

**Congress of the United States**  
**Washington, DC 20515**

August 7, 2012

Marilyn Tavenner  
Acting Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Room 445-G, Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

RE: Medicare Audit Programs

Dear Administrator Tavenner:

We are writing to request an immediate suspension and review of the ongoing Medicare audit programs in Colorado, Delaware, the District of Columbia, Maryland, New Jersey, New Mexico, Oklahoma, Pennsylvania, and Texas related to major lower extremity joint replacement (diagnosis-related group (DRG) 470).

Medicare audits have an important role to play in insuring the integrity of the Medicare program. However, at times in an effort to protect taxpayers and beneficiaries, the Centers for Medicare and Medicaid Services (CMS) issue rules that may have an unforeseen but substantial impact on patient care and we feel it is appropriate to discuss these concerns with CMS. In these cases, where unnecessary rules are adopted without a proper reflection on long-term patient access, hospitals and physicians may have to fight for months or even years to rectify erroneous, improper payment determinations by a Medicare Administrative Contractor (MAC) or Recovery Audit Contractor (RAC). Money that could have been spent on improving patient care or investing in research must now be spent fighting determinations made by contractors. We feel actions being undertaken in some regions regarding DRG 470 raise these concerns.

Specifically, we are concerned at the means by which MACs are focusing their medical necessity audits for DRG 470 on conservative management prior to surgery. They are requiring that the hospital record document a minimum of three months of conservative management, such as physical therapy, prior to surgery. Yet, orthopaedic surgeons recognize that conservative management is not appropriate for many of their senior patients because significant numbers of them wait as long as possible before their first visit with the physician and further delay could lead to further deterioration. It is our view that course of treatment should be established based on the clinical judgment of the physician and the determination of whether physical therapy services are needed should be based on the judgment of the provider and patient. While physical therapy is the appropriate course of treatment for some patients, it is not the correct clinical choice for all beneficiaries. Ordering treatment that is not medically necessary is not beneficial to the patients nor is it cost effective for the Medicare program. Moreover, such requirements often are not spelled out in any official coverage policy.

Patients deserve access to the best care possible. We are deeply concerned that in this specific regard, audit contractors are unintentionally wandering into the realm of making treatment

decisions rather than medical professionals, thereby threatening the very access that patients need to get healthy.

We have consulted with representatives of the American Association of Orthopaedic Surgeons and the American Association of Hip and Knee Surgeons, and it is our understanding that Medicare reviewers are delving deeper into medical decision making when they conduct DRG validations and medical-necessity audits of joint replacement surgery. Some Medicare contractors are rejecting claims because they do not agree with the physician's determination of a particular patient's need for a procedure. In the past, auditors focused on whether charts contained proper documentation for medical services. Now, it has been reported that Medicare auditors are looking at the diagnosis, the history, what tests were performed, and the decision-making prior to procedures. This would represent a significant change in administration, and one where Medicare Administrative Contractors would be making health care decisions, rather than the board certified surgeon. Further, these contractors would be making critical surgical decisions based not on the patient's needs, but rather on the contractor's arbitrary metrics.

To compound matters, Medicare coverage for outpatient physical therapy is capped at \$1,880 per year in 2012. At this rate of reimbursement, if therapy is required for three months prior to consideration of surgery, then the Medicare dollars will be used up well before twelve weeks of therapy are complete. To make matters worse, if the patient fails this kind of "conservative management" and the surgeon must proceed to a joint replacement, there would be no access to physical therapy following the surgery when that therapy would be most appropriate, because all the physical therapy coverage would have already been used up.

While medical necessity reviews are certainly appropriate when they address a particular patient's needs, we believe that this may not be the case with conservation management for many Medicare beneficiaries. We understand that some MACs are using the InterQual® Criteria or the Milliman Care Guidelines® to determine the medical necessity of surgery. It is our belief that these guidelines are not patient specific and were never intended for this purpose. MACs ought not to be making medical decisions that are best left as a joint decision between patients, their physicians, and their physical therapist. It also appears that some sections of these proprietary guidelines were not based on input from clinicians. Education of the physician and hospital community is an important part of achieving compliance with documentation requirements that has not been included in the present approach to conservation management reviews.

We support efforts to enhance program integrity, and recognize the important role that Medicare auditors play in ensuring payments are paid properly, but we have concerns with regard to how these reviews are being conducted. We suspect that these new onerous requirements—requirements that do not take the best interest of the patient into account—are an unintended negative consequence of a broader, more laudable goal of rooting out fraud, something we wholeheartedly support. Accordingly, we urge you to address this issue to ensure appropriate orthopaedic care criteria for patient care are adopted, or clarifying local coverage determinations (LCDs) are implemented.


We ask that these reviews be suspended until these issues can be addressed in the current process and changes instituted that ensure appropriate coverage criteria for total joint replacements and clarify documentation requirements for providers. We must ensure patients are not further harmed by unnecessary barriers to appropriate care. Moreover, we ask CMS to work with the

medical community to define and implement reasonable and necessary criteria for Medicare coverage of total joint replacement procedures, and to provide clear guidance to providers regarding medical necessity criteria as well as required documentation going forward. Should you have any questions regarding this letter, please feel free to contact JP Paluskiewicz in Congressman Burgess' office at [James.Paluskiewicz@mail.house.gov](mailto:James.Paluskiewicz@mail.house.gov) or Walter Gonzales in Congressman Ruppertsberger's office at [Walter.Gonzales@mail.house.gov](mailto:Walter.Gonzales@mail.house.gov).

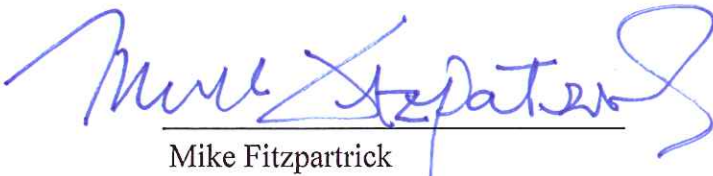
Sincerely,

  
Michael Burgess, M.D.  
Member of Congress

  
C.A. Dutch Ruppertsberger  
Member of Congress

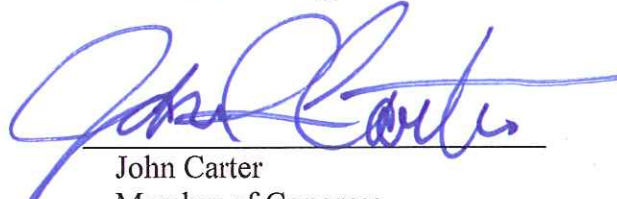
  
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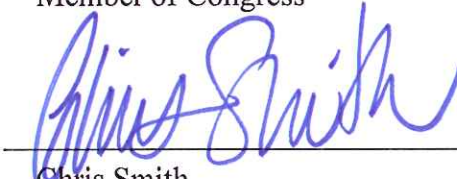
  
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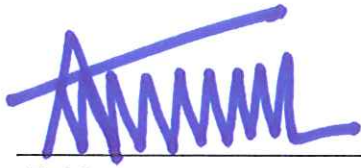
  
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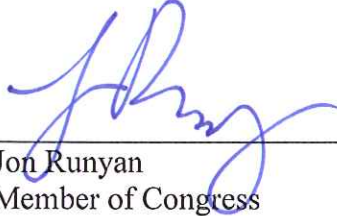
  
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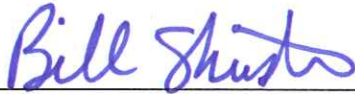
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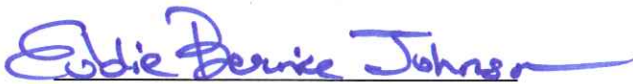
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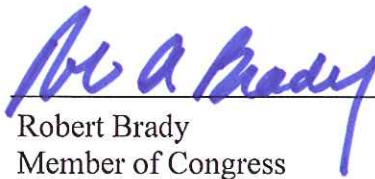
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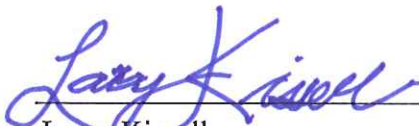
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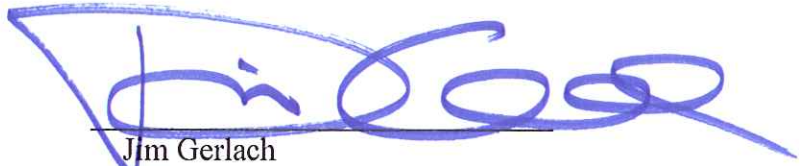
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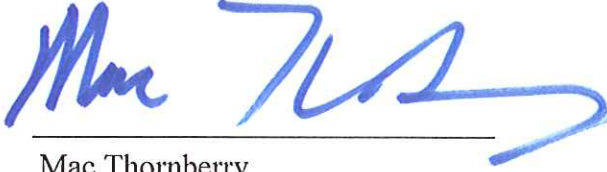
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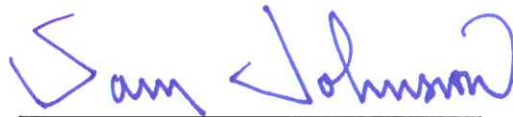
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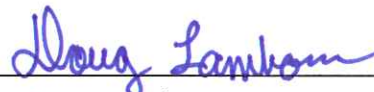
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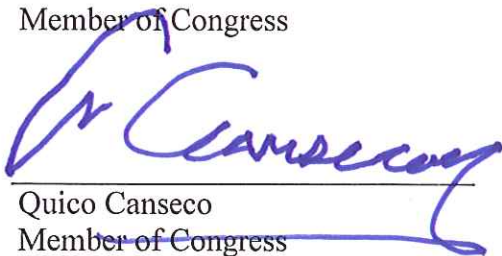
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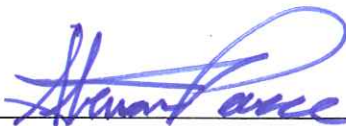
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