality of care overall did not necessarily result in an adverse outcome. No comparable data exists for a related population (i.e., surgical cases in small rural hospitals, performed by local surgeons) to determine if itinerant surgery alone accounts for the adverse outcomes.

However, the OIG has conducted a major analysis of quality of care, in a random sample of 7,050 records from 239 hospitals under the prospective payment system. Further analysis of data from this study, called the National DRG Validation Study, revealed that 30 surgical cases had been reviewed which met the criteria established for the itinerant surgery study:

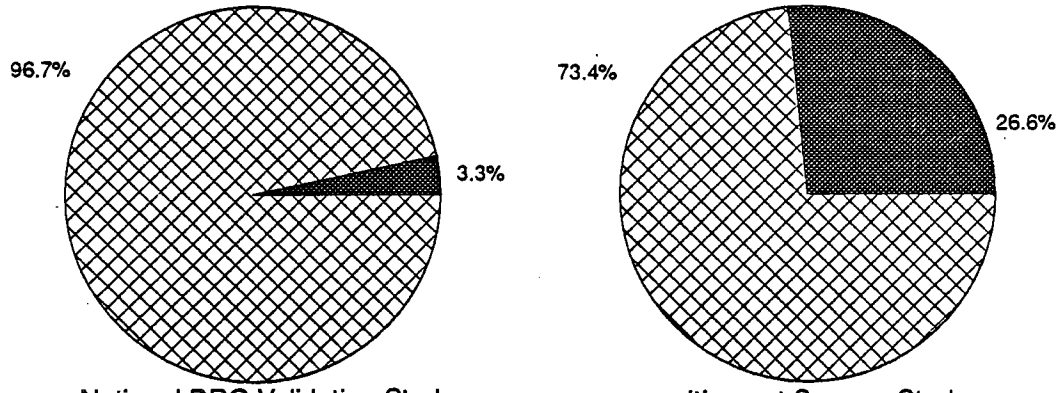
- the cases occurred in rural hospitals with 50 or fewer beds; and

- the surgical procedures involved the 12 DRGs most commonly performed in rural hospitals.

The rate of poor quality care in this national validation subsample was 3.3 percent (1 case out of 30). This 3.3 percent, however, is not fully comparable to the 16.3 percent rate of adverse outcomes in this itinerant surgery study, as the national validation study measured the overall quality of care, rather than the outcome alone. In order to compare quality, the OIG medical

officer who examined the quality summaries from the National DRG Validation Study (to ensure consistency of the reviewers' judgments) also reviewed the summaries written by Forensic Medical Advisory Service. He applied the same criteria to the itinerant surgery cases that had been applied in the earlier study. The medical officer determined that the comparable rate of poor quality care in the itinerant surgery sample was 26.6 percent (47 out of 177 cases). This difference in rates of poor quality care (3.3 percent vs. 26.6 percent) is statistically significant (Chi-square = 6.5, p = 0.0107; Fisher's exact test, p = 0.00216). Thus the observed differences are highly unlikely to be due to chance alone.

Figure 3
RELATIVE RATES OF POOR QUALITY CARE
NATIONAL DRG VALIDATION STUDY
VS. ITINERANT STUDY



Analysis of information obtained in this review of a sample of records indicates an association between poor quality of care and itinerant surgery. Although not directly attributed to itinerant surgery, poor quality of care occurred usually with the findings of no preoperative care, no postoperative care, and/or an adverse outcome with the itinerant surgery cases in this inspection. Insufficient patient histories, inadequate preoperative workups, and/or no postoperative care existed in cases aggravated by itinerant surgery. Itinerant surgeons, in many cases, do not see their patients prior to the day of surgery and, for this reason, may not receive a complete picture of the patient's medical history or problems. In addition, preoperative workups may be inadequate. The fact that many itinerant surgeons provide no postoperative or limited postoperative care may contribute to postsurgical complications aggravating an adverse outcome. (See appendix III.)

In summary, this comparison indicates that itinerant surgery may result in poor quality of care delivered in hospitals that use itinerant surgeons.

Medicare Pays Many Itinerant Surgeons For Postoperative Care Which Is Not Performed

No Postoperative Care by the Surgeon

The review of individual medical records for aftercare by the surgeon focused on written entries in the record signed by or on behalf of the itinerant surgeon. Among the areas reviewed in each record was the postoperative period, which was defined as beginning the day after surgery and including all subsequent days until the day of discharge. Of the 177 medical records reviewed, 116 contained no documented entries of postoperative care by the itinerant surgeons who performed the surgeries. In these cases, the postoperative care, when present, was provided by the attending physicians. A breakout of the 116 cases and the number of days in the postoperative period is shown below.

Number of Cases	*Number of Postoperative Days*
56	1 to 4
30	5 to 7
19	8 to 10
7	11 to 14
4	15 or more

Since global fees are intended to cover postoperative care, an analysis was conducted of the Medicare carrier payment histories for those 116 admissions to determine if the itinerant surgeons billed for global fees when, in fact, they had performed surgery only. The carriers' payment histories reflect that the itinerant surgeons were paid a global fee by the Medicare program without a surgery-only modifier in 113 cases. In the remaining three cases, the itinerant surgeons billed with a surgery-only modifier.

Based on our analysis, 28 of 43 itinerant surgeons (65 percent) were overpaid a total of $15,387 by Medicare for postoperative care that was billed using a global fee code, but was not provided. If the Medicare program paid itinerant surgeons only for surgery, it could have saved $289,927 nationally. The methodology that was used to calculate the program overpayments and savings is outlined in appendix IV.

Limited Postoperative Care By the Surgeon

In 45 cases, itinerant surgeons provided limited postoperative care of at least one day or more beginning the day after surgery. In 39 cases, the itinerant surgeons were paid a global fee. In the remaining six cases, the itinerant surgeons billed with a modifier.

The 45 medical records and payment histories were reviewed in the same manner as described in the previous finding. The number of cases and the identified number of limited postoperative hospital visits are shown below.

Number of Cases	*Postoperative Visits*
22	1
13	2
10	3 or more

Overpayments were not calculated on the 39 cases where limited postoperative visits were made because specific criteria do not exist which would identify the number of postoperative visits required in order to qualify for payment for surgical aftercare.

Use of the Modifier "54"

Of the 12 carriers contacted in this inspection, 10 adjust global fees based on the physician's use of the procedure code modifier "54," which indicates the surgeon performed only surgery and did not provide postoperative care. The other two carriers do not recognize the modifier "54," and routinely pay global fees (appendix V, column A). Thus, the two carriers' procedures do not allow for adjustments to the global fees.

Variance in Global Fees

There are no HCFA guidelines regarding:

- the number of postoperative days covered by a global fee; and

- the percentage of the global fee allocated for the surgery and for postoperative care.

We contacted the Medicare carriers servicing the claims in this inspection regarding global fees. Of the 12 carriers, 4 base the number of postoperative days included in the global fee on the procedure or type of surgery performed. The postoperative period covered by the global fee for the other eight carriers varied by type of surgery and ranged from 10 to 45 days (appendix V, column B). The carriers also reported the percentage of the global fee allocated for surgical care and for postoperative care. The allocations ranged from 80/20 to 70/30. The variance in global fee allocations is shown in appendix V, column C.

Because of the lack of a common policy covering the number of postoperative days covered by the global fee and the allocated amounts for a global fee, nationwide variances exist in program adjustments and/or payments, unrelated to surgical procedures or practices.

RECOMMENDATIONS AND AGENCY COMMENTS

Improve The Quality Of Care In Itinerant Surgery Cases

RECOMMENDATION - Rural physicians and hospital administrators should develop and monitor implementation of procedures to ensure adequacy of:

- preoperative workups;
- the patient's opportunity to seek a second opinion;
- postoperative plans of care; and
- postoperative communication between the attending physician and the itinerant surgeon.

AGENCY COMMENTS - The HCFA stated that although this recommendation is not directed to the PROs, it should be noted that the PROs currently review records to ascertain that care delivered to Medicare beneficiaries in both urban and rural ural settings meets acceptable standards. This review includes preadmission/admission workups and discharge planning. The HCFA also stated that the patient, like all Medicare beneficiaries, can seek a second opinion under Medicare's voluntary second opinion program.

OIG RESPONSE - The OIG supports the PRO's review of quality of care in rural as well as urban settings. However, the ultimate responsibility for care in hospitals rests on hospital administrators and physicians. In the rural setting, the Medicare patient's ability to seek a second opinion must be facilitated.

RECOMMENDATION - The HCFA should require that PROs review procedures performed by itinerant surgeons to determine if the quality of patient care is affected because preoperative or postoperative care is not provided by the surgeon. Particular attention should be paid to adverse outcomes related to itinerant surgery.

AGENCY COMMENTS - The HCFA does not agree with this recommendation for the following reasons: (1) Sufficient data does not exist to perform the analysis necessary to justify revising the PRO scope of work and implementing a new review procedure. In addition, under the current review process, PROs review a significant percentage of hospital admissions and intensify review where quality problems are identified. Therefore, any patterns of quality problems with a physician will be identified and resolved, and (2) "Itinerant" surgeons are not identified separately from "non-itinerant" surgeons. PROs would not have the means to identify and focus on these surgeons. Therefore, it would not be feasible to implement this type of review.

OIG RESPONSE - We recognize the efforts now expended by PRO's in their review of rural as well as urban hospitals. However, because of the joint care being provided by itinerant surgery, we continue to believe that a review of all surgeries is warranted. In small hospitals,

it would not be difficult to identify through hospital administration those surgeons who practice itinerant surgery. Also, minimal new review procedure should be required, and local PROs should be aware of itinerant surgeons in their service area.

Recover And Reduce Medicare Overpayments For Postoperative Care Billed But Not Performed By Itinerant Surgeons

RECOMMENDATION - The HCFA should instruct Medicare carriers to recover overpayments from itinerant surgeons identified in this study who billed a global fee but did not provide postoperative care.

AGENCY COMMENTS - The HCFA agreed that overpayments should be recovered where payment was made for services that were not performed. HCFA stated that each affected carrier will be so instructed.

OIG RESPONSE - The OIG will provide a list to HCFA of each affected carrier and the respective names of itinerant surgeons who billed a global fee but did not provide postoperative care.

RECOMMENDATION - The HCFA should instruct all carriers to require the use of procedure code modifier "54" to eliminate Medicare overpayments in cases where itinerant surgeons provided surgery only. The HCFA should also instruct carriers to:

- educate surgeons regarding the use of modifiers for itinerant surgery cases; and

- identify rural hospitals that allow itinerant surgery. All claims for surgery performed in these rural hospitals by itinerant surgeons should be reviewed to determine the extent of itinerant surgery and the billing of global fees including the use of the modifier "54." Action should be taken to recover any incorrect payments identified.

AGENCY COMMENTS - The HCFA agreed that the use of modifier "54" is important in cases where itinerant surgeons provide surgery only and they are reminding all carriers of the use of all CPT-4 modifiers as part of the 1989 HCFA Common Procedure Coding System update.

OIG RESPONSE - We are pleased that HCFA concurs with the importance of modifiers when only a portion of services represented by a global fee are performed, and that HCFA is reminding carriers of the use of modifiers. However, in their comments, HCFA failed to address the remaining parts of the recommendation. The OIG continues to recommend that HCFA instruct carriers to educate surgeons regarding the use of modifiers. In addition, claims for itinerant surgery should be reviewed to detect global fee problems and recover any incorrect payments.

RECOMMENDATION - The HCFA should develop guidelines regarding the percentage allocation of global fees for surgery and postoperative care. These guidelines would provide criteria for consistent claims adjudication, and should be disseminated nationwide.

AGENCY COMMENTS - The HCFA stated "As part of our effort to develop a uniform definition of services, as required by section 4055(a)(2) of the Omnibus Budget Reconciliation Act of 1987, we are considering establishing a uniform reduction in the global charge where the surgeon does not perform the postoperative care."

OIG RESPONSE - We are pleased that the HCFA is taking action to identify mechanisms pertinent to implementing this recommendation.

RECOMMENDATION - The HCFA should review the issue of limited postoperative care and consider whether policy should be established to determine a minimal level of postoperative care which would justify payment of a global fee.

AGENCY COMMENTS - The HCFA stated that they will consider the need for a minimum standard for postoperative care before a global charge is recognized.

OIG RESPONSE - We are pleased that HCFA's comments reflect a positive response. We believe a national definition of the care which must be rendered to justify postoperative payments is clearly needed.

GENERAL AGENCY COMMENTS

The HCFA stated that although the OIG provided percentages and several examples to demonstrate poor quality of care, it did not present the report in a manner which would permit them to fully analyze its results. The HCFA also stated that the meaning of the statement "the adverse outcome was aggravated by the itinerant surgery" was not explained. In addition, HCFA suggested that it would be very useful to have the quality of care problems further defined by the actual type of problems and severity. A copy of HCFA's comments is included in appendix VI.

OIG RESPONSE - We appreciate HCFA's comments regarding the content and presentation of this report. The quality of care findings in this report are based on the results of analysis of itinerant surgery cases by the medical review contractor. Their analysis included the use of some descriptive terms, e.g. "cases had adverse outcomes" and "aggravated by itinerant surgery" that described the severity of poor quality of care. The medical contractor was not asked to describe each identified finding by the specific type of problem. We believe this report includes sufficient descriptions and case examples of poor quality care to support our conclusions.

Health Organization Comments

The OIG issued the draft inspection report on "Itinerant Surgery" to six health organizations for comments, with responses received from the American Hospital Association and the American Academy of Family Physicians. Copies of the comments are included in appendix VI. The remaining four organizations did not respond. The following is a summary of the comments received from the American Hospital Association and the American Academy of Family Physicians.

The American Hospital Association commented, regarding our sampling methodology, that broad conclusions were inappropriately drawn from a small sample and that data from this study was inappropriately compared to data from an earlier unrelated study. The American Hospital Association did not agree with the recommendation regarding the PROs review of itinerant surgery procedures and the recommendation on second opinions for itinerant surgery. However, the American Hospital Association said on the whole the recommendations in the report seem quite sensible. Specifically, the American Hospital Association agreed with the recommendation that rural physicians and hospital administrators develop procedures to ensure pre- and postoperative care and to improve communication between the attending physician and the itinerant surgeon. This recommendation agrees with a document prepared by the American Hospital Association called "Guidelines-Credentialing of Outreach Surgeons," which was sent to all Association members during 1988 and was included as attachment A with the Association comments (see appendix VI). In addition, the American Hospital Association is in agreement with the report recommendations dealing with the recovery of overpayments and instructions to Medicare carriers and physicians regarding the use of modifiers for improved billing procedures.

The American Academy of Family Physicians questioned the extent of the quality problems related to itinerant surgery because of the small number of cases reviewed, the absence of a control group and medical criteria to support judgements, and whether the medical reviewers were, in fact, true peers of the physicians being reviewed.

In general however, the American Academy of Family Physicians indicated agreement with the report recommendations. Their comments, in part, states that "protocols to assure quality care and optimal outcomes when outreach surgery is performed should be instituted in all hospitals where these services are performed." The Academy also worked closely with the American Hospital Association to develop the guidelines contained in appendix VI of this report.

In other areas, the American Academy of Family Physicians supports the education of all the physicians involved in itinerant surgery in regard to the use of modifiers. The Academy also indicated that HCFA should oversee the uniform application of modifier "54" by all carriers including the education of physicians regarding the proper use of pertinent modifiers.

OIG RESPONSE - We appreciate receiving comments to the program inspection report from organizations that are so important to medical care today such as the American Hospital Association and the American Academy of Family Physicians.

In their comments both organizations shared a concern that conclusions were reached from a small sample of surgical cases. The design and methodology for this inspection, as for all program inspections, are approved by OIG statistical staff to ensure accuracy and consistency of the inspection process. The conclusions or findings in this particular study are based on the analysis of facts and data drawn from valid random samples.

APPENDIX I

Sampling Methodology

Universe of Hospitals

1328 – rural hospitals identified nationwide, 50 beds or fewer, and not located in metropolitan statistical areas

Sample of Hospitals

72 – hospitals selected at random and contacted to determine if itinerant surgery was performed in the facility

52 – hospitals dropped from sample of 72

- 11 *no surgery was performed in the hospital*
- 41 *no itinerant surgeon(s) used or no major surgery was performed in the hospital*

20 – hospitals located in 14 States identified with at least 1 itinerant surgeon

Admissions

243 – admissions identified at the 20 hospitals using the 12 most common surgical diagnosis-related groups (DRGs) in rural hospitals

1 – admission dropped from the sample (only case at that hospital and carrier)

242 – total number of hospital admission records reviewed to determine frequency of itinerant surgery

65 – records dropped (surgery performed by local surgeon or attending physician)

Itinerant Surgery Cases

177 – records of itinerant surgery

16 – records excluded from further review (itinerant surgeon provided complete postoperative care)

Payment Histories

161 – beneficiary payment histories reviewed (from 12 carriers) for global fee billings and use of modifier "54"

9 – records excluded from further review (itinerant surgeon billed using a modifier "54")

Medicare Overpayment

152 – global fee paid for no or limited postoperative care

113 – no postoperative care

39 – limited postoperative care (not included in overpayment calculation)

APPENDIX II

Data Elements

I. IDENTIFICATION/DEMOGRAPHIC ELEMENTS

A. Unique Number:

B. HIC Number:

C. Date of Surgery:

D. Age:

E. Race:

F. Sex:

G. Length of Stay:

1. Preop length of stay:

H. Preoperative Physician:

I. Surgeon:

J. Postoperative Physician 1:

K. Postoperative Physician 2:

L. Postoperative Physician 3:

M. Discharge Status:

1. Alive at discharge? *(Y/N)*
    a. *Transferred to other hospital? (Y/N)*
    b. *Transferred to swing bed? (Y/N)*
    c. *Transferred to skilled care facility? (Y/N)*
    d. *Transferred to nursing home? (Y/N)*
    e. *Transferred to other facility? (Y/N)*
    f. *Transferred home? (Y/N)*

2. Expired? *(Y/N)*

II. QUALITY OF CARE ELEMENTS

A. Preoperative:

1. Indication for surgery:
    a. *Documented? (Y/N)*
    b. *Valid indication? (Y/N)*
    c. *Elective? (Y/N)*
    d. *Contraindication? (Y/N)*

    Statement of contraindication:
    i. *By attending? (Y/N)*
    ii. *By surgeon? (Y/N)*
    iii. *By other? (Y/N)*

2. Surgical note before anesthesia:
    a. *Present? (Y/N)*
    b. *Adequate? (Y/N)*

3. Surgical clearance:
    a. *Present? (Y/N)*
    b. *Adequate? (Y/N)*
    c. *By attending? (Y/N)*
    d. *By surgeon? (Y/N)*
    e. *By other? (Y/N)*

4. Preoperative workup:
    a. *Adequate? (Y/N)*
    b. *By attending? (Y/N)*
    c. *By surgeon? (Y/N)*
    d. *By other? (Y/N)*

5. Was surgery appropriate to setting? *(Y/N)*

B. Postoperative:

1. Frequency of surgical follow-up:
    a. *Day of surgery only? (Y/N)*
    b. *Day after surgery only? (Y/N)*
    c. *Approximately once per week? (Y/N)*
    d. *Approximately twice per week? (Y/N)*
    e. *Daily? (Y/N)*
    f. *None? (Y/N)*
    g. *Other? (Y/N)*

2. Frequency of attending follow-up:

   a. *Day of surgery only? (Y/N)*
   b. *Day after surgery only? (Y/N)*
   c. *Approximately once per week? (Y/N)*
   d. *Approximately twice per week? (Y/N)*
   e. *Daily? (Y/N)*
   f. *None? (Y/N)*
   g. *Other? (Y/N)*

3. Adverse outcome? (Y/N)

   a. *Related to surgery? (Y/N)*
   b. *Aggravated by itinerant surgery? (Y/N)*
   c. *Who responded:*

      i. *Attending? (Y/N)*
      ii. *Surgeon? (Y/N)*
      iii. *No one? (Y/N)*
      iv. *Other? (Y/N)*

III. A. Reviewer
B. Date Reviewed

APPENDIX III

Provider Itinerant Surgery Cases with Findings

Provider	*Number of Surgeries by an Itinerant Surgeon*	*No Preoperative Evaluation*	*No Postoperative Examination*	*Adverse Outcome*	*Poor Quality*
A	34	5	33	3	12
B	1	0	0	0	0
C	9	6	1	2	2
D	17	9	1	4	2
E	0	0	0	0	0
F	8	1	4	0	2
G	5	4	4	1	4
H	11	0	11	2	3
I	2	2	2	2	1
J	3	0	0	1	0
K	14	0	5	5	6
L	28	2	24	1	1
M	3	0	2	1	2
N	9	0	8	1	0
O	3	0	3	0	0
P	1	1	1	0	0
Q	18	6	17	2	11
R	0	0	0	0	0
S	11	5	0	4	1
Totals	**177**	**41**	**116**	**29**	**47**

APPENDIX IV

Methodology to Calculate Overpayments

A program overpayment of $15,387 exists for the 113 cases reviewed for the period of the study where the surgeon billed a global fee and provided no postoperative care. Program savings of $289,927 were projected for the nation. These calculations were made as follows:

Program Overpayments

- The global-fee allowable charge on each case was adjusted based on the global-fee split used by the applicable carrier. The global-fee split is a percentage reduction of the allowable charge. For example, a global fee of $100 for only the surgery using a 80/20 global-fee split would result in an allowable charge of $80, which would be subject to the 20 percent coinsurance amount due from the Medicare beneficiary.

- Four carriers stated they used an 80/20 global-fee split, and two carriers stated they used a 70/30 split. The remaining carriers stated they either did not recognize the use of modifiers or did not have a global-fee split. For these carriers, a split of 80/20 was used for calculations.

- Once the allowable charge was adjusted for each case, a new payment amount was determined. The overpayment is the difference between the original payment and the revised payment amount.

Program Savings

- The national projection of savings is based on a random sample of 1,328 rural hospitals. The inspection found that itinerant surgery is performed in 28 percent of the sample hospitals. The projection is computed only on those cases where the itinerant surgeon did not provide postoperative care, but billed a global fee. The projected savings would be larger if the cases involving limited postoperative care were included.

APPENDIX V

Carrier Use Of Modifier "54" And Global Fee Data

	A.	B.	C.
Carrier	*Use of Modifier 54 (Surgery Only)*	*Postoperative Days Included in the Global Fee (1)*	*Global Fee Surgery/Postoperative Percentage Allocation*
A	No	28	N/A (2)
B	Yes	14	80/20
C	Yes	30	N/A
D	Yes	Variable	Variable
E	Yes	Variable	70/30
F	Yes	45	80/20
G	Yes	Variable	75/25
H	Yes	14	80/20
I	No	10	N/A
J	Yes	Variable	70/30
K	Yes	14	N/A .
L	Yes	14	80/20

(1) With some carriers, the allowance for postoperative days may depend on the surgical procedure code billed to the Medicare program. With those carriers, the postoperative days vary from one procedure to another.

(2) "N/A" (not applicable) applies to those carriers which either do not use a modifier (carriers A and I) or make an adjustment after reviewing charges instead of using a percentage allocation of the global fee (carriers C and K).

APPENDIX VI

Text Of Comments On The Draft Report

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

JAN 3 1989

Memorandum

Date

From William L. Roper, M.D.
Administrator

Subject OIG Draft Report: Itinerant Surgery - OAI-07-88-00850

To The Inspector General
Office of the Secretary

We have reviewed the OIG draft inspection report which examined the extent to which rural hospitals utilize itinerant surgeons, the potential impact of itinerant surgery on quality of care, and the billing practices of itinerant surgeons.

In the interest of clarity, we are submitting our comments to each recommendation in an attachment.

Thank you for giving us the opportunity to comment on this draft report.

Attachment

Health Care Financing Administration
Comments on the OIG Draft Report
"Itinerant Surgery"
OAI-07-88-00850

Recommendation 1:

Rural physicians and hospital administrators should develop and monitor implementation of procedures to ensure adequacy of:

- preoperative workups;
- the patients' opportunity to seek a second opinion;
- postoperative plans of care; and
- postoperative communication between the attending physician and the itinerant surgeon.

HCFA Comments:

While this recommendation is not directed at the Peer Review Organization (PRO) program, it should be noted that the PROs currently review to ascertain that care delivered to Medicare beneficiaries in both urban and rural settings meets acceptable standards. (This includes preadmission/admission workups and discharge planning.) In addition, the patient, like all Medicare beneficiaries, can seek a second opinion under Medicare's voluntary second opinion program.

Recommendation 2:

The HCFA should require that PROs review procedures performed by itinerant surgeons to determine if the quality of patient care is affected because preoperative or postoperative care is not provided by the itinerant surgeon. Particular attention should be paid to adverse outcomes related to itinerant surgery.

HCFA Comments:

We do not agree with the recommendation that HCFA require PROs to review procedures performed by itinerant surgeons for the following reasons.

(1) We do not have sufficient data to perform the analyses necessary to justify revising the PRO scope of work and implementing a new review procedure. While the OIG indicates that they identified a significant number of quality problems, we have no indication as to the severity and type of quality problem. PROs already review a significant percentage of hospital admissions and intensify review where quality problems are identified. Therefore, under the current PRO review process, any patterns of quality problems with a physician will be identified and resolved.

(2) "Itinerant" surgeons are not identified separately from "non-itinerant" surgeons. PROs would not have the means to identify and focus on these surgeons. Therefore, it would not be feasible to implement this type review.

Recommendation 3:

The HCFA should instruct Medicare carriers to recover overpayments from itinerant surgeons who billed a global fee but did not provide postoperative care.

HCFA Comments:

We agree that overpayments should be recovered where payment was made for services that were not performed. Each affected carrier will be so instructed.

Recommendation 4:

The HCFA should instruct all carriers to require the use of procedure code modifier 54 to eliminate Medicare overpayments in cases where itinerant surgeons provided surgery only.

HCFA Comments:

We agree that the use of modifier 54 (Surgical Care Only) is important in cases where itinerant surgeons provided surgery only. Additionally, the appropriate use of modifiers 52 (Reduced Services), 55 (Postoperative Management Only) and 56 (Preoperative Management Only) will alert carriers to situations requiring adjustments to a global allowance. We are reminding carriers of the use of all CPT-4 modifiers as part of the 1989 HCFA Common Procedure Coding System update.

Recommendation 5:

The HCFA should develop guidelines regarding the percentage allocation of global fees for surgery and postoperative care. These guidelines would provide criteria for consistent claims adjudication, and should be disseminated nationwide.

Recommendation 6:

The HCFA should review the issue of limited postoperative care and consider whether policy should be established to determine a minimal level of postoperative care which would justify payment of a global fee.

HCFA Comments to Recommendations 5 and 6:

As part of our effort to develop a uniform definition of services, as required by section 4055(a)(2) of the Omnibus Budget Reconciliation Act of 1987, we are considering establishing a uniform reduction in the global charge where the surgeon does not perform the postoperative care. We will consider the need for a minimum standard for postoperative care before a global charge is recognized.

General Comments:

The OIG provides general percentages of "cases with poor quality care," "cases with adverse outcomes," "cases where the adverse outcome was aggravated by the itinerant surgery," and "cases of elective surgeries found to be contraindicated." While they provide several examples to demonstrate poor quality care, they do not present the report in a manner which would permit us to fully analyze their results. For example, a case can have an adverse outcome without poor quality care, so the point that 16.3 percent of the cases had adverse outcomes is not meaningful.

The OIG also states that in 10 cases, the adverse outcome was "aggravated by the itinerant surgery." However, the meaning of this statement is not explained. It would be very useful to have the quality problems further defined by the actual type of problem and severity, i.e., how many were documentation problems; how many were unnecessary surgery; how many were poor surgical techniques; and what was the severity level of the quality problem.

American Hospital Association

AHA

840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone 312.280 6000
Cable Address AMHOSP

To call writer, telephone

December 16, 1988

Richard P. Kusserow
Inspector General
Office of Inspector General
HHS North Building, Room 5250
330 Independence Avenue, S.W.
Washington, DC 20201

re: Draft report on Itinerant Surgery #OAI-07-88-00850

Dear Mr. Kusserow

On behalf of its nearly 6,000 institutional members, the American Hospital Association appreciates this opportunity to comment on the draft report, "Itinerant Surgery", which was prepared by the Inspector General's Office of Analysis and Inspections.

We have reviewed the report carefully, and agree with the report recommendation calling for hospital internal procedures to ensure adequacy of pre and post operative care and improved patient/physician and physician/surgeon communication. This recommendation is in concert with the attached guidelines for the credentialing of outreach surgeons which were recently developed and sent by the AHA to all member hospitals. We also support recommendations which would correct apparent disparities in the billing rules established by fiscal intermediaries.

We do not, however, support the recommendation which calls for a separate or distinct review of itinerant surgical procedures. Itinerant surgery should be subject to review within the same parameters as any surgical procedure performed within the local hospital.

Nor do we agree with the recommendation calling for mandated second opinions on itinerate surgery. The methodology used in conducting the survey, which is the basis of the findings and these particular recommendations, is seriously flawed. Broad conclusions are inappropriately drawn from an extremely small survey sample, and data from this study are inappropriately compared to data from an earlier unrelated study. Moreover, the study only focused on potential adverse outcomes; there was no attempt to identify and report on positive results which would have provided a balanced perspective.

Setting aside the methodological problems, the report generally presents a balanced discussion of differing opinions of itinerant surgery by various professional groups. Even here, however, the report lacks major contextual elements. It does not address the frequency of this practice by rural hospitals on either a nationwide or regional basis, which was one of the stated objectives for the study. Nor does it address the value of the practice in terms of cost or in meeting the psycho-social needs of an elderly,

less mobile rural population. Finally, it does not discuss the impact on rural populations, communities, and hospitals if the practice were not available.

The decision on whether to offer itinerant surgery as an alternative to out-of-area care is one that should be made by rural hospitals and their communities. If offered, it is important that hospitals ensure the quality of this service, as well as determine and apply appropriate criteria for credentialing the physicians and surgeons who provide the service. It is important that hospitals and physicians receive clear instructions regarding physician billing modifications to reflect this practice.

We hope these comments will provide a useful perspective. If you have any questions, please address them to Syl Boeder (312/280-6442) in our Chicago office or to Milton Dezube (202/638-2318) in our Washington Office.

Sincerely

Carol M. McCarthy

Carol M. McCarthy, Ph.D., J.D.

cc: James Wolf
Regional Inspector General

Comments
Draft Report on
Itinerant Surgery
by the Office of Inspector General

American Hospital Association
December 1988

The American Hospital Association, on behalf of its nearly 6,000 hospital members, welcomes this opportunity to submit comments on the HHS Office of Inspector General's draft report on Itinerant Surgery. Comments are organized according to the subheadings that appear in the report.

OBJECTIVES

Our primary concern is related to the degree to which the stated objectives are actually addressed in the final report. We find no evidence that any substantive ~~information~~ in the report addresses the frequency of itinerant surgery in rural hospitals throughout the nation. Nor does the report indicate any variation in frequency of the practice from region to region which might assist in identifying regional practice patterns and their impact on billing or payment mechanisms.

In assessing itinerant surgery, a more balanced perspective which also presents positive aspects of this practice (particularly in areas of the country where it is the only option because of distance or lack of local physicians) would be helpful. The extreme limitations of the small study sample also preclude making generalized statements of broad applicability regarding quality, billing practices, and the relationship between itinerant surgery and quality of care.

BACKGROUND

While the report presents a balanced discussion of varying positions on appropriateness of itinerant surgery, it fails to address the impact on rural populations and hospitals if the practice was not available. In correctly identifying sparse, rural populations as users of this service, no information was included regarding alternatives to itinerant surgery that might be available, at what distance and cost. To many elderly rural residents, the psycho-social aspects of receiving care close to home and family weigh heavily in their choice to seek care locally.

The discussion regarding surgical coding procedure requirements indicates considerable variation in billing requirements by fiscal intermediaries. There is, however, no information regarding such differences in coding requirements which would have affected the billing for the specific procedures reviewed in this report.

METHODOLOGY

Given the universe of 1,328 rural hospitals with fewer than 50 beds, the size of the random sample selected (72 hospitals) seems unrealistically small in structuring a report which seeks to provide broad findings on the practice of itinerant surgery throughout the country. The further narrowing of the sample through removal of those hospitals in which no itinerant surgery was performed has reduced an already small sample by over seventy-two percent, to a mere nineteen hospitals. It is necessary, therefore, to question the generalizing of findings based on such a narrow field of study.

In January, 1988, the American Hospital Association submitted a letter to the Regional Office of the Inspector General requesting clarification of the qualifications of individuals who would conduct the review of medical records, as well as the criteria and methodology which would be used to conduct the review. We find no indication in the draft report that reviewers were familiar with small rural hospital operational capabilities, practitioner arrangements or resource availability. Nor do we find evidence that the study incorporates adequate consultation with physicians involved in the particular cases under consideration. This lack of evidence raises questions regarding findings based solely on charting and coding which may be inadequate, rather than on additional and substantive information as to the quality of care provided. A statement on page 5, "The scope of review did not include a review of patient visits, if any, to the surgeon's office after the hospital discharge." is indicative of the absence of additional data which might affect the outcome of the survey For example, a lack of information on pre-operative workup in the inpatient chart may be due to the fact that the patient was originally seen in an outpatient setting, perhaps in the physician's office. The same could be true of post operative notes, particularly if the procedure was done as same day or outpatient surgery. In this instance, the physician could have clarified a circumstance which would not have been apparent from a review of written material. Furthermore, the lack of communication between reviewing physicians and the physicians who provided the care —a standard element of peer review protocols— leaves open the question of the degree to which many of the quality problems cited were a function of inadequate charting or of inadequate care.

The secondary methodology which involves the use of a separate study conducted for an entirely different purpose (The National DRG Validation Study) is also a cause of concern. There is certainly question as to the comparability of findings based on a sample preselected for an entirely different purpose. In addition, the problem of small numbers again presents itself, as a universe of 7,050 records is narrowed to thirty surgical cases deemed comparable to those used in the itinerant surgery study. To establish a comparative percentage of poor quality care determined by one case in thirty also brings into question the validity of using the National DRG Validation Study Sample.

FINDINGS

SOME RURAL HOSPITALS MAKE EXTENSIVE USE OF ITINERANT SURGERY

This statement, which opens the Findings section of the report (page 6), is

inappropriately broad when considered in light of the supporting data. It should be clarified to indicate that while 28 percent of the hospitals in the survey sample reported the use of itinerant surgery, only seven hospitals (10 percent) used it extensively. These seven hospitals account for 134 of the 177 itinerant surgery procedures included in the data set.

MANY RURAL HOSPITALS SEE ITINERANT SURGERY AS A COST-EFFECTIVE MEANS OF PROVIDING NEEDED SURGERY WHICH MIGHT NOT OTHERWISE BE AVAILABLE IN SOME RURAL AREAS

The discussion which follows this statement (FINDINGS, p.7) is supported by comments to the American Hospital Association by members of the AHA's Section for Small or Rural Hospitals. However, any study of rural health care options needs to be a sensitive to the unique aspects of the rural environment, particularly in these regions of the United States where access to health care is affected by geography, weather or sparseness of the population. This sensitivity could be maintained by using reviewers who are familiar with practice patterns, resource and manpower constraints common in rural areas. The report should also address the issue in a manner that reflects the full context of rural health delivery.

- What would be the impact on the quality of rural medicine if itinerant surgery was not an option?
- What would be the impact on cost of care if patients could not be treated in the rural setting?
- What would be the individual social and economic impact if rural patients, particularly the rural elderly, needed to be transferred to hospitals outside the local community?

NEVERTHELESS, THERE IS A HIGHER-THAN-AVERAGE RISK OF POOR QUALITY CARE IN ITINERANT SURGERY

This statement (Findings, p. 8) raises questions as to the validity of equating poor quality with the itinerant nature of the surgery, especially since the report state. that no comparable data exists for a related population (i.e. surgical cases in small rural hospitals performed by local surgeons) to determine if itinerant surgery alone accounts for adverse outcomes (Findings, p. 11).

The examples which are included cite instances of poor quality care. Poor quality care is inappropriate and should not be defended. However, the report does a poor job of presenting the findings in a balanced fashion. For example, this discussion gives the impression that there consistently was a higher than usual level of poor quality in hospitals using itinerant surgery, leaving buried in an appendix the fact that one-half of the 47 cases involving poor quality occurred in only 2 of the 19 studied providers. Furthermore it is unclear that the quality of care is a result of the itinerant nature of the practice. Poor quality care is unacceptable in any setting and should be addressed by each hospital through appropriate credentialing, quality assurance, and peer review. It is unfortunate, however, that no examples of good quality care were cited in the report to give some perspective on this issue.

OVERALL QUALITY OF CARE WAS SIGNIFICANTLY WORSE IN THESE CASES THAN IN A RANDOM SAMPLE OF SURGICAL CASES IN SMALL RURAL HOSPITALS

We again maintain the inappropriateness of using an unrelated study as a basis of comparison, and question the validity of such comparisons when small numbers are translated into percentages (one case in thirty = 3.3%) and compared under a nebulous heading such as Poor Quality Care or Good Quality Care.

Qualifying statements are included within the text of the report, but are ignored in making generalized statements of findings. Broad statements are unsupported by the data which has been presented. Two examples follow:

> "Although not directly attributed to itinerant surgery, poor quality of care occurred usually with the findings of no preoperative care, no post operative care, and/or an adverse outcome with the itinerant surgery cases in this inspection.", (Findings p. 12) [emphasis added]

> "In summary, this comparison indicated that itinerant surgery may result in poor quality of care delivered in hospitals that use itinerant surgeons."(Findings p. 13) [emphasis added]

The section of the report dealing with findings about payment indicates the need for uniform coding requirements which are known to participating physicians, and the need to address a lack of common policy regarding post operative days or amounts covered by a global fee.

RECOMMENDATIONS

The recommendations seem on the whole quite sensible. If a hospital chooses to provide itinerant surgery as an option which broadens choice and meets the needs of its constituents, that hospital has the responsibility to monitor the quality of care of those services —in this case, consistent and within the scope of policies which govern the provision of all surgical services within the institution. The American Hospital Association finds the recommendations regarding implementation of procedures to ensure adequacy of preoperative workups, post operative care plans, and post operative communication between the attending physician and the itinerant surgeon to be in concert with our "Guidelines - Credentialing of Outreach Surgeons," which were distributed to all AHA members earlier this year (see Attachment A).

The methodology PROs will use to review surgical procedures should be more clearly defined, and should be governed by criteria which take into account the appropriate standards of medical practice and operational capabilities of

rural hospitals of this size. The use of flawed methodology within this survey also invalidates conclusions that result in recommendations for a separate or distinct review of itinerant surgical procedures by PROs. These procedures should be reviewed within the same parameters as any surgical procedures performed within the hospital. In addition, methodological flaws preclude any recommendation regarding second opinions. While patients should be made aware of such an option, it must be recognized that the option may not be locally available, particularly if the community needs to rely on itinerant surgeons. Patients who opt for local surgery may be unable to leave the community for a second opinion.

In addressing post operative care, it should be noted that complications are usually chronic medical conditions exacerbated by surgery and/or anesthesia and are often more appropriately managed by internists, family practitioners or subspecialists. Surgeons usually restrict themselves to managing problems at the operative site.

The recommendation to recover overpayments is appropriate and the recommendation to instruct carriers and participating physicians in the use of appropriate coding should help dispel confusion and misinformation about billing procedures.

CONCLUSION

The American Hospital Association is grateful for the opportunity to review and comment on this draft report. We take no significant issue with its recommendations; however, we wish to state our concern with the overstatements in the findings which are based on a methodology which extrapolates a very narrow sample into broad statements of findings.

As evidenced by the development and issuance of our own guidelines, the American Hospital Association and its members are committed to ensuring the availability of high quality care in rural communities. If we can be of any further assistance, please contact Syl Boeder (312/280-6442) in our Chicago office or Milton Dezube (202/638-2318) in our Washington Office.

AHA

Guidelines

Credentialing of Outreach Surgeons*

This guideline document is intended to provide general advice to the membership of the American Hospital Association.

Introduction

For many years, society in general and the health care industry in particular have acknowledged that the delivery of medical care must meet the needs and desires of the community being served while maintaining appropriate standards of care. In many rural areas elective surgical procedures are performed by surgeons who commute from more populated areas. They may delegate postoperative care and selected aspects of preoperative care to other physicians. This practice is often called outreach surgery. When done appropriately, it provides a valuable and sometimes necessary service that a community would not otherwise have.

This document offers guidance to hospitals and their medical staffs to assist them in promoting high-quality medical and surgical care that can be provided by outreach surgeons.

Guidelines

Outreach surgeons should be credentialed in the same manner as all other medical staff members. The information on their applications for staff appointment should be verified, and they should be evaluated for reappointment at least every two years. The clinical privileges granted to them should correlate with their residency training and should not exceed the privileges granted to them at their primary institutions. Privileges should be evaluated at least every two years and should reflect an assessment of the practitioner's expertise and ability. Morbidity and mortality studies, comparison of preoperative and postoperative diagnoses, rehospitalization rates, blood use, emergency room return visits, and transfer rates are examples of clinical indicators that might be included in the review of the surgeon's practice patterns.

The types of procedures appropriate for outreach surgery should be determined, with board approval, by the medical staff and hospital executive management. Consideration should be given to the degree of sophistication of the support services, anesthesia capabilities, and technology available within the facility and the expertise and experience of the surgeon, the anesthetist, and the postoperative care givers.

Specific requirements that relate to the outreach surgery, such as responsibility for case selection, identification of attending physicians for postoperative management, routine and emergency orders, scope of privilege, transfer protocol, etc., should be defined in the medical staff rules and regulations. The surgeon's responsibilities to the medical staff organization, such as participation on medical staff committees, should be proportional to the amount of surgical activity performed by the surgeon at the institution.

The outreach surgeon should be included in the preoperative assessment process and should be instrumental in the decision to operate. The surgeon should participate in the determination of the preoperative testing needed for the patient, and the results of all testing should be available for review by the surgeon prior to surgery. The patient should be fully informed of, understand, and approve the conditions under which the procedure will be performed and the postoperative care provided.

The attending physician responsible for postoperative care should be able to treat routine postoperative complications and be experienced in distinguishing which medical and surgical complications require transfer. This physician

*These guidelines do not constitute an AHA policy on outreach surgeons. They were developed by the American Hospital Association's Division of Medical Affairs to assist member hospitals with outreach surgery programs to establish institutional protocols on credentialing and quality assurance. The AHA recognizes that the practice of outreach surgery is controversial and is, in fact, opposed by the American College of Surgeons.

This document was developed at the request of the American Hospital Association's Section for Small or Rural Hospitals and has been approved by that section's governing council, the AHA Committee on Hospital Medical Staffs, and the AHA Institutional Practices Committee. The guidelines are intended to assist hospitals and their medical staffs in the credentialing and subsequent assessment of care provided by outreach surgeons. This document was approved by the AHA Board of Trustees on August 9, 1988.

should be identified when the procedure is scheduled and should be available for the duration of the hospital stay.

Explicit postoperative orders as well as operative reports should be completed by the surgeon before leaving, and the surgeon should be available by phone to consult on difficulties if the need arises. A mechanism for transferring patients whose condition appears to require resources not available at the hospital should be in place and well understood by the hospital staff.

The entire process—assessment of preoperative judgment, intraoperative skill, and postoperative management—should be included in the hospital's quality assurance program, and the findings should be evaluated along with other factors at the time of reappointment and privilege review. Any adverse findings should be evaluated by the medical staff, and appropriate action should be taken when warranted. The action may be a restriction of privileges or revocation of staff appointment. Regardless of the action taken, the fair hearing procedures outlined in the medical staff bylaws must be followed.

Conclusion

A hospital offering outreach surgery is responsible for assuring that high quality is provided by outreach surgeons. Implementation of these guidelines, as a whole, will help to promote high-quality outreach surgery. Credentialing and appropriate limits on clinical privileges, scrutiny to determine what types of surgery are appropriate for an institution's outreach surgery program, and clearly-defined and well understood preoperative and postoperative procedures and requirements are all essential to assuring high-quality outreach surgery services.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

8880 WARD PARKWAY KANSAS CITY, MISSOURI 64114-2797

OFFICE OF THE PRESIDENT
JAMES G. JONES, M.D.
DEPARTMENT OF FAMILY MEDICINE
SCHOOL OF MEDICINE
BRODY 4N64
EAST CAROLINA UNIVERSITY
GREENVILLE, NORTH CAROLINA 27858-4354

December 23, 1988

Mr. Richard P. Kusserow,
Inspector General
Department of Health & Human Services
Washington, DC 20201

Dear Mr. Kusserow:

The American Academy of Family Physicians greatly appreciates the opportunity to review and comment on your office's draft report on "Itinerant Surgery". Known as "Outreach Surgery" to the Academy, it has been an issue that has received a considerable amount of attention and resources from the Academy in recent years. Included in Attachment A are a definition and policy of "outreach surgery" as approved by the Academy's Congress of Delegates in 1987.

Academy staff has carefully reviewed your report and concurs that the results raise concerns regarding the quality of outreach surgery that require further analysis and appropriate action. The Academy questions the extent of the quality problem in outreach surgery as reported in your study for the following reasons:

(1) the small number of outreach surgical cases reviewed;

(2) the absence of a control group;

(3) the absence of criteria upon which medical judgments regarding "adequacy" and "appropriateness" were determined, and;

(4) the qualifications of the reviewers and whether they were true peers of those being reviewed.

In the absence of an appropriate control, it is difficult to ascertain whether the large number of adverse outcomes are directly related to "itinerant surgery" or other physician, hospital or patient factors. This deficiency in the study requires additional study to validate the results.

The Academy's policy on peer review states, in part, that "clinical policies in patient care should be established by practicing physicians and based upon needs appropriate to the local area. Local circumstances and considerations such as

those frequently found in inner city or rural areas may modify final interpretations as to whether or not a standard of care is met." The qualifications of the reviewers and the selection of criteria upon which the medical judgments are made should be made explicit in describing the peer review process.

In spite of these deficiencies in the study design, it is unlikely that all adverse outcomes are unrelated to deficiencies in the outreach surgery process. Protocols to assure quality care and optimal outcomes when outreach surgery is performed should be instituted in all hospitals where these services are performed.

To that end, the Academy has encouraged and worked closely with the American Hospital Association to develop guidelines for "Credentialing of Outreach Surgeons" (see Attachment B). The guidelines address, and in some cases exceed, the recommendations contained in your report to establish institutional protocols on credentialing and quality assurance for outreach surgery. The Academy actively supports implementation of these guidelines which address credentialing and clinical privileges, selection of outreach surgical cases, and pre and postoperative protocols to assure high quality outreach surgery services.

The Academy also agrees with and supports the need to clarify proper coding, by all physicians involved, when outreach surgery is performed. Uniform application of the "54" modifier by all carriers and education of physicians regarding its proper use should be encouraged by HCFA.

Again, thank you for the opportunity to comment on this important report while still in its draft form. The appropriate body within the Academy structure is meeting in mid-January and it will further discuss the draft report. Any additional comments/suggestions will be forwarded to you at the conclusion of that meeting. The Academy would welcome the opportunity to work with the appropriate individuals from your office in further studying the issue or designing programs to assure ongoing access to high quality outreach surgery for Medicare beneficiaries.

Sincerely,

Robert Graham, M.D.

JAS/RG:dab

Attachments

SUBSTANCE ABUSE (Continued)

Treatment Programs (Continued)

(b) Acceptable to the impaired physicians program of the state in which the impaired physician practices.

Programs providing treatment should:

(a) Be duly licensed, and

(b) Meet accreditation requirements of the state physicians committee and/or the Joint Commission on Accreditation of Healthcare Organizations for psychiatric facilities (in states without impaired physicians programs). (1987)

SURGERY

Office-Based

The AAFP is in favor of surgery performed in the physician's office or other appropriate outpatient facility when the patient's risk will not be increased by doing such without requiring inpatient hospitalization. Under these circumstances, the physician should be reimbursed for overhead costs as well as for professional services. (1982)

Outreach - Definition

The American Academy of Family Physicians defines outreach surgery as surgery performed by a qualified physician/surgeon where the post-operative care and selected aspects of the pre-operative care of the patient are provided by another physician. That other physician is often the patient's family physician. (1987)

Outreach - Policy

The AAFP recognizes the importance of outreach surgery to assure access to health care for rural citizens nationally. As an essential component of care rendered in outreach surgery, family physicians provide high quality pre-operative and post-operative care consistent with their training and experience. The AAFP supports the practice of outreach surgery when coordinated by a team of the patient's family physician and a physician/surgeon, with appropriate coordination of patient care between team members during each phase of surgical care (pre-operative, intra-operative and post-operative). (1987)