Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PREPROCEDURE REVIEW

Richard P. Kusserow
INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this report is to assess the cost-effectiveness of the Medicare Peer Review Organizations' (PROs) current preprocedure review process.

BACKGROUND

In each State, the Health Care Financing Administration (HCFA) contracts with a Utilization and Quality Control Peer Review Organization, commonly known as a PRO, to review the appropriateness and quality of surgery physicians perform on Medicare beneficiaries. The HCFA renews or competitively rebids PROs' contracts on a 3-year cycle. The HCFA administers the Medicare program and has regulatory oversight of PRO activities. As of April 1989 all PROs were operating under the third scope of work.

The Consolidated Omnibus Budget Reconciliation Act of 1985 calls for 100 percent peer review of certain surgical procedures. Under the same Act, the PRO may require a second surgical opinion when it questions the reasonableness and necessity of a proposed surgery. Regulations to implement the second opinion provision are currently being formulated at HCFA.

METHODOLOGY

We obtained HCFA data on the preprocedure reviews PROs conducted under the third scope of work. The data included the total number of requests for preprocedure review, the percentage of denied requests, and the negotiated cost associated with the preprocedure review. We compared this data with the results of a companion OIG study of necessity and quality of outpatient surgery.

We also obtained information from PROs responsible for 28 States representing over 80 percent of both the Medicare physician expenditures and the eligible population. The information requested included total number of preprocedure requests; number of preprocedure requests by procedure; number of requests forwarded to PRO physicians; overall percentage of denied requests; and denial percentage by procedure. We analyzed secondary data on the preprocedure review process and its effectiveness. Finally, we obtained PROs' views on the current preprocedure review process, and suggestions to improve its effectiveness.

FINDINGS

- PRO preprocedure review for cataract extraction is not cost-effective.

Cataract surgery comprises 52 percent of all preprocedure review requests at the PROs surveyed. Last year, we estimated PROs for 17 States representing over half of the Medicare eligible population paid $13.3 million for preprocedure review of cataract surgery. The resulting PRO denials saved only $1.4 million.

Only 0.07 percent of cataract surgeries reviewed by the PROs were denied. By way of contrast, a companion OIG study found, based on a review of records, that 1.7 percent of cataract extractions were not medically indicated.

- The cost-effectiveness of the preprocedure review process is doubtful for other procedures as well.

Last year, the denial rate for all surgery reviewed was 0.15 percent. Even this figure overstates denials based on medical necessity, because it includes technical denials for site of service.

- A targeted, more intensive approach could improve preprocedure review for cataract extraction.

A targeted program would give the PROs the flexibility to perform their review in the way most suited to local conditions and practices. Two-thirds of the PROs stated a limited second opinion program would improve preprocedure review. Most indicated it would be effective for cataract extractions.

- More data could help PROs identify other procedures for a targeted, more intensive review.

The PROs would need local rather than national data to select procedures for a targeted, more intensive review program because practice patterns differ between and within States. Medicare carriers routinely collect provider profile data. The PROs could use such data to focus a targeted program on particular providers, procedures, or geographic areas.

RECOMMENDATIONS

The HCFA should:

- *substitute a targeted, more intensive review for the current mandatory preprocedure review of cataract surgery.*

- *review the current preprocedure review process to determine whether it is cost-effective for other surgical procedures.*

- *continue efforts to implement data exchange between PROs and Medicare carriers.*

HCFA COMMENTS AND OIG RESPONSE

In its comments the HCFA took exception to the finding that PRO preprocedure review for cataract extraction is not cost-effective. The HCFA disagreed with the recommendation to substitute a targeted, more intensive review for the current mandatory preprocedure review of cataract surgery. The HCFA did agree with the other two recommendations and is taking action to address them.

The HCFA did not dispute the fact that preprocedure review for cataract extraction was not cost-effective. It questioned only the negotiated rate used in the calculation. According to HCFA's Health Standards and Quality Bureau, the total cost of a preprocedure review was $25.70. The cost was composed of $9.00 in variable cost and $16.70 in fixed cost. The HCFA stated the national average negotiated rate per review was $9.00 which is only part of the total cost.

The HCFA believes that they have no data to support targeting high volume ophthalmologists. We did not suggest that targeting be based solely on volume. Our examples of targeting options included not only high volume providers but also certain geographical areas as well as random selection. A targeted program would give the PROs the flexibility to perform their review according to local conditions and practices.

The HCFA also suggested that the sentinel effect be considered before implementing targeted reviews. A targeted program such as a second opinion program would still provide a sentinel effect since physicians know that they could face peer review. In fact a targeted program would be more efficient since it would still provide a sentinel effect without doing a 100 percent review.

The full text of HCFA's comments and our detailed responses to them appear in Appendix C.

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INTRODUCTION

PURPOSE

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BACKGROUND

In each State, HCFA contracts with a Utilization and Quality Control Peer Review Organization, commonly known as a PRO, to review the appropriateness and quality of surgery physicians perform on Medicare beneficiaries. The HCFA administers the Medicare program and has regulatory oversight of PRO activities. The HCFA renews or competitively rebids PRO contracts on a 3-year cycle. The PRO contracts are renewed on a staggered basis. However, as of April 1989 all PROs were operating under the third scope of work.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) calls for 100 percent peer review of certain surgical procedures. The COBRA also permits PROs to require a second surgical opinion when it questions the reasonableness and necessity of the proposed surgery. Regulations to implement the COBRA second opinion provision are currently being formulated at HCFA.

Currently, each PRO conducts 100 percent review of 10 different elective surgical procedures prior to surgery to determine reasonableness and medical necessity. The HCFA requires review of cataract extraction and carotid endarterectomy. Each PRO chooses eight other surgical procedures and submits documentation to support these selections. The PRO also reviews 5 percent of the selected procedures retrospectively, verifying the information on which it based its preprocedure determinations.

METHODOLOGY

We obtained HCFA data on the preprocedure reviews conducted under the third scope of work through calendar year 1989. The data included the total number of requests for preprocedure review, the percentage of denied requests, and the negotiated cost associated with the preprocedure review. We compared this data with the results of a companion OIG study of the necessity and quality of outpatient surgery.

We contacted the American Medical Peer Review Association (AMPRA), a trade association which represents PROs, to advise them of our review and solicit their help in facilitating contacts with the PROs.

We obtained data on the preprocedure review process from PROs responsible for 28 States (some PROs have contracts with more than one State). These PROs represent over 80 percent of both Medicare physician expenditures and the Medicare eligible population.

We gathered information from PROs about their preprocedure review process. The data requested included total number of preprocedure requests; number of preprocedure requests by procedure; number of requests forwarded to PRO physicians; overall percentage of denied requests; and percentage of denial rates by procedure. We also analyzed secondary data concerning the preprocedure review process and its effectiveness. Finally, we obtained PROs' views on the current preprocedure review, as well as suggestions to improve its effectiveness.

We did not analyze the deterrent or "sentinel effect" of preprocedure review due to lack of historical data. The sentinel effect causes physicians to recommend fewer unnecessary surgeries because they know their recommendations face peer review. We understand that HCFA is now launching longitudinal studies to evaluate the sentinel effect.

PRO PREPROCEDURE REVIEW PROCESS: OVERVIEW

Surgical procedures

The HCFA instructs PROs to select eight surgical procedures for review (in addition to cataract extractions and carotid endarterectomies) and submit documentation supporting their choices. The PROs select these 8 from a list of 11 procedures provided by HCFA (see Appendix A). The HCFA procedures are based on national data. They are high cost, high volume, or have a high nonconfirmation rate when subject to review. Most are performed on an inpatient basis.

The PROs can, based on supporting documentation and subject to HCFA approval, select procedures not on the HCFA list. However, few PROs have done so.

Review criteria

Each PRO develops review criteria against which it screens preprocedure requests. Typically, PROs develop their criteria in consultation with State medical specialty societies representing the selected procedures. As a result, criteria can vary from State to State.

The PROs submit the criteria to the HCFA regional office, which must review and approve them before they can be used. Once HCFA approves the criteria, the PROs must share them with providers.

Review process

The review process itself does not vary significantly among PROs. Physicians initiate the review process when they recommend a Medicare beneficiary undergo 1 of the 10 procedures for which the PRO requires preprocedure review. Typically, the recommending surgeon, a staff member, or hospital staff, telephones the PRO to review the patient's condition and seek preprocedure approval. Most PROs also accept mail requests and a few accept them via facsimile machine.

Initial review by registered nurses

Registered nurses (RNs) review the initial preprocedure request, comparing the physician's diagnosis and the patient's symptoms against the PRO criteria for that surgical procedure. The RNs can approve the request based on the information the physician (or physician's representative) provides.

However, if the request does not meet the criteria or if the physician proposes a setting the PRO believes is inappropriate, the RN refers the case to the PRO physician advisor for review.

PRO physician review

The PRO physician conducts a second review of the requests which have not met the criteria, often contacting the recommending surgeon to discuss the case further. After the review, the

PRO physician has three choices: approve the procedure for inpatient surgery, approve the procedure for outpatient surgery, or deny the request altogether.

When a PRO approves a preprocedure request, it assigns the case an approval number. When the PRO denies a request altogether, it typically informs both the surgeon and the patient of the decision, the rationale, and an explanation of appeal rights.

Retrospective validation review

The HCFA requires PROs to retrospectively review the medical records from 5 percent of their preprocedure requests on a quarterly basis. The purpose of retrospective review is to verify the PRO's preprocedure determination of medical necessity.

FINDINGS

PRO PREPROCEDURE REVIEW FOR CATARACT EXTRACTION IS NOT COST-EFFECTIVE.

The PROs responsible for 17 States, representing over half of the Medicare eligible population, provided detailed information which clearly demonstrate that preprocedure review for cataract extraction is not cost-effective. (The PROs responsible for the other 11 States in our review did not provide detailed information.) From the beginning of the third contract cycle through January 30, 1990, those 17 PROs processed about 519,000 preprocedure requests for cataract extractions. Only about 370 (0.07 percent) were denied.[1] By way of contrast, a companion OIG study to be released under separate cover found that, based on a review of patient records, 1.7 percent of the cataract extractions were not medically indicated.

Based on a HCFA-negotiated cost of $25.70 per preprocedure review and an average reimbursement amount from a 10-State sample of $3,695 for a cataract extraction, Medicare paid about $13.3 million to save $1.4 million from surgery denials.[2]

Our results are corroborated by a recent study performed in Michigan, which reported the Michigan PRO denied only 14 of 38,008 preprocedure review requests for cataract extractions. This is a denial rate of less than 0.04 percent. According to this study, Medicare spent $980,000 to deny $42,000 worth of cataract extractions.[3]

THE COST-EFFECTIVENESS OF THE PREPROCEDURE REVIEW PROCESS IS DOUBTFUL FOR OTHER PROCEDURES AS WELL.

Our analysis of PRO data indicates very few preprocedure requests are reviewed by PRO physicians, and almost none are denied.

- ***PROs deny fewer than 15 out of each 10,000 preprocedure requests. Some of these are technical denials.***

  Virtually all PROs have denied less than 1 percent of their preprocedure requests since the third contracts began (see Appendix B). The overall denial rate is 0.15 percent, but even this rate is misleading, because it includes technical denials for site of service. While we did not determine the actual number of technical denials, we were told by a number of PROs that many of their denials were for site of service.

  The overall denial rate for the third PRO contracts' review of 10 procedures has dropped since the second contracts. The PROs reviewed five procedures under the second contracts, during which HCFA reported a denial rate of 0.6 percent.

➤ ***Most PROs approve over 90 percent of preprocedure requests without physician review.***

The PROs representing 27 States provided information on the percentage of preprocedure requests which are approved without physician review (one PRO did not respond to this question). These PROs referred an average of 6 percent of preprocedure requests for physician review. The PROs for 22 of these States referred an average of 2.4 percent of their preprocedure requests, while 5 PROs estimated their referral rates between 12 and 25 percent.

➤ ***The PROs doubt the current Medicare preprocedure review is cost-effective.***

The PROs representing 27 States responded to our inquiry on the cost-effectiveness of preprocedure review. Ten said the process is not cost-effective due to low denial rates. Fifteen others indicated they were unable to evaluate cost-effectiveness because they lack historical data. These 15 PROs also indicated, however, that the process is time consuming and labor intensive, and that their denial rates are very low.

The two remaining PROs indicated that preprocedure review is cost-effective. The denial rates for each of these PROs were less than 1 percent.

Some PROs offered alternative strategies to improve the process. Twenty-six said Medicare carriers should share provider profile data with PROs to help them identify problem providers or procedures. Six noted HCFA could target preprocedure review efforts where PROs have identified problem procedures and or providers. Three PROs suggested a more focused retrospective review on specific procedures or settings.

A TARGETED, MORE INTENSIVE APPROACH COULD IMPROVE PREPROCEDURE REVIEW FOR CATARACT EXTRACTION.

A targeted program would give the PROs the flexibility to perform their review in the way most suited to local conditions and practices. For example, targeting could be done on high volume providers, certain geographic areas, or on a random basis. For these cases, the PROs could require a second opinion and subject them to physician review.

The volume of preprocedure requests for cataract extractions and resulting low denial rates have prompted some PROs to explore other ways to prevent unnecessary surgery. Three PROs with high volumes of cataract requests submitted unsolicited proposals to HCFA for a pilot cataract second opinion program. One State's Ophthalmology Society even agreed to pay the cost of second opinion consultations. Other PROs informed us they had considered proposing such a pilot program, but did not take action after they learned HCFA had not taken action on similar proposals.

Nineteen of the PROs contacted said a limited second opinion program would improve preprocedure review. Sixteen of these indicated it would be most effective for cataract extractions. The AMPRA also favors a focused elective surgery second opinion program coupled with Medicare's existing preprocedure review.

The HCFA has recognized the need to allow PROs the flexibility to require second opinions for surgical procedures performed by certain physicians. The HCFA is exploring whether the current statute (COBRA) allows the PROs to require second opinions for physicians believed to be performing significant numbers of unnecessary procedures.

MORE DATA IS NEEDED TO IDENTIFY OTHER PROCEDURES SUITABLE FOR TARGETED, INTENSIVE REVIEW.

The PROs would need local rather than national data to select procedures for a targeted program because practice patterns tend to differ between and within States. Possible sources of local data are Medicare carriers, which routinely collect and profile provider data. The PROs could use such data to focus a targeted program on particular providers, procedures, or geographic areas. The HCFA has recognized that information exchange between PROs and carriers can enhance the effectiveness of the review function and is currently working to implement this information exchange.

While several PROs felt they could identify additional procedures for a second opinion program, there was no consensus regarding which procedures they would select. Procedures mentioned most often include hysterectomy, major joint replacement, and prostatectomy.

RECOMMENDATIONS

The HCFA should:

- *substitute a targeted, more intensive review for the current mandatory preprocedure review of cataract surgery.*

- *review the current preprocedure review process to determine whether it is cost-effective for other surgical procedures.*

- *continue efforts to implement data exchange between PROs and Medicare carriers.*

SUMMARY OF RECOMMENDATIONS AND AGENCY COMMENTS

OIG Finding

PRO preprocedure review for cataract extraction is not cost-effective.

Agency Comments

The HCFA takes exception to the $25.70 negotiated rate and would like the OIG to explain how it was derived.

OIG Response

The HCFA did not question the fact that preprocedure review for cataract extraction is not cost-effective. The HCFA questioned only the negotiated rate used in the calculation. The rate of $25.70 per preprocedure review was obtained from HCFA's Health Standards and Quality Bureau, Office of Peer Review, Division of Program Operations. The $25.70 is the total cost to perform a preprocedure review. The total cost represents $16.70 fixed cost and $9.00 in variable cost. We used the total cost figure in calculating the amount paid for the preprocedure review. However, the HCFA chose to use the variable cost of $9.00 per review. The $9.00 does not represent the fixed cost but would represent the cost savings per review if preprocedure review was eliminated. However, even if the $9.00 were used, Medicare would still have paid about $4.6 million to save $1.4 million from surgery denials. Preprocedure review is not cost-effective for cataract extractions whether the total cost or the variable cost is used.

OIG Recommendation

The HCFA should substitute a targeted, more intensive review for the current preprocedure review of cataract surgery.

Agency Comments

The HCFA disagrees with this recommendation. The HCFA believes that they have no data to support targeting high volume ophthalmologists. The HCFA also believes that the sentinel effect should be studied prior to making a final decision about the appropriateness of the recommendation.

OIG Response

The HCFA objects to targeting based solely on volume. However, this is not what we are suggesting. We provided examples on how targeting could be done. Our examples of targeting options included not only high volume providers but also certain geographic areas as well as random selection. Data analysis would reveal problem areas to be targeted. A targeted program would give the PROs the flexibility to perform their reviews in a way most suited to local conditions and practices.

We recognize the importance of the sentinel effect. We believe if a targeted program such as a second opinion program were instituted, a sentinel effect would still be present, since physicians know that their recommendation for surgery would face peer review. A targeted review would also be more efficient since it would not be a 100 percent review. In fact, a targeted program could achieve the same or higher denial rate than the current preprocedure review.

OIG Recommendation

The HCFA should review the current preprocedure review process to determine whether it is cost-effective.

Agency Comment

The HCFA agrees with this recommendation and is currently performing a study to assist in making accurate determinations of cost-effectiveness.

OIG Recommendation

The HCFA should continue efforts to implement data exchange between PROs and Medicare carriers.

Agency Comment

The HCFA agrees with this recommendation and is actively working to establish regular systematic data exchanges.

ENDNOTES

1. Twelve PROs provided cataract extraction data through January 31, 1990, and five PROs provided cataract extraction data through December 31, 1989.

2. Cataract extraction cost taken from Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections, Region IX study on Medicare outpatient surgery.

3. Dwight E.M. Angell, "Cataract Surgeons Face a Critical Eye," *Health Week*, April 23, 1990.

APPENDIX A

HCFA Procedure List — PRO Third Scope of Work

1. Cholecystectomy
2. Major Joint Replacement
3. Coronary Artery Bypass Graft Surgery
4. Percutaneous Transluminal Coronary Angioplasty
5. Laminectomy
6. Complex Peripheral Revascularization
7. Hysterectomy
8. Bunionectomy
9. Inguinal Hernia Repair
10. Prostatectomy
11. Pacemaker Insertion

APPENDIX B

PRO Prior Authorization
Third Scope of Work
Denial Rates

PRO	Number of Cases	Percent Denied
Alabama	28,848	0.04
Alaska	808	0.00
Arizona	20,035	2.15
Arkansas	22,342	0.04
California	151,134	0.12
Colorado	12,706	0.25
Connecticut	18,473	0.09
Delaware	5,748	0.06
District of Columbia	4,876	0.00
Florida	97,420	0.04
Georgia 3	2,249	0.26
Hawaii	6,076	0.24
Idaho	5,690	0.01
Illinois	73,277	0.08
Indiana	59,889	0.04
Iowa	18,364	0.43
Kansas	18,336	0.13
Kentucky	30,448	0.06
Louisiana	23,910	0.07
Maine	5,415	0.12
Maryland	18,892	0.12
Massachusetts	23,222	0.46
Michigan	70,357	0.05
Minnesota	20,287	0.20
Mississippi	8,104	0.01
Missouri	75,982	0.03
Montana	8,679	0.01
Nebraska	18,928	0.62
Nevada	9,477	0.07
New Hampshire	5,249	0.59
New Jersey	61,238	0.01
New Mexico	7,290	0.06
New York	98,224	0.17
North Carolina	42,568	0.16
North Dakota	5,498	0.01
Ohio	108,834	0.20
Oklahoma	41,842	0.07

PRO	Number of Cases	Percent Denied
Oregon	14,622	0.19
Puerto Rico	6,987	0.00
Rhode Island	8,763	0.11
South Carolina	21,133	0.08
South Dakota	4,465	0.00
Tennessee	36,072	0.37
Texas	104,346	0.00
Utah	12,972	1.23
Vermont	2,896	0.75
Virgin Islands	9	11.11
Virginia	23,965	0.14
Washington	42,294	0.08
West Virginia	14,663	0.06
Wisconsin	33,523	0.02
Wyoming	3,017	0.00
National Total	**1,590,442**	**0.15**

Thirteen States' PROs began preprocedure review between October and December 1988: Delaware, Indiana, Kentucky, Missouri, Montana, Nebraska, Nevada, New Jersey, Oklahoma, Rhode Island, South Carolina, Washington, and Wyoming. The remainder, except for Pennsylvania, began preprocedure review on April 1, 1989. The Pennsylvania PRO began its contract on December 1, 1989. Pennsylvania processed 10,000 requests and denied 11 during the first two months of their contract.

National denial rate is based on a weighted average to account for differences in volume of requests between States.

The Alaska, Idaho, and Washington State data we obtained from HCFA was incorrect. The correct percentages we obtained from the PRO are used in this Appendix.

Source: HCFA report thru 1/29/90

APPENDIX C

HCFA COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

[1]

Memorandu

Date OCT 15 1990

From

Gail R. Wilensky, Ph.D.
Administrator

Subject

OIG Draft Report - "Medicare Preprocedure Review" (OEI-03-89-01520)

To

Inspector General
The Office of the Secretary

We have reviewed the subject draft report which examines the cost effectiveness of the Medicare Peer Review Organizations' (PROs) current preprocedure review process.

The report questions the cost effectiveness of the preprocedure review process for all procedures and specifically concludes that PRO preprocedure review for cataract extraction is not cost effective. The report also concludes that a more targeted program of preprocedure review would give the PROs the flexibility to perform their review in a way more suited to local conditions and practices. The report contains three recommendations pertaining to these findings. Our comments on each of these recommendations are attached.

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

Attachment

IG	✓
PDIG	✓
DIG-AS	
DIG-EI	✓
DIG-OI	
AIG-MP	✓
OGC/IG	
EX SEC	✓
DATE SENT	10/15

FACT SHEET
OIG Draft Report
Medicare Preprocedure Review
(OEI-03-89-01520)

General Comments:

Background

The Executive Summary and Introduction of the report state, "Most PROs were in their third cycle of contracts in April 1989." This statement is not correct. The difference between contract cycle and scope of work requires clarification. Most PROs, at the time of the study, were performing under the third scope of work, but were not, however, in the third contract cycle. As a result of the Omnibus Budget Reconciliation Act of 1987, the length of PRO contracts was changed from 2 to 3 years and we were given the authority to renew contracts on a staggered basis. PRO contractors were broken down into four groups with contract renewals for the first group for the third cycle, beginning on October 1, 1988. Contract renewals continued at 6 month intervals for each of the remaining three groups. Contracts of PROs not under the third contracting cycle on April 1, 1989, were modified so that all PROs were under the third scope of work. Therefore, although all PROs were operating under the third scope of work as of April 1, 1989, most were not in the third cycle of contracts.

Findings

PRO preprocedure review for cataract extraction is not cost effective

OIG found that Medicare expended about $13.3 million (based upon an alleged HCFA-negotiated rate of $25.70 per preprocedure review) to realize savings of $1.4 million due to surgery denials. HCFA takes exception to the negotiated rate used in OIG's projection. The national average negotiated rate per review for the third contract cycle paid for ambulatory reviews (which includes preprocedure reviews) is $9.00. Since there is a significant difference between the rate per review cited by OIG and that used by HCFA, it would be helpful if OIG explained how it derived the $25.70 rate per preprocedure review.

Recommendation No. 1

HCFA should substitute a targeted, more intensive review for the current mandatory preprocedure review of cataract surgery.

HCFA Response

We disagree with this recommendation. If we were to target high volume ophthalmologists, we believe that we could be challenged for identifying them for intensified review without justification. We have no data to support targeting these ophthalmologists for review. In fact, the opposite situation may exist. Ophthalmologists who have "average" or "below average" surgical rates and practice in an area where a high volume physician practices, may be performing unnecessary surgery to compensate for the loss of revenue. HCFA is currently studying the effectiveness of PRO review. We will decide how extensive a review of cataract surgery should be performed after these studies are completed. An additional factor that should be considered before implementing targeted reviews is the sentinel effect of the preprocedure review. The sentinel effect causes physicians to recommend fewer unnecessary surgeries because they know their recommendations face peer review. Although OIG recognizes the sentinel effect of preprocedure review was not considered in this report, we believe a study of this subject should be completed before HCFA makes a final decision about the appropriateness of the recommendation. In fact, HCFA is conducting a longitudinal study of the sentinel effect of the preprocedure review of cataract surgery which should clarify OIG's concerns regarding the cost effectiveness of the existing preprocedure review program.

Recommendation No. 2

HCFA should review the current preprocedure review process to determine whether it is cost effective for other surgical procedures.

Response

We agree with this recommendation. HCFA is currently analyzing the data submitted by PROs to determine review levels and denial rates. In addition, HCFA is performing a study which will assist in making an accurate determination of cost effectiveness of the reviews being performed. Since the preprocedure review is Congressionally mandated, we are in the process of making decisions about which surgical procedures should be subjected to prior authorization and will modify review requirements as appropriate.

Recommendation No. 3

HCFA should continue efforts to implement data exchange between PROs and Medicare carriers.

Response

We agree with this recommendation. HCFA is actively working to establish regular, systematic data exchanges between PROs and carriers. PROs and carriers were recently asked to make recommendtions concerning the types of information to be exchanged. We are in the process of analyzing the results of our inquiries and will be issuing instructions that will enhance information exchanges between the PROs and carriers.