Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OUTPATIENT SURGERY: MEDICARE PAYMENTS FOR UNNECESSARY AND POOR QUALITY CATARACT SURGERIES

MANAGEMENT ADVISORY REPORT

Richard P. Kusserow
INSPECTOR GENERAL

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This report was prepared in San Francisco under the direction of Regional Inspector General Kaye D. Kidwell and Deputy Regional Inspector General Paul A. Gottlober. Project staff included:

Deborah Harvey, Project Leader
Brian Pattison, Lead Analyst
Mollyann Brodie
Robert Gibbons
Corrinne Harol
Cynthia Lemesh
Brad Rollin
W. Mark Krushat, Headquarters
Wayne Powell, Headquarters

EXECUTIVE SUMMARY

PURPOSE

This report estimates the amount Medicare paid for beneficiaries who underwent cataract surgery with intraocular lens implant (1) that was deemed to be medically unnecessary or (2) whose quality did not meet professionally recognized standards of care. This report also estimates the amount Medicare paid for preoperative tests that were medically unnecessary.

BACKGROUND

Section 1862(a)(1)(A) of the Social Security Act states that Medicare will not pay for services that are not reasonable and necessary under Part A or Part B. We recently completed an inspection in which we examined 802 Medicare outpatient cataract surgeries performed in ambulatory surgical centers (ASCs) and hospital outpatient departments (OPDs). For the sampled cataract surgeries with adequate documentation, the independent medical review contractor found that 1.7 percent of the surgeries were unnecessary and 1.8 percent of the beneficiaries received poor quality care. By reviewing the beneficiary histories and claims obtained from the Medicare carriers and fiscal intermediaries, we determined the payments for the unnecessary and poor quality cataract surgeries.

FINDINGS

MEDICARE SPENT:

- $29.4 million in 1988 for medically unnecessary cataract surgeries,
- $41.7 million in 1988 for poor care rendered to cataract patients, and
- approximately $245,700 in 1988 for medically unnecessary B-scans and endothelial cell counts.

RECOMMENDATIONS

THE HEALTH CARE FINANCING ADMINISTRATION SHOULD:

- reduce the incidence of payments for medically unnecessary and poor quality cataract surgeries and
- reemphasize medical and postpayment review of cataract providers who routinely bill for B-scans and endothelial cell counts and postpayment review.

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PURPOSE

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BACKGROUND

Medicare regulations do not specifically define medical necessity or quality of care. The concepts are characterized by the practices in local medical communities. Section 1862(a)(1)(A) of the Social Security Act states that Medicare will not pay for services that are not reasonable and necessary under Part A or Part B. In recent years, many professional organizations, such as the American Academy of Ophthalmology, have issued guidelines to their members outlining medical necessity criteria and suggesting standards of care.

PRO Responsibilities

Prior to 1985, the peer review organizations (PROs) were not responsible for reviewing outpatient quality of care. Since then, several legislative bills, including the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 and the Sixth Omnibus Budget Reconciliation Act (SOBRA) of 1986, expanded the PRO authority. The COBRA authorized PROs to deny payment for questionable care while SOBRA mandated PROs to review quality of care in postacute and ambulatory care settings.

In April 1989, PROs implemented 100 percent preprocedure review of at least 10 nonemergency inpatient or outpatient surgical procedures. The PROs were given this authority under Section 9401 of Public Law 99-272. Currently, cataract extraction is one of two mandatory PRO review procedures. The PROs retrospectively review 5 percent of their preprocedure approvals on a quarterly basis. They can deny payment based on this review. Under the upcoming scope of work, the Health Care Financing Administration (HCFA) has eliminated mandatory review of nonemergency inpatient or outpatient surgical procedures. The PROs would be authorized to focus their resources on surgical or nonsurgical procedures and other services which appear to be overutilized or substandard. The PROs will retrospectively review 3 percent of their preprocedure approvals.

Medicare Carrier Responsibilities

In addition to processing Medicare claims for payment, Section 1842(a)(2)(B) of the Social Security Act requires Medicare carriers to apply "safeguards against unnecessary utilization of services furnished by providers." Carrier responsibilities are detailed in the Medicare Carrier's Manual (MCM). The carriers are responsible for identifying providers, by locality and specialty, whose utilization patterns are different from medically recognized community standards and norms. The carriers are required to monitor claims data to develop profiles on providers and their specialty groups. The carriers also conduct studies to identify areas of special concern.

The HCFA periodically alerts Medicare fiscal agents of current abusive practices through intermediary letters or carrier bulletins. In this way, the carriers can refocus their monitoring activities while the MCM is updated.

Prior Office of Inspector General Studies

We recently completed an inspection in which we examined Medicare outpatient surgery performed in ambulatory surgical centers (ASCs) and hospital outpatient departments (OPDs). In February 1991, we released the medical outcome analysis in a final report entitled "Outpatient Surgery--Medical Necessity and Quality of Care" (OEI-09-88-01000). The independent medical review contractor found that 1.7 percent of cataract surgeries were medically unnecessary and 1.8 percent of the beneficiaries received poor quality care. The medical outcome report discusses the most common reasons why the cases were deemed medically unnecessary or the beneficiaries received poor care.

This management advisory report is limited to a discussion of the costs associated with the medically unnecessary cataract surgeries and poor care rendered to Medicare beneficiaries. The sampled surgeries were completed before the national implementation of PRO preprocedure review.

METHODOLOGY

Our random sample of 1,170 Medicare beneficiaries included 802 cataract surgeries. Half of the surgeries were completed in ASCs, half in OPDs. The surgeries were performed in the 10 States with the highest number of Medicare-certified ASCs in February 1988: Arizona, California, Florida, Illinois, Louisiana, Maryland, North Carolina, Ohio, Pennsylvania, and Texas. The surgeries were completed during the first quarter of calendar year 1988.

After collecting the medical records from the ophthalmologists, ASCs, and OPDs, we used an independent medical review contractor to examine the records. The contractor used physician specialists to develop the procedure-specific criteria. The physicians then reviewed each record for medical necessity, appropriateness of the

outpatient setting, and quality of care. In addition, we interviewed representatives of the American Academy of Ophthalmology and a sample of ASC and OPD ophthalmologists to identify currently acceptable standards for medical necessity and quality of care.

We determined OPD and ASC payments by reviewing the beneficiary histories and claims obtained from the Medicare carriers and fiscal intermediaries. For OPDs, the payments represent the interim payments. These interim payments are subject to adjustment based on the intermediary's audit of the hospital cost report for the fiscal year in which the services were rendered. For cataract surgeries, our analysis included the ophthalmologist's surgical fees, ASC and OPD facility payments, preoperative tests (e.g., A-scans, B-scans, and endothelial cell counts), office visits within 90 days after surgery, and IOL payments.

In order to gain a national perspective, we made two nonstatistical projections for the data. First, we projected the 10 States' quarterly costs to annual costs. Second, since the number of procedures in our sample represents 49 percent of the Medicare procedures performed nationally, we calculated the national costs by dividing the sampled costs by 0.49. This methodology assumes the 10 sampled States are representative of the nation as a whole.

FINDINGS

MEDICARE SPENT $29.4 MILLION IN 1988 FOR MEDICALLY UNNECESSARY CATARACT SURGERIES.

The medical review contractor found that (a) 96.9 percent of our sample (777 of 802 cases) had documentation for determining medical necessity and (b) 1.7 percent of these (13 of 777) were not medically necessary. Table 1 in the appendix details the $29.4 million national cost projection for these medically unnecessary cataract surgeries.

MEDICARE SPENT $41.7 MILLION IN 1988 FOR POOR CARE RENDERED TO CATARACT PATIENTS.

The medical review contractor found that 92.8 percent of our sample (744 of 802 cases) had adequate documentation to determine quality of care. Of these, 1.8 percent of the cataract beneficiaries (13 of 744) received poor care. Table 2 in the appendix details the $41.7 million cost projection for poor quality care.

MEDICARE SPENT APPROXIMATELY $245,700 IN 1988 FOR MEDICALLY UNNECESSARY B-SCANS AND ENDOTHELIAL CELL COUNTS.

Ophthalmologists interviewed as part of our study indicated that B-scans and endothelial cell counts are rarely necessary for cataract surgery. While these tests are not routine, physicians administer them if a patient's condition warrants it. A physician may perform an ophthalmic ultrasound, called a B-scan, when the density of the cataract precludes him from viewing the back of the patient's eye. The B-scan will rule out serious conditions, such as tumors or a partially or totally detached retina. Endothelial cells, which line the inside of the cornea, keep the cornea clear and healthy by preventing eye fluid from entering the area. Once the cells are lost, the cornea does not easily generate new cells to repair itself. The endothelial cell count can determine the corneal health and predict how well it will tolerate cataract surgery. If the cell count is low, the physician can take precautions during surgery to lessen endothelial cell loss.

In our sample, Medicare paid $13,729 for the optional tests--$3,746 for 32 B-scans and $9,983 for 133 endothelial cell counts. (Some patients received more than one test.) Projected nationally, Medicare paid $14.4 million for these tests--$4.4 million for B-scans and $10.0 million for endothelial cell counts. Since the medical reviewers determined that 1.7 percent of the cataract surgeries were medically unnecessary, Medicare could have saved approximately $245,748 for the tests--$75,337 for B-scans and $170,411 for endothelial cell counts. Tables 3 and 4 in the appendix show the cost projections.

Questions about physicians' practice patterns may arise if they routinely submit claims for additional tests. Some sampled providers billed routinely for B-scans and endothelial cell counts. We found that 86 percent of the physicians who billed for endothelial cell counts did so for all of their sampled patients. The other 14 percent performed these tests on most of their patients (e.g., 13 of 14 sampled patients). In addition, we found that one physician accounted for almost 16 percent of all B-scans in our sample. This evidence suggests that practice patterns, not medical exigencies, may account for the additional tests.

RECOMMENDATIONS

THE HCFA SHOULD:

(1) REDUCE THE INCIDENCE OF PAYMENTS FOR MEDICALLY UNNECESSARY AND POOR QUALITY CATARACT SURGERIES.

This recommendation could be accomplished through a combination of efforts by both the PROs and carriers who can target their reviews on providers whose practice profiles indicate a higher than average likelihood of unnecessary or poor quality care. In this way, HCFA could save as much as $71.1 million in medically unnecessary and poor quality cataract surgeries.

(2) REEMPHASIZE MEDICAL AND POSTPAYMENT REVIEW OF CATARACT PROVIDERS WHO ROUTINELY BILL FOR B-SCANS AND ENDOTHELIAL CELL COUNTS AND POSTPAYMENT REVIEW.

The HCFA could issue a carrier bulletin to reemphasize the need for Medicare carriers to follow MCM Sections 7500-7514 regarding medical review controls and postpayment review. The postpayment alert list in MCM Section 7514(E) states that carriers should monitor excessive cataract preoperative visual acuity tests such as B-scans and endothelial cell counts. The HCFA could save as much as $247,500 for unnecessary preoperative tests.

APPENDIX: METHODOLOGY

The tables on the following pages represent the cost savings for medically unnecessary cataract surgeries (table 1), poor care (table 2), unnecessary B-scans (table 3) and unnecessary endothelial cell counts (table 4).

TABLE 1: ESTIMATED ANNUAL SAVINGS FOR MEDICALLY UNNECESSARY CATARACT SURGERIES

STATE	SITE	SAMPLE CASES	MEDICALLY UNNECESSARY CASES	PERCENT MEDICALLY UNNECESSARY	AVERAGE QUARTERLY PAYMENTS	AVERAGE ANNUAL PAYMENTS	ADJUSTED UNIVERSE	ESTIMATED ANNUAL SAVINGS
Arizona	OPD	17	0	0.00%	$0.00	$0.00	1468	$0.00
	ASC	17	0	0.00%	$0.00	$0.00	2197	$0.00
California	OPD	75	0	0.00%	$0.00	$0.00	5228	$0.00
	ASC	74	5	6.76%	$3,385.21	$13,540.84	8280	$7,575,551.03
Florida	OPD	83	0	0.00%	$0.00	$0.00	15470	$0.00
	ASC	84	1	1.19%	$2,361.29	$9,445.16	7334	$824,652.42
Illinois	OPD	29	0	0.00%	$0.00	$0.00	3262	$0.00
	ASC	29	0	0.00%	$0.00	$0.00	3262	$0.00
Louisiana	OPD	15	0	0.00%	$0.00	$0.00	3904	$0.00
	ASC	16	0	0.00%	$0.00	$0.00	880	$0.00
Maryland	OPD	10	0	0.00%	$0.00	$0.00	1759	$0.00
	ASC	10	0	0.00%	$0.00	$0.00	67	$0.00
North Carolina	OPD	23	0	0.00%	$0.00	$0.00	2633	$0.00
	ASC	23	0	0.00%	$0.00	$0.00	1530	$0.00
Ohio	OPD	29	0	0.00%	$0.00	$0.00	7388	$0.00
	ASC	30	2	6.67%	$2,593.93	$10,375.72	978	$676,496.94
Pennsylvania	OPD	31	0	0.00%	$0.00	$0.00	8034	$0.00
	ASC	32	0	0.00%	$0.00	$0.00	971	$0.00
Texas	OPD	77	2	2.60%	$3,190.73 *	$12,762.92	13260	$2,197,874.28
	ASC	73	3	4.11%	$2,912.21	$11,648.84	6514	$3,118,378.51
	TOTALS:	777	13	N/A	$14,443.37	$57,773.48	94419	$14,392,953.18

* One case did not have adequate paid information to be included in calculations.

ESTIMATED NATIONAL ANNUAL SAVINGS:

$29,373,373.83

TABLE 2: ESTIMATED ANNUAL SAVINGS FOR POOR QUALITY CATARACT SURGERIES

STATE	SITE	SAMPLE CASES	POOR QUALITY CASES	PERCENT POOR QUALITY	AVERAGE QUARTERLY PAYMENTS	AVERAGE ANNUAL PAYMENTS	ADJUSTED UNIVERSE	ESTIMATED ANNUAL SAVINGS
Arizona	OPD	16	0	0.00%	$0.00	$0.00	1468	$0.00
	ASC	15	0	0.00%	$0.00	$0.00	2197	$0.00
California	OPD	72	0	0.00%	$0.00	$0.00	5228	$0.00
	ASC	68	2	2.94%	$3,441.13	$13,764.52	8280	$3,352,065.46
Florida	OPD	81	1	1.23%	$2,935.34	$11,741.36	15470	$2,242,454.80
	ASC	82	0	0.00%	$0.00	$0.00	7334	$0.00
Illinois	OPD	27	0	0.00%	$0.00	$0.00	3262	$0.00
	ASC	27	1	3.70%	$3,401.76	$13,607.04	3262	$1,643,932.02
Louisiana	OPD	15	0	0.00%	$0.00	$0.00	3904	$0.00
	ASC	15	0	0.00%	$0.00	$0.00	880	$0.00
Maryland	OPD	8	0	0.00%	$0.00	$0.00	1759	$0.00
	ASC	10	0	0.00%	$0.00	$0.00	67	$0.00
North Carolina	OPD	23	0	0.00%	$0.00	$0.00	2633	$0.00
	ASC	22	0	0.00%	$0.00	$0.00	1530	$0.00
Ohio	OPD	27	0	0.00%	$0.00	$0.00	7388	$0.00
	ASC	27	2	7.41%	$2,593.93	$10,375.72	978	$751,663.27
Pennsylvania	OPD	32	0	0.00%	$0.00	$0.00	8034	$0.00
	ASC	31	0	0.00%	$0.00	$0.00	971	$0.00
Texas	OPD	75	4	5.33%	$3,316.19	$13,264.76	13260	$9,380,838.27
	ASC	71	3	4.23%	$2,792.53	$11,170.12	6514	$3,074,457.54
	TOTALS:	744	13	N/A	$18,480.88	$73,923.52	94419	$20,445,411.36

ESTIMATED NATIONAL ANNUAL SAVINGS:

$41,725,329.31

TABLE 3: ESTIMATED ANNUAL SAVINGS FOR B-SCANS

STATE	SITE	SAMPLE CASES	B-SCANS	PERCENT B-SCANS	AVERAGE QUARTERLY PAYMENTS	AVERAGE ANNUAL PAYMENTS	ADJUSTED UNIVERSE	ESTIMATED ANNUAL PAYMENTS
Arizona	OPD	17	0	0.00%	$0.00	$0.00	1468	$0.00
	ASC	17	0	0.00%	$0.00	$0.00	2197	$0.00
California	OPD	75	1	1.33%	$131.36	$525.44	5228	$36,626.67
	ASC	74	2	2.70%	$95.77	$383.08	8280	$85,727.09
Florida	OPD	83	9	10.84%	$75.21	$300.84	15470	$504,650.04
	ASC	84	2	2.38%	$113.73	$454.92	7334	$79,437.70
Illinois	OPD	29	0	0.00%	$0.00	$0.00	3262	$0.00
	ASC	29	6	20.69%	$177.73	$710.92	3262	$479,797.46
Louisiana	OPD	15	0	0.00%	$0.00	$0.00	3904	$0.00
	ASC	16	0	0.00%	$0.00	$0.00	880	$0.00
Maryland	OPD	10	1	10.00%	$111.67	$446.68	1759	$78,571.01
	ASC	10	0	0.00%	$0.00	$0.00	67	$0.00
North Carolina	OPD	23	0	0.00%	$0.00	$0.00	2633	$0.00
	ASC	23	0	0.00%	$0.00	$0.00	1530	$0.00
Ohio	OPD	29	1	3.45%	$53.92	$215.68	7388	$54,946.34
	ASC	30	0	0.00%	$0.00	$0.00	978	$0.00
Pennsylvania	OPD	31	4	12.90%	$133.30	$533.20	8034	$552,739.20
	ASC	32	3	9.38%	$129.11	$516.44	971	$47,012.18
Texas	OPD	77	3	3.90%	$121.93	$487.72	13260	$251,967.55
	ASC	73	0	0.00%	$0.00	$0.00	6514	$0.00
	TOTALS:	777	32	N/A	$1,143.73	$4,574.92	94419	$2,171,475.24

$2,171,475.24 / 0.49 =

ESTIMATED NATIONAL ANNUAL PAYMENTS: $4,431,582.12

1.7% x $4,431,582.12 =

ESTIMATED NATIONAL ANNUAL SAVINGS: $75,336.90

TABLE 4: ESTIMATED ANNUAL SAVINGS FOR ENDOTHELIAL CELL COUNTS

STATE	SITE	SAMPLE CASES	CELL COUNTS	PERCENT CELL COUNTS	AVERAGE QUARTERLY PAYMENTS	AVERAGE ANNUAL PAYMENTS	ADJUSTED UNIVERSE	ESTIMATED ANNUAL SAVINGS
Arizona	OPD	17	0	0.00%	$0.00	$0.00	1468	$0.00
	ASC	17	2	11.76%	$104.01	$416.04	2197	$107,534.10
California	OPD	75	0	0.00%	$0.00	$0.00	5228	$0.00
	ASC	74	19	25.68%	$53.84 *	$215.36	8280	$433,746.68
Florida	OPD	83	15	18.07%	$71.59	$286.36	15470	$800,600.46
	ASC	84	14	16.67%	$60.10	$240.40	7334	$293,848.93
Illinois	OPD	29	3	10.34%	$87.38	$349.52	3262	$117,944.92
	ASC	29	10	34.48%	$93.32	$373.28	3262	$419,875.64
Louisiana	OPD	15	4	26.67%	$92.12	$368.48	3904	$383,612.25
	ASC	16	3	18.75%	$76.45	$305.80	880	$50,457.00
Maryland	OPD	10	0	0.00%	$0.00	$0.00	1759	$0.00
	ASC	10	3	30.00%	$35.63	$142.52	67	$2,864.65
North Carolina	OPD	23	4	17.39%	$37.60	$150.40	2633	$68,870.12
	ASC	23	16	69.57%	$47.62	$190.48	1530	$202,736.97
Ohio	OPD	29	8	27.59%	$76.19	$304.76	7388	$621,121.90
	ASC	30	6	20.00%	$72.93	$291.72	978	$57,060.43
Pennsylvania	OPD	31	3	9.68%	$52.09	$208.36	8034	$161,996.54
	ASC	32	0	0.00%	$0.00	$0.00	971	$0.00
Texas	OPD	77	5	6.49%	$98.50	$394.00	13260	$339,249.35
	ASC	73	18	24.66%	$132.35	$529.40	6514	$850,317.93
	TOTALS:	777	133	N/A	$1,191.72	$4,766.88	94419	$4,911,837.88

* One case did not have adequate paid information to be included in calcualtions.

$4,911,837.88 / 0.49 =

ESTIMATED NATIONAL ANNUAL PAYMENTS: $10,024,158.94

1.7% x $10,024,158.94 =

ESTIMATED NATIONAL ANNUAL SAVINGS: $170,410.70