Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PHYSICIAN OFFICE SURGERY

JUNE 1993

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program and management problems and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. This report was prepared in the Kansas City regional office under the direction of Jim Wolf, Regional Inspector General. Project staff:

Kansas City

Tim Dold, Project Leader
Dennis Tharp, Program Analyst

Headquarters

Cathaleen Ahern, Program Specialist
Barbara Tedesco, Statistician

To obtain a copy of this report, call the Kansas City Regional Office at (816) 426-3697.

EXECUTIVE SUMMARY

PURPOSE

To evaluate the appropriateness of the surgical setting, the medical necessity of the surgery, and quality of care for selected surgical procedures performed in physicians' offices.

BACKGROUND

The volume of outpatient surgery continues to increase as reimbursement regulations change for inpatient surgical procedures. As medical technology improves, more surgeries are being performed in outpatient settings. These settings include ambulatory surgical centers, emergency centers, and single/multi-specialty physicians' offices. Surgeries in these settings can be as simple as laceration repair and as complex as cataract surgery.

The Health Care Financing Administration (HCFA) is concerned that the services provided to Medicare beneficiaries may not be reasonable and necessary. However, neither the Social Security Act nor the Medicare regulations specifically define quality of care for particular services performed in an office setting.

Until recently, the quality of procedures rendered to Medicare beneficiaries in physicians' offices was not subject to any type of review. Section 1154(a)(4)(A) of the Social Security Act required that "Each peer review organization (PRO) shall provide ... a reasonable allocation of such [quality review] activities is made among the different cases and settings" except that PRO review in physician offices could not begin before January 1, 1989. Currently, HCFA is conducting two pilot projects involving a total of 10 PROs. These PROs will review medical services provided in physicians' offices. However, there is no general quality of care review of physician office surgery currently in place.

METHODOLOGY

We selected a sample of surgeries containing procedure codes for bunionectomies, dilation and curettage, and excisions of breast lesions. We drew the sample from 1989 Part B Medicare Annual Data which showed these surgeries were performed in physicians' offices. A medical contractor reviewed office medical records for these surgeries. We also obtained allowable charge information on certain procedure codes from 11 Medicare carriers.

FINDINGS

One-Fifth of Medical Records Reviewed Did Not Document Reasonable Quality of Care

The physician reviewers found that in 25 of the 122 surgeries (20 percent) the medical records did not document reasonable quality of care. This projects nationally to 2,500 physician office surgeries for those procedure codes where medical records do not document reasonable quality of care.

Thirteen Percent of the Medical Records Did Not Document an Indication For Surgery

The physician reviewers found in 16 of the 122 surgeries (13 percent) the medical records did not document an indication for surgery, and therefore were not medically necessary. Projected nationally, Medicare paid $603,058 for medically unnecessary bunionectomies and excisions of breast lesions.

The Physician's Office Was Not An Appropriate Setting for A Small Number of Surgeries

The physician reviewers found that in six surgeries the physician's office was not an appropriate setting for the surgeries. The office setting was inappropriate due to the patient's level of illness or the type of anesthesia.

In 16 Percent of Our Sample Cases, Procedure Codes Did Not Match the Surgeries Performed

The physician reviewers found in 20 cases that the specific surgeries performed did not match one of the procedure codes included in this study. In only one instance did a physician bill a procedure code with an allowable charge that was less than the appropriate procedure code. All the others were billed in excess of the allowable charge for the correct procedure code. The difference in allowable charges between the submitted procedure code and the correct code amounts to $3,130.98. This projects nationally to $313,098 in upcoded claims for the procedure codes under study.

RECOMMENDATIONS

PROs Should Extend Their Review to Surgery Performed in Physicians' Offices

The results of this inspection confirm that quality assurance and peer review activities are needed in physicians' offices, for the reasons cited in section 1154 of the Social Security Act. As discussed in section 1154, (1) we have demonstrated problems exist regarding quality of care, (2) the yield in terms of numbers and seriousness of quality of care problems is apt to be significant, and (3) there is no other source of quality review, quality assurance, or peer review.

AGENCY COMMENTS

We have received comments on the draft report from HCFA. While HCFA generally concurs with our findings and recommendation, they wish to defer comment on the recommendation pending the completion of two PRO pilot projects to test the feasibility of physician office review and the development of a review protocol. We

agree that information gained in the pilot projects is important and should be considered in any proposal to expand review in outpatient sites.

The full text of their comments is included in Appendix E.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

To evaluate the appropriateness of the surgical setting, the medical necessity of the surgery, and quality of care for selected surgical procedures performed in physicians' offices.

BACKGROUND

The volume of outpatient surgery continues to increase as reimbursement regulations change for inpatient surgical procedures. As medical technology improves, more surgeries are performed in outpatient settings. These settings include ambulatory surgical centers (ASCs), emergency centers, and single/multi-specialty physicians' offices. Surgeries in these settings can be as simple as laceration repair and as complex as cataract surgery. The following illustrates the recent increases in the total number of surgeries allowed by Medicare and performed in physicians' offices.

FISCAL YEAR	ALLOWED PROCEDURES	ALLOWED CHARGES
1987	24,397,912	$1,387,857,158
1989	30,010,156	$1,768,395,391
1991	38,475,582	$2,027,877,728

The Health Care Financing Administration (HCFA) is concerned that the services provided to Medicare beneficiaries may not be reasonable and necessary. Section 1862(a)(1)(A) of the Social Security Act states that "Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services which ...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." However, neither the Social Security Act nor the Medicare regulations specifically define quality of care for particular services performed in an office setting.

Section 1154(a)(4)(A) of the Social Security Act required that "Each peer review organization (PRO) shall provide that . . . a reasonable allocation of such [quality review] activities is made among the different cases and settings (including post-acute-care settings, ambulatory settings, and health maintenance organizations) except that PRO review in physician offices could not begin before January 1, 1989. In establishing such allocation, the organization shall consider (i) whether there is reason to believe that there is a particular need for reviews of particular cases and settings because of previous problems regarding quality of care, (ii) the cost of such reviews and the likely yield of such reviews in terms of number and seriousness of quality of

care problems likely to be discovered as a result of such reviews, and (iii) the availability and adequacy of alternative quality review and assurance mechanisms."

Currently, HCFA is conducting two pilot projects involving a total of 10 PROs which address peer review of services provided in a physicians' offices. The Delmarva Foundation (Maryland PRO) is working on a pilot project with two PROs, reviewing primary-care services provided in physician offices. The scheduled completion date for this project is September 1993. The other project, The Wisconsin Ambulatory Review Project (WARP), involves seven PROs. This project will develop and assess a system for monitoring the quality and cost effectiveness of ambulatory medical care for office-based practices. The WARP began December 1, 1989, and was scheduled to last for two years. It was extended through November 1992.

METHODOLOGY

We selected a sample of 364 surgeries. We drew the sample from 1989 Part B Medicare Annual Data (BMAD) which showed these surgeries were performed in physicians' offices. We chose seven procedure codes for bunionectomies, dilation and curettage (D & C), and the excision of a breast lesion to represent the more complex surgeries completed in physicians' offices. According to BMAD data, these procedures had general anesthesia claims associated with at least 25 percent of the surgeries. A chart showing the place of service of the selected codes is shown in Appendix A.

We obtained copies of medical records for the selected surgeries. We worked with Medicare carriers to get copies of claims, beneficiary payment histories, and names and mailing addresses of physicians who performed office surgeries. We obtained medical records for 247 surgeries. For a variety of reasons, we were not able to obtain the medical records for the remaining 117 surgeries. A detailed explanation of the 117 surgeries is in Appendix B.

Based on our review of these records, we determined that 91 surgeries had been performed in hospitals or ASCs. The medical records for the remaining 156 surgeries were sent to Forensic Medical Advisory Service (FMAS), a medical review contractor.

The FMAS, working with the Office of Inspector General (OIG), developed worksheets to review the medical records. The worksheets contained a variety of data elements that focused on preoperative, operative, and postoperative care. Separate worksheets were used for each of the three surgical groups. The FMAS used surgeons who were experts in their specialty to develop current evaluative criteria for each of the procedures. The reviewers, using professional judgement, completed a narrative summary and a worksheet for each case. An example of a medical review worksheet is in Appendix C.

In their review, FMAS found that 14 of the 156 surgeries were not performed in the office setting, but in a hospital or ASC. Also, FMAS did not complete all of the

information in the medical review worksheets for 20 surgeries because these particular surgeries did not match one of the procedure codes in this study. The medical review worksheets were completed for the remaining 122 surgeries.

We also obtained allowable charge information on certain procedure codes from 11 Medicare carriers.

We conducted our review according to the ***Quality Standards for Inspections*** issued by the President's Council on Integrity and Efficiency.

FINDINGS

One-Fifth of Medical Records Reviewed Did Not Document Reasonable Quality of Care

The physician reviewers found in 25 of the 122 surgical cases (20 percent) that the medical records did not document reasonable quality of care. We found that these cases involved surgeries in each of the three surgical groups. Eighteen were bunionectomy cases, four were D & C cases, and three cases involved the excision of breast lesions. This projects nationally, for physician office medical records that do not document reasonable quality of care, to:

Type of Surgeries	Bunionectomies	D & Cs	Breast Lesions
Projected Number of Surgeries	1,800 (±35.8%)	400 (±80.8%)	300 (±95.8%)
90 Percent Confidence Interval	1,155 - 2,444	76 - 723	218 - 581

The physician reviewers found that in 16 of the 25 cases the preoperative evaluations were not adequate. In one case, the physician reviewer stated "there is a marked lack of information regarding a preoperative history and physical evaluation and laboratory studies." In another case, the reviewer noted "the preoperative evaluation is lacking for indications for surgical intervention as well as documentation of vascular status and overall history and physical."

The reviewers also found that 3 of the 25 cases had postoperative complications. In a case involving a breast lesion, the patient developed a postoperative hematoma, (a localized swelling filled with blood) which took several months to heal. In a bunionectomy case a procedure was performed while an existing infection of the skin was present. A cast was applied despite the infection. The patient was put on an antibiotic regimen, but complications ensued.

A distribution of the preoperative and postoperative issues is shown in the table on the next page.

DISTRIBUTION OF PREOPERATIVE AND POSTOPERATIVE ISSUES

Surgery Type	Inadequate Quality of Care	Inadequate Preop Evaluations	Postoperative Complications
Bunionectomy	18	14	2
Breast Lesion	3	2	1
D & C	4	0	0

Thirteen Percent of the Medical Records Did Not Document an Indication For Surgery

The physician reviewers found in 16 of the 122 surgeries (13 percent) the medical records did not document an indication for surgery, and therefore were not medically necessary. For example, one reviewer noted there is no evidence documenting the indication for correction of a bunion. In another case a reviewer stated that there was no documentation of the necessity for the removal of a breast lesion.

The 16 surgeries involve 14 bunionectomies and 2 excisions of breast lesions. Nine of these 16 cases are also among the 25 cases where the reviewers determined that the medical records did not document a reasonable quality of care.

The physicians were paid a total of $6,030.58 for the 16 surgeries. Because of our sampling of records for only seven procedure codes, this projects nationally to only $603,058 (±52.3%) for medically unnecessary surgery in physician offices. Therefore, this estimate can vary by $315,441 for a range of $287,617 - $918,499 at the 90 percent confidence level.

The Physician's Office Was Not An Appropriate Setting for A Small Number of Surgeries

The physician reviewers found that in 6 of 122 surgeries, the physician's office was not an appropriate setting for the surgeries. The office setting was inappropriate due to the patient's level of illness or the type of anesthesia administered. The reviewers also found 1 of the 6 cases not to be medically necessary, and all 6 cases are among the 25 cases where the reviewers determined that the medical records did not document a reasonable quality of care.

Level of Illness

For three cases, the physician reviewers found the setting was not appropriate for the type of procedure given the patient's level of illness. For example, one case involved an 80 year-old female that underwent a bunion procedure. The physician reviewer stated that according to the medical record, the patient had small vessel disease in the

lower extremities. For this reason, the reviewer stated that the setting for the surgery was not appropriate.

Type of Anesthesia

Physician reviewers determined for three D & C cases that the setting was not appropriate due to the type of anesthesia administered. In each of these cases, the type of anesthesia included an IV sedative/hypnotic and local anesthesia. In one of the three cases, the type of anesthesia also included an IV narcotic. The physicians administered the anesthesia in these cases.

The reviewers stated in each of these cases that the setting was not appropriate because of insufficient monitoring of anesthesia and inadequate recording of vital signs. The medical records did not document the existence of the necessary additional medical staff to conduct these activities. A reviewer commented:

> "It is important that the patient be monitored carefully, not necessarily by an anesthesiologist or anesthetist, but by a nurse or physician assistant who could appropriately record the vital signs of the patient before, during, and after the procedure."

In 16 Percent of Our Sample Cases, Procedure Codes Did Not Match the Surgeries Performed

The physician reviewers found that in 20 cases the surgeries documented in the medical records did not match one of the procedure codes in this study. For each of these cases, the physician reviewers identified the correct procedure code.

Through the carriers, we obtained allowable charge information for the revised procedure codes. We requested allowable charges for these physicians for 1989, the year in which the surgeries were performed.

Allowable charge information was obtained for 17 of the 20 cases. We found that upcoding occurred in 16 cases and downcoding occurred in 1 case. We were unable to determine a dollar amount for the remaining three cases. For example, a carrier could not provide allowable charge information because the provider never billed the procedure code in question and prevailing information had been purged for 1989.

We compared the original allowable charges with the allowable charges for the revised procedure codes. We found upcoding in the 16 cases because the allowable charges for the original procedure codes were higher than the allowable charges for the revised procedure codes. The total net overpayment amounts to $3,130.98 as shown in Appendix D. Again, our use of only seven procedure codes in this study allows us to project our results only for those codes. This results in a modest national projection of upcoding of $313,098 (±44.6%). This estimate can vary by $139,709 for a range of $173,389 - $452,807 at the 90 percent confidence level.

RECOMMENDATIONS

PROs Should Extend Their Review to Surgery Performed in Physicians' Offices

We recognize that the role of PROs and to some degree Medicare carriers, in conducting the quality assurance function, is evolving from a case-by-case review to general studies of medical practice. We believe, however, that physician office surgery involving complex procedures once provided only in an institutional setting deserves attention.

The results of this inspection confirm that quality assurance and peer review activities are needed in physicians' offices, for the reasons cited in section 1154 of the Social Security Act. As discussed in section 1154, (1) we have demonstrated problems exist regarding quality of care, (2) the yield in terms of numbers and seriousness of quality of care problems is apt to be significant, and (3) there is no other source of quality review, quality assurance, or peer review.

The findings of this inspection relating to quality of care should be compared with the findings of the PRO pilot projects, to determine whether only surgical cases or both medical and surgical cases should be subject to the review allocation required by section 1154.

Such PRO review should include: (1) assurance that medical records document reasonable quality of care (both in the sense that documentation is adequate and that quality care is rendered), (2) that physicians perform only those procedures appropriate for an office setting, (3) that physicians perform only medically necessary procedures, and (4) that accurate procedure codes are used to submit claims for physician services.

AGENCY COMMENTS

We received comments from HCFA which generally concur with the findings in the report. The full text of their comments are included in Appendix E.

The HCFA has indicated that they wish to defer comment on the recommendation that PRO review be extended to surgery performed in physicians' offices pending the completion of two PRO pilot projects to test the feasibility of physician office review and the development of a review protocol. We agree that information gained in the pilot projects is important and should be considered in any proposal to expand review in outpatient sites.

The HCFA also expressed concern regarding our estimates and our ability to distinguish between poor quality of care and poor documentation. The following information provides additional clarification of these points.

Projections of dollars paid for unnecessary surgery: The projected dollars associated with medically unnecessary surgery are conservative in that they were based on our original sample of 328 claims rather than the 122 cases for which we obtained records. The 206 cases which we did not review were assumed to represent medically-necessary surgery.

Projections for poor quality care: The projection for poor quality surgeries in physicians' offices is based on the 122 cases for which we obtained records. While it is true that 206 out of our original sample of 328 did drop out, due to either miscoding of place of service or non-response to our request for records, the remaining 122 cases are still a random sample. The distribution of this resultant sample represents a subset of the original. Therefore, the estimates of poor quality of care and the precision given in the report are based on this subset of the original sample.

The HCFA also questioned whether poor documentation is sufficient proof of poor quality of care or lack of an indication for surgery. We agree that it is possible that appropriate care was given in some cases but not documented. However, the vast majority of cases reviewed were almost certainly unnecessary or of poor quality. For example, medical review of quality of care revealed that in 18 cases the care was poor regardless of the presence or absence of information. In seven cases the care may have been appropriate, but missing information in the medical records made it impossible to tell. In all cases including the last seven, the missing information would hamper appropriate care in cases in which another physician renders care following the original procedure, and must use an inadequate record of indications, test results, or other pertinent information. HCFA agrees that even percentages smaller than those we report represent serious problems.

The HCFA acknowledges the dangers of administering anesthesia in physician office settings but feels it cannot determine the relative danger because the offices vary

greatly in standard of care, equipment, and personnel training. Our inspection report, "Surgery in Outpatient Settings: A Four-State Study" (OEI-07-91-01470), released in 1992, identified this danger and recommended that States examine their licensure rules to ensure the quality of high-risk outpatient procedures, such as those performed under general anesthesia or intravenous sedation.

The HCFA also suggested clarifications of some details in the report; we have made pertinent modifications.

APPENDIX A

1989 BMAD Procedure Codes by Place of Service

HCPCS Code (Number performed)	Description	% in Office	% in Inpatient Hospital	% in Outpatient Hospital	% in ASC
19120 (119,906)	Excision of cyst, etc., from breast	8.2	23.8	63.2	4.2
28290 (9,139)	Bunionectomy, Silver type	24.5	24.9	37.0	12.8
28292 (31,049)	Bunionectomy, Keller, McBride or Mayo type	27.3	22.9	39.9	8.9
28293 (7,363)	Bunionectomy, resection of joint with implant	13.6	26.1	48.6	10.9
28296 (14,622)	Bunionectomy, with metatarsal osteotomy	22.3	25.4	42.4	8.6
28298 (3,931)	Bunionectomy, by phalanx osteotomy	45.5	14.8	32.1	6.8
58120 (63,734)	Dilation and curettage, (non-obstetrical)	9.9	29.1	55.4	5.1

APPENDIX C

MEDICAL REVIEW WORKSHEET
EXAMPLE

DHHS TASK ORDER 26: PHYSICIAN OFFICE SURGERY STUDY

EXCISION OF BREAST LESION

MEDICAL REVIEW WORKSHEET

I. PATIENT IDENTIFICATION/DEMOGRAPHIC ELEMENTS:

1. Unique identifier code
2. HIC number
3. Surgical setting
4. Date of surgery
5. Age of patient
6. Race of patient
7. Sex of patient
8. Surgical procedure (use HCPCS codes)

(Code for procedure actually done as documented; not necessarily what was submitted to HCFA for reimbursement.)

II. QUALITY OF CARE ELEMENTS

PREOPERATIVE

1. Indication for surgery documented?
(Describe in dictated narrative if not indicated.)

   a. Presence of palpable lump. Must be demonstrated by palpation on physical examination. Includes lump which has not completely subsided after needling with production of fluid or has recurred after needling with production of fluid

   b. Other indication

   (Specify)_____
   (Describe in dictated narrative.)

2. Generally not indicated?
(Describe in dictated narrative.)

   a. Not appropriate procedure for lump which has subsided after needling with production of fluid, i.e., a resolved cyst

Unique identifier code

b. Other non-indication

(Specify)_____

3. Preoperative Screening

a. Mammography or sonography performed?

i. If yes, did lesion appear to be a cyst?

ii. Did lesion feel like a cyst upon physical examination?

iii. If lesion appeared to be a cyst on mammogram or sonogram or appeared to be a cyst by physical examination (yes to 3ai or 3aii) was an aspiration biopsy performed?

b. Is there documentation of historical questioning regarding bleeding or coagulation problems?

i. If yes, was a bleeding or coagulation problem identified?

ii. If yes, were coagulation studies done?

c. Is there documentation of historical questioning regarding cardiac or pulmonary disease?

i. If yes, was a significant cardiac or pulmonary disease identified?

ii. If 3ci = yes and if patient is >40 and received anesthesia, was an ECG done within three weeks prior to procedure?

iii. If 3ci = yes and patient >40 and received anesthesia, was a chest x-ray done within three weeks prior to procedure?

4. Preoperative History and Physical

a. Is there documentation of a history and physical having been done by the operating surgeon?

b. Is there documentation concerning a history and physical or medical clearance from the patient's general medical physician?

Unique identifier code

c. Was an anesthesiologist or CRNA indicated for this case? (Answer yes if an anesthesiologist or CRNA was present or there was a need for monitoring or supervision by anesthesiologist or CRNA.)

i. If yes, is preoperative anesthesia review documented?

ii. If yes, adequate?

iii. Performed by anesthesiologist?

iv. Performed by CRNA?

d. Were the preoperative evaluations adequate? (If IV sedation or general anesthesia, should have either a history and physical by surgeon or medical clearance or history and physical by general medical physician within one week prior to procedure. Local anesthesia requires only a brief history and physical. If inadequate, describe in dictated narrative.)

5. Consent form in record?

6. If IV sedation or general anesthesia:

a. Was preoperative blood pressure documented?

b. Was preoperative pulse documented?

c. Was preoperative temperature documented?

d. If yes, were vital signs appropriately stable prior to procedure?

7. If IV sedation or general anesthesia, was patient NPO prior to procedure?
(If no, describe in dictated narrative.)

8. Appropriateness of setting:
(If any no, describe in dictated narrative.)

a. Was the setting appropriate for the type of procedure given the patient's level of illness?

b. Was the type of anesthesia administered appropriate for the patient?

c. Was the setting appropriate for the type of anesthesia administered?

Unique identifier code

d. Was a mass present only on mammogram or sonogram, i.e., not on palpation?
(In that case would require needle localization in x-ray department, and would not be appropriate for office setting.)

OPERATIVE

1. If IV sedation or general anesthesia, did patient have IV inserted for duration of procedure?

2. Total operating (procedure) time: _____min.

3. Total anesthesia time: _____min.
(If no anesthesia time was documented and the anesthesiologist or CRNA was not present, enter N/A for not applicable.)

4. Type of anesthesia: Administered by:

a. Intravenous narcotic

b. Intravenous sedative/hypnotic

c. Local

d. General

5. If IV sedation or general anesthesia, does record document vital signs during surgery?

a. If yes, completed by:

i. Anesthesiologist

ii. Surgeon

iii. CRNA

iv. Other RN

v. Other

(Specify)_____

Unique identifier code

6. Intraoperative complications?
(Describe in dictated narrative.)

   a. If yes, was procedure completed?

   b. If complication, appropriate intervention?

   c. If yes to any above, related to anesthesia?

   d. If yes to any above, related to setting?

7. If procedure was begun under local, was it necessary to advance to IV sedation or general anesthesia?
(If yes, describe in dictated narrative.)

8. Pathological diagnosis documented?

   a. If yes, list pathological diagnoses below and describe in dictated narrative.

   _____
   _____
   _____

POSTOPERATIVE

1. Complications? (If yes, check any that apply. Describe in dictated narrative.)

   a. Infection

   b. Incisional skin slough

   c. Incomplete removal

   d. Severe postoperative pain

   e. Significant postoperative deformity

   f. Significant hematoma

   g. Other

      (Specify)_____
      (Describe in dictated narrative.)

   h. If yes to any above, related to anesthesia?

   i. If yes to any above, related to setting?

Unique identifier code

2. Was there documentation of postoperative instructions being given?

3. Were postoperative medications indicated?

   a. If yes, were they appropriately administered?

4. Surgical followup (postoperative visit) within 10 days after surgery?

5. Was a postoperative management plan documented?

6. Was there a postoperative note prior to discharge?

   a. If yes, documented by:

      i. Anesthesiologist

      ii. Surgeon

      iii. CRNA

      iv. Other RN

      v. Other

         (Specify)_____

7. a. If IV sedation or general anesthesia given:

      i. Was postoperative blood pressure documented?

      ii. Was postoperative pulse documented?

   b. If yes, were vital signs appropriately stable before discharge?
   (If no, describe in dictated narrative.)

8. Patient alive?
(Describe death or transfer in dictated narrative.)

   a. If yes, patient released home?
   (Answer yes if nursing home resident returns to nursing home.)

   b. If yes, patient transferred to hospital? (Yes, if direct admit.)

Unique identifier code

c. If yes, patient transferred (not to hospital)?

d. If transferred, specify location._____

9. Admitted to hospital within 15 days (related to procedure)?

(Describe in dictated narrative.)

10. Did patient have followup surgery within 15 days related to previous procedure?
(Describe in dictated narrative.)

11. Overall, was a reasonable quality of care documented in this patient's medical record?
(If no, describe in dictated narrative and indicate need for second reviewer under Part III.2.)

PART III: REVIEW INFORMATION

1. Reviewer ID: _____

2. Second reviewer needed? #11
(Second reviewer needed if ~~#10~~ above is no or for other significant quality or medical necessity issues.)

3. If yes, second reviewer ID_____

4. Does second reviewer agree with the opinion of the first reviewer?
(If no, describe in dictated narrative.)

5. Date of first review: __/__/__

6. Date of second review: __/__/__

Answers to questions are indicated according to the following code unless otherwise specified:

1 = YES

2 = NO

3 = NOT DOCUMENTED OR CANNOT TELL (N/D)

4 = NOT APPLICABLE (N/A)

Exceptions:

Identification/Demographic Question 3
1 = Office
2 = Other

Demographic Information Question 6
1 = White
2 = Black
3 = Asian
4 = American Indian
5 = Spanish origin/Hispanic
6 = Not Documented

Demographic Information Question 7
1 = Male
2 = Female
3 = Unknown

Operative Questions 2. and 3. are indicated with actual time in minutes.

Operative Questions 4.a., 4.b., 4.c. and 4.d. have the following legend:

Administered by:
a. = Anesthesiologist
b. = Surgeon
c. = CRNA
d. = Other RN
e. = Other
f. = Not documented or cannot tell
g. = Not applicable

Reviewer Information Questions 1 and 3 = Three digit coded physician number.

Reviewer Information Questions 5 and 6 = mm/dd/yy.

APPENDIX D

DIFFERENCES IN ALLOWABLE CHARGES

(A) BILLED CODE	(B)[1] ALLOWABLE CHARGE	(C) REVISED CODE	(D)[2] REVISED ALLOWABLE CHARGE	(E) DIFFERENCE BETWEEN (B)&(D)
28293	779.00	28285	339.30	439.70
28292	565.50	28110	295.00	270.50
28292	848.25	28285	510.30	337.95
28292	475.10	28110	307.50	167.60
58120	280.07	57800	57.97	222.10
58120	264.20	58100	292.03	(27.83)[3]
58120	212.80	58100	54.10	158.70
58120	203.60	58100	40.80	162.80
58120	130.00	57500	49.80	80.20
58120	239.20	58100	50.40	188.80
58120	210.00	58100	55.20	154.80
58120	165.99	58100	52.15	113.84
58120	224.02	58100	49.30	174.72
58120	249.60	58100	40.70	208.90
19120	400.00	11402	100.00	300.00
19120	226.10	11401	75.00	151.10
19120	75.00	11400	47.90	27.10
TOTALS	$5,548.43		$2,417.45	$3,130.98

[1] Allowable charge for the procedure code billed.

[2] Allowable charge for the procedure code matching the surgery performed.

[3] The Medicare carrier advised that the physician never billed the revised procedure

APPENDIX E

HEALTH CARE FINANCING ADMINISTRATION COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Financing Administration

Memorandum

Date APR 26 1993

From William Toby, Jr.
Acting Administrator

Subject Office of Inspector General (OIG) Draft Report: "Physician Office Surgery" (OEI-07-91-00680)

To Bryan B. Mitchell
Principal Deputy Inspector General

We reviewed the above-referenced report which evaluates the appropriateness of the surgical setting, the medical necessity of the surgery, and quality of care for selected surgical procedures performed in physicians' offices. The report concludes that physician office surgery suffers from both quality and utilization problems. As a result, OIG recommends that the Peer Review Organizations (PRO) extend their review to surgery performed in physicians' offices. The report further suggests that its findings be compared to findings from PRO pilot projects on physician office review.

We would like to defer comment on the recommendation. The PRO pilot projects were designed to test the feasibility of physician office review and to aid in the development of a review protocol. These pilot projects are still ongoing and the results are preliminary. After these projects are completed, we plan to develop implementation options which would relate to the monitoring of both medical services and surgical procedures and, at that time, will take into account OIG's recommendation. Our detailed comments are attached for your consideration.

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

Attachment

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG) Draft Report:
Physician Office Survey
OEI-07-91-00680

Recommendation

PROs should extend their review to surgery performed in physicians' offices.

HCFA Response

Because Peer Review Organization (PRO) review of physician office care is an important and complex area, careful attention in the development of good review methods is necessary before implementing this new PRO review system. Recognizing the uncertainty of how such review could best be performed, beginning in 1989, HCFA funded pilot projects to explore alternative approaches to physician office review. We believe that we must await the results of these projects and develop options for implementation before we can conduct a review of medical and/or surgical services provided in physicians' offices. We hope to be ready to implement such review beginning with the Fifth PRO Contract Cycle in 1996.

Although we agree that the physician office is a likely and appropriate setting for further PRO review, our ability to move forward with such reviews will also depend largely on obtaining additional funding. The cost of the PRO program would dramatically increase with the inclusion of physician office review, even if limited to surgical procedures. The actual cost increase would be based on the level and type of review required. In the current cost cutting environment, HCFA may have a difficult time obtaining additional funds for the PRO program without substantial outside support. In light of the medical community's resistance to PRO physician office review, this support may be difficult to secure.

General Comments

- Executive summary, page i, Background, third paragraph, second sentence should read: "Section 1154(a)(4)(A) . . . except that PRO review in physician offices could not begin before January 1, 1989."

- Introduction, page 2, first paragraph, sixth sentence, after "years" an additional sentence should be added to read - "It was extended for 1 more year."

- Pages 2-3, we have some concern over the small size of the sample, as well as its randomness after so large a number of cases selected were removed from the sample prior to (or during) the actual review.

- The purpose of the study is stated as: "To evaluate the appropriateness of the surgical setting, the medical necessity of the surgery, and quality of care for selected surgical procedures performed in physicians' offices." In the findings section of the report, under the heading One-fifth of Medical Records Reviewed Did Not Document Reasonable Quality of Care (pages 4-5), the report states that the medical records did not document reasonable quality of care in 20 percent (25 of 122) cases. Under the heading Thirteen Percent of Office Surgeries Were Not Medically Necessary (page 5), the report states that the medical records did not document an indication for surgery in 13 percent (16 of 122) cases.

  OIG apparently assumes that poor documentation proves that a poor quality of care existed and that an indication for surgery was not, in fact, present. This may have been the case. However, since the physician reviewers did not request additional information from the physicians under review, it is difficult to assess whether the concerns encountered reflected poor quality of care and lack of medical necessity or simply poor documentation. Although good documentation can establish the medical necessity and good quality of care for a procedure, it is not necessarily true that poor documentation proves that the medical necessity for a procedure was not present or that a poor quality of care was rendered. Therefore, it is reasonable to assume that the true figure for poor quality of care is below 20 percent and that the true figure for a lack of medical necessity for the procedure is less than 13 percent. We would agree, however, that percentages considerably less than these figures are still a significant cause for concern.

- OIG projects that Medicare paid $603,058 for medically unnecessary bunionectomies and excisions of breast lesions (presumably in 1989) (page 5). Again this figure is likely to be somewhat inflated since the physician reviewers in the study made their decisions according to the documentation in the medical record alone and did not request additional information.

- The report states that 6 of 122 surgeries were performed in an inappropriate setting (page 5). This figure points up a problematic area in the review of care rendered to Medicare beneficiaries. Presently, there is no routine way of identifying these cases for medical review. If, after office surgery, a patient is admitted to a hospital, some of these cases may be identified by the PRO in the course of its review of its sample cases.

The report states that three cases were determined to have been performed in an inappropriate setting due to the type of anesthesia involved (page 6). It is difficult to determine the relative dangers of the administration of anesthesia in office settings. Physicians' offices are not routinely inspected or certified by any group or agency. Therefore, the standard of care, presence of necessary equipment, and the training of personnel vary greatly.

- The report states that procedure codes did not match the surgery performed in 20 cases (page 6). In 16 of the cases, the procedure was determined to be upcoded. For the 7 procedures, OIG projects a cost of upcoding at $313,098. This finding presents one of the difficulties inherent in reviewing office procedures from a cost containment perspective. The medical review of office records by the clinicians necessary to make the determinations involved is an expensive process. To limit the costs of review, it is usually performed on a focused or targeted basis. Thus, it is expected that a certain amount of upcoding in the general population of claims will not be identified.