DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

APR 20 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005 (A-05-07-00077)

The attached final report provides the results of our review of evaluation and management (E&M) services included in eye and ocular adnexa (eye) global surgery fees for calendar year (CY) 2005. The Centers for Medicare & Medicaid Services (CMS) requested this review.

Medicare pays for physicians' services furnished on or after January 1, 1992, based on an established fee schedule that CMS updates annually. The fee schedule amounts are based on the resources, such as physician time and intensity of the work (measured in relative value units), involved with furnishing services. Included on the fee schedule are global surgery fees, which include payment for a surgical service and the related preoperative and postoperative E&M services provided during the global surgery period. The period for major surgeries includes the day before the surgery, the day of the surgery, and the 90 days immediately following the day of the surgery. In determining a global surgery fee, CMS estimates the number of E&M services that a physician provides to a typical beneficiary during the global surgery period. CMS reimbursed physicians approximately $1.6 billion for major eye global surgeries performed during CY 2005.

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

Eye global surgery fees often did not reflect the number of E&M services that physicians provided to beneficiaries during the global surgery periods. The fees reflected the number of E&M services provided during the global surgery periods for 60 of the 300 global surgeries that we sampled. The fees for the remaining 240 global surgeries did not reflect the number of E&M services provided. Specifically, physicians provided fewer E&M services than were included in 201 global surgery fees and provided more E&M services than were included in 39 global surgery fees.

Using the net results, we estimated that Medicare paid $97.6 million for E&M services that were included in eye global surgery fees but not provided during the global surgery periods in CY 2005. The global surgery fees did not reflect the number of E&M services provided to beneficiaries because CMS had not adjusted or recently adjusted the relative value units for most of the sampled surgeries.

We recommend that CMS consider:

- adjusting the estimated number of E&M services within eye global surgery fees to reflect the number of E&M services actually being provided to beneficiaries, which may reduce payments by an estimated $97.6 million, or

- using the financial results of this audit, in conjunction with other information, during the annual update of the physician fee schedule.

In written comments on our draft report, CMS acknowledged the merit of our findings but believed that it would be prudent to conduct further analysis before proposing any changes in the number of E&M services assigned to eye surgeries.

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Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov. Please refer to report number A-05-07-00077 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NATIONWIDE REVIEW OF EVALUATION AND MANAGEMENT SERVICES INCLUDED IN EYE AND OCULAR ADNEXA GLOBAL SURGERY FEES FOR CALENDAR YEAR 2005

Daniel R. Levinson
Inspector General

April 2009
A-05-07-00077

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the Freedom of Information Act, 5 U.S.C. ' 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

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

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

The American Medical Association Current Procedural Terminology (CPT) identifies codes that physicians use to report medical services and procedures and claim reimbursement through the physician fee schedule. The CPT includes 196 codes for major eye and ocular adnexa (eye) global surgeries. CMS reimbursed physicians approximately $1.6 billion for 195 of these CPT codes for surgeries performed during calendar year (CY) 2005.

CMS requested this review.

OBJECTIVE

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

SUMMARY OF RESULTS

Eye global surgery fees often did not reflect the number of E&M services that physicians provided to beneficiaries during the global surgery periods. The fees reflected the number of E&M services provided during the global surgery periods for 60 of the 300 global surgeries that we sampled. The fees for the remaining 240 global surgeries did not reflect the number of E&M services provided. Specifically, physicians provided fewer E&M services than were included in 201 global surgery fees and provided more E&M services than were included in 39 global surgery fees.

Using the net results, we estimated that Medicare paid $97.6 million for E&M services that were included in eye global surgery fees but not provided during the global surgery periods in

CY 2005. The global surgery fees did not reflect the number of E&M services provided to beneficiaries because CMS had not adjusted or recently adjusted the RVUs for most of the CPT codes in our sample.

RECOMMENDATIONS

We recommend that CMS consider:

- adjusting the estimated number of E&M services within eye global surgery fees to reflect the number of E&M services actually being provided to beneficiaries, which may reduce payments by an estimated $97.6 million, or

- using the financial results of this audit, in conjunction with other information, during the annual update of the physician fee schedule.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS acknowledged the merit of our findings but believed that it would be prudent to conduct further analysis before proposing any changes in the number of E&M services assigned to eye surgeries.

CMS's comments, except for technical comments, are included as Appendix D.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance coverage to people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, requested this review.

Physician Fee Schedule

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

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

Global Surgery Fees

The "Medicare Claims Processing Manual," Pub. No. 100-04, ch. 12, § 40, contains the national policy on global surgeries. A global surgery is a group of clinically related services, including the surgical service and related preoperative and postoperative services, that are treated as a single unit for purposes of coding, billing, and reimbursement.

To ensure consistent payment for the same surgery across Medicare carrier jurisdictions nationwide, CMS established global surgery fees. CMS determines each fee based on the RVUs for a typical beneficiary receiving the surgery and related E&M services during a global surgery period. The period for major surgeries includes the day before the surgery, the day of the surgery, and the 90 days immediately following the day of the surgery. CMS estimates the number of E&M services that a typical beneficiary receives during the global surgery period and includes reimbursement for those E&M services in the global surgery fee. If the surgeon transfers postoperative care to another physician, the physicians split the fee.

[1] E&M services are nonsurgical services provided for the purpose of diagnosing and treating diseases or counseling and evaluating beneficiaries.

Eye and Ocular Adnexa Global Surgeries

The American Medical Association Current Procedural Terminology (CPT) is a listing of descriptive terms and codes that physicians use to report medical services and procedures and claim reimbursement through the physician fee schedule. The CPT includes 196 codes for major eye and ocular adnexa (eye) global surgeries, such as cataract surgery, glaucoma surgery, and correction of astigmatism. CMS reimbursed physicians approximately $1.6 billion for 195 of these CPT codes for surgeries performed during calendar year (CY) 2005.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed Medicare payments totaling approximately $1.6 billion made to physicians nationwide for 3,438,973 major eye global surgeries and related E&M services provided during CY 2005.

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

We performed our fieldwork from July 2007 through May 2008 by coordinating our methodology with CMS staff and obtaining medical records from physicians who received Medicare reimbursement for the global surgeries that we sampled.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- discussed Medicare global surgery policy and procedures, including the establishment and update of global surgery fees, with CMS staff;
- identified a sampling frame of 3,438,973 major eye global surgeries totaling approximately $1.6 billion and divided the sampling frame into three strata:
    - stratum 1 for CPT code 66984 for cataract surgeries, which represented about 60 percent of the total payments in the sampling frame,

- stratum 2 for the 119 CPT codes (excluding code 66984 for cataract surgeries) that included four or more E&M services in the global surgery fees, and

- stratum 3 for the 75 CPT codes that included fewer than four E&M services in the global surgery fees;

- randomly selected 100 surgeries from each stratum for a total of 300 surgeries with payments totaling $149,131 for 45 CPT codes (Appendix A);

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

  - identified the name of the beneficiary, date of the surgery, applicable 92-day global surgery period, and name(s) of the physician(s) who provided the surgery and postoperative care;

  - requested and received medical records from the physician(s), identified the number of office visits provided during the global surgery period, and counted each office visit as an E&M service; and

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

- used the sample results to estimate the Medicare reimbursement for E&M services that were included in eye global surgery fees but not provided to beneficiaries during global surgery periods in CY 2005 (Appendix B).

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

RESULTS OF AUDIT

Eye global surgery fees often did not reflect the number of E&M services that physicians provided to beneficiaries during the global surgery periods. The fees reflected the number of E&M services provided during the global surgery periods for 60 of the 300 global surgeries that we sampled. The fees for the remaining 240 global surgeries did not reflect the number of E&M services provided. Specifically, physicians provided fewer E&M services than were included in 201 global surgery fees and provided more E&M services than were included in 39 global surgery fees.

Using the net results, we estimated that Medicare paid $97.6 million for E&M services that were included in eye global surgery fees but not provided during the global surgery periods in

CY 2005. The global surgery fees did not reflect the number of E&M services provided to beneficiaries because CMS had not adjusted or recently adjusted the RVUs for most of the CPT codes in our sample.

FEDERAL REQUIREMENTS

The "Medicare Claims Processing Manual," Pub. No. 100-04, ch. 12, § 40, provides that the global surgery fee includes payment for the surgical service and preoperative and postoperative E&M services provided during the global surgery period. The period for major surgeries includes the day before the surgery, the day of the surgery, and the 90 days immediately following the day of the surgery. CMS compensates physicians for the surgical service and related E&M services included in the fee regardless of the E&M services actually provided during the global surgery period.

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

For 240 of the 300 eye global surgeries sampled, the global surgery fees did not reflect the number of E&M services actually provided during the global surgery periods. As shown in the following table, a total of 1,254 E&M services were included in the global surgery fees for the 300 sampled surgeries, but physicians provided 945 E&M services, a difference of 309 E&M services totaling $12,277.

E&M Services Included in Global Surgery Fees Versus Services Provided

Stratum	Number of E&M Services Included in Fees	Number of Sampled Global Surgeries	Number of E&M Services Included in Sampled Fees	Number of E&M Services Provided	Difference	Net Dollar Value of Difference[2]
1	4	100	400	362	38	$1,154
2	≥ 4	100	611	428	183	7,507
3	< 4	100	243	155	88	3,616
Total		**300**	**1,254**	**945**	**309**	**$12,277**

Using the net results, we estimated that Medicare paid $97.6 million for E&M services that were included in eye global surgery fees but not provided during the global surgery periods in CY 2005 (Appendix B).

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

RELATIVE VALUE UNITS NOT ADJUSTED

Eye global surgery fees did not reflect the number of E&M services provided to beneficiaries because CMS had not adjusted or recently adjusted the RVUs for most of the 45 eye global surgery CPT codes in our sample. Specifically, as of January 25, 2008, CMS:

- had not adjusted the RVUs for 24 codes since the fee schedule was established in 1992;
- adjusted the RVUs for 10 codes in 1997;
- adjusted the RVUs for 9 codes in 2007; and
- had not adjusted the RVUs for 2 codes established in 1999 and 2001, respectively.

Appendix C contains details on these adjustments.

RECOMMENDATIONS

We recommend that CMS consider:

- adjusting the estimated number of E&M services within eye global surgery fees to reflect the number of E&M services actually being provided to beneficiaries, which may reduce payments by an estimated $97.6 million, or
- using the financial results of this audit, in conjunction with other information, during the annual update of the physician fee schedule.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS acknowledged the merit of our findings but believed that it would be prudent to conduct further analysis before proposing any changes in the number of E&M services assigned to eye surgeries. CMS said that it would continue to work with the American Medical Association Relative Value Update Committee and the relevant physician specialty societies to identify and correct those services for which the number of E&M services in the global period has changed. CMS also provided technical comments, which we addressed as appropriate.

CMS's comments, except for technical comments, are included as Appendix D.

APPENDIXES

SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicare-paid major eye global surgeries with dates of service in calendar year 2005.

SAMPLING FRAME

The sampling frame consisted of 3,438,973 major eye global surgeries with Medicare payments totaling $1,587,571,001. The table below shows the sampling frame information for each stratum.

Sampling Frame

Stratum and Description	Number of Surgeries	Payments
1—Cataract surgeries (CPT 66984)[1]	1,812,179	$959,275,605
2—Surgeries (excluding CPT 66984) with four or more E&M services included in the fee[2]	459,311	283,636,920
3—Surgeries with fewer than four E&M services included in the fee	1,167,483	344,658,476
Total	**3,438,973**	**$1,587,571,001**

SAMPLE UNIT

The sample unit was a major eye global surgery.

SAMPLE DESIGN AND SIZE

We used a stratified random sample that consisted of 300 lines of surgery for three strata (100 sample items per stratum).

SOURCE OF RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services, statistical software to generate the random numbers.

[1]CPT = Current Procedural Terminology.

[2]E&M = evaluation and management.

METHOD OF SELECTING SAMPLE ITEMS

After sorting each stratum's surgeries by health insurance claim number, date of service, and payment amount from low to high, we sequentially numbered the lines of surgery. We selected a global surgery for review when the random number value equaled the sequential number.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services, statistical software to estimate the dollar value of E&M services included in global surgery fees but not provided during the global surgery periods.

APPENDIX B

SAMPLE RESULTS AND ESTIMATES

Sample Results: E&M Services Included in Global Surgery Fees Versus Services Provided

Stratum	Number of E&M Services Included in Global Surgery Fees	Number of Sampled Surgeries	Number of Surgeries With Equal E&M Services Provided	Number of Surgeries With Fewer E&M Services Provided	Number of Surgeries With More E&M Services Provided	Total Number of Surgeries With E&M Services Provided That Did Not Equal E&M Services Included in Fees	Net Dollar Value of Difference in Number of E&M Services[1]
1	4	100	32	51	17	68	$1,154
2	≥ 4	100	10	79	11	90	7,507
3	< 4	100	18	71	11	82	3,616
Total		**300**	**60**	**201**	**39**	**240**	**$12,277**

Estimated Dollar Value of E&M Services Included in Global Surgery Fees but Not Provided

Stratum	Point Estimate	Limits Calculated for a 90-Percent Confidence Interval	
		Lower Limit	Upper Limit
1	$20,921,425	$7,231,587	$34,611,264
2	34,481,901	28,536,475	40,427,326
3	42,212,916	32,880,183	51,545,649
Overall	**$97,616,242**	**$80,178,134**[2]	**$115,054,351**[2]

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

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

CURRENT PROCEDURAL TERMINOLOGY CODES AND DATES OF ADJUSTMENTS FOR SAMPLED SURGERIES

Our sample of 300 eye global surgeries included 45 CPT codes. The following tables identify the 45 CPT codes by stratum and indicate the year in which the Centers for Medicare & Medicaid Services (CMS) last adjusted the relative value units for each code since establishing the fee schedule in 1992.

Stratum 1

CPT Code	Description	Last CMS Adjustment
66984	Cataract surgery with intraocular lens, 1 stage	2007

Stratum 2

CPT Code	Description	Last CMS Adjustment
65400	Removal of eye lesion	Not adjusted
66940	Extraction of lens	Not adjusted
67010	Partial removal of eye fluid	Not adjusted
67036	Removal of inner eye fluid	Not adjusted
67039	Laser treatment of retina	Not adjusted
67040	Laser treatment of retina	Not adjusted
67107	Repair detached retina	Not adjusted
67108	Repair detached retina	Not adjusted
67255	Reinforce/graft eye wall	Not adjusted
67314	Revise eye muscle	Not adjusted
68320	Revise/graft eyelid lining	Not adjusted
68700	Repair tear ducts	Not adjusted
68750	Create tear duct drain	Not adjusted
67220	Treatment of choroid lesion	Not adjusted[1]
66982	Cataract surgery, complex	Not adjusted[2]
65450	Treatment of corneal lesion	1997
66170	Glaucoma surgery	1997
66172	Incision of eye	1997
66180	Implant eye shunt	1997
66825	Reposition intraocular lens	1997
67015	Release of eye fluid	1997
68720	Create tear sac drain	1997

[1]CPT code 67220 was established in 1999.

[2]CPT code 66982 was established in 2001.

CPT Code	Description	Last CMS Adjustment
67038	Strip retinal membrane	2007
67445	Explore/decompress eye socket	2007
67904	Repair eyelid defect	2007
67911	Revise eyelid defect	2007
67966	Revision of eyelid	2007

Stratum 3

CPT Code	Description	Last CMS Adjustment
65772	Correction of astigmatism	Not adjusted
65810	Drainage of eye	Not adjusted
66250	Follow-up surgery of eye	Not adjusted
66762	Revision of iris	Not adjusted
67105	Repair detached retina	Not adjusted
67141	Treatment of retina	Not adjusted
67880	Revision of eyelid	Not adjusted
67908	Repair eyelid defect	Not adjusted
67909	Revise eyelid defect	Not adjusted
67916	Repair eyelid defect	Not adjusted
67961	Revision of eyelid	Not adjusted
67210	Treatment of retinal lesion	1997
67312	Revise two eye muscles	1997
67900	Repair brow defect	1997
66761	Revision of iris	2007
66821	After-cataract laser surgery	2007
67228	Treatment of retinal lesion	2007

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: FEB 2 0 2009

TO: Daniel R. Levinson
Inspector General

FROM: Charlene Frizzera
Acting Administrator

SUBJECT: Office of Inspector General's Draft Report: "Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005" (A-05-07-00077)

Thank you for the opportunity to review and comment on the Office of Inspector General's (OIG) draft report entitled, "Nationwide Review of Evaluation and Management Services Included in Eye and Ocular Adnexa Global Surgery Fees for Calendar Year 2005." We appreciate the OIG's continuing efforts to examine the number of post operative evaluation and management (E&M) visits performed during the global period for physician services.

The OIG report presents findings from a review of a national sample of 300 global surgeries. The payments for these services reflect the typical number of E&M services provided to a beneficiary during the global period. The OIG analysis showed that the number of E&M services that the Centers for Medicare & Medicaid Services (CMS) assumes are necessary in the global period were performed in only 60 of the 300 services reviewed. For the other 240 services sampled, the OIG found that in 201 instances fewer E&M services were provided than were accounted for in the global period, and in 39 instances more E&M services were provided than were accounted for in the global period. The OIG estimates that CMS paid $97.6 million for E&M services that were included in eye global surgery fees but not provided during the global surgery periods in calendar year 2005.

Medicare first applied the concept of global surgery fees on January 1, 1992, with the inception of the Resource Based Relative Value Scale. The source of information for the assumed number of E&M services typically performed within a global period is variable, with some coming from the late 1980s/early 1990s Harvard study, others coming from the American Medical Association Relative Value Update Committee (AMA RUC) recommendations, and still other E&M inclusions coming from CMS.

OIG Recommendation

Adjust the estimated number of E&M services within eye global surgery fees to reflect the number of E&M services actually being provided to beneficiaries which may reduce payments by an estimated $97.6 million.

CMS Response

Although we acknowledge the merit in the OIG findings, CMS believes that it would be prudent to conduct further analysis before proposing any changes in the current number of E&M services assigned to eye surgeries. The level of the E&M services being performed is also an important factor for determining relative values for global surgeries. Although the OIG found that the number of visits assigned to the eye surgery services is not being performed in approximately ⅔ of the services sampled, the OIG did not look at the intensity level of the E&M services that were actually performed.

We plan to continue our work with the AMA RUC and the relevant physician specialty societies to identify and correct those services where the number of E&M services has changed in the global period.

OIG Recommendation

Use the financial results of this audit, in conjunction with other information, during the annual update of the physician fee schedule.

CMS Response

Although we acknowledge the merit in the OIG findings, CMS believes that it would be prudent to conduct further analysis before proposing any changes in the current number of E&M services assigned to eye surgeries.

We note that any change in payments realized from our ongoing review of the number of E&M services included in the global period of both eye surgeries and any other surgical services would be redistributed to all services on the physician fee schedule and would not result in savings to the Medicare program because such changes must be done in a budget neutral manner as required by the Medicare statute.