United States General Accounting Office

GAO

Report to Congressional Committees

October 2002

MEDICARE PHYSICIAN PAYMENTS

Medical Settings and Safety of Endoscopic Procedures

GAO-03-179

Contents

Figures

Abbreviations

ASC	ambulatory surgical center
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000
CMS	Centers for Medicare & Medicaid Services
CON	certificate of need
CPT	Current Procedural Terminology
HCFA	Health Care Financing Administration

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United States General Accounting Office
Washington, DC 20548

October 18, 2002

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United States Senate

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House of Representatives

Every year millions of Americans covered by Medicare[1] undergo endoscopic medical procedures in a variety of health care settings ranging from physicians' offices to hospitals. These invasive procedures call for the use of a lighted, flexible instrument and are used for screening and treating disease. Although some of these endoscopic procedures, such as the sigmoidoscopic examination of the large bowel, can be performed while the patient is fully awake, most require some form of sedation and are usually provided in health care facilities such as hospitals or ambulatory surgical centers (ASC). Some physician specialty societies have expressed concern that Medicare's reimbursement policies may offer a financial incentive to physicians to perform endoscopic procedures in

[1]The Medicare program is administered by the Centers for Medicare & Medicaid Services (CMS), a federal agency within the U.S. Department of Health and Human Services. On July 1, 2001, the Secretary of Health and Human Services changed the name of the Health Care Financing Administration (HCFA) to CMS. This report refers to the agency as CMS when discussing actions taken since the name change and as HCFA when discussing actions taken before the name change.

their offices and that these procedures may be less safe because physicians' offices are less closely regulated and therefore there is less oversight of the quality of care.[2]

Medicare provides higher payments for medical procedures performed in physicians' offices than if they were performed in hospitals or ambulatory surgical centers. These differences are based on relative resources used in the delivery of medical services. Physicians conducting procedures in their offices are responsible for providing clinical staff, supplies, and equipment. However, physicians who conduct procedures in hospitals or ASCs have fewer expenses, since these facilities provide many of the necessary services.[3] As a result, Medicare payments for procedures in physicians' offices are higher to account for the increased practice expenses. These differences in Medicare reimbursements based on the setting are known as "site-of-service payment differentials." The payment differentials have been phased in since 1999, and were fully implemented in 2002. During this time, the site-of-service payment differentials have increased for most endoscopic procedures.

Section 411 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)[4] directed us to examine the practice of providing physician services that are ordinarily performed in health care facilities—such as gastroenterological and urological endoscopic procedures—in physicians' offices. We were directed to (1) review safety evidence regarding medical settings, (2) assess whether the practice expense site-of-service payment differential has served as an incentive for physicians to perform such procedures in their offices rather than in other medical settings, and (3) assess whether access to care by Medicare beneficiaries would be affected if these procedures were no longer reimbursed by Medicare when conducted in physicians' offices.

For our study, we selected 12 gastroenterological and 8 urological procedures that are ordinarily performed in health care facilities for

[2]The specialty societies' concerns are outlined in 65 *Fed. Reg.* 65,400 (Nov. 1, 2000).

[3]Medicare provides a facility fee to hospitals and ASCs to reimburse their expenses for clinical staff, supplies, and equipment.

[4]Pub. L. No. 106-554, App. F, 114 Stat. 2763, 2763A-508.

Medicare beneficiaries.[5] In 2001, there were about 4.8 million of these gastroenterological procedures performed, of which about 156,000 (3.3 percent) were conducted in physicians' offices. During this same year, there were about 306,000 of these urological procedures performed, of which about 12,000 (3.8 percent) were conducted in physicians' offices. To determine the relative safety of these procedures conducted in different medical settings in the 50 states and the District of Columbia, we reviewed the scientific literature maintained by the National Library of Medicine and interviewed physicians; medical directors at Medicare carriers, which are the CMS contractors that process and review Medicare claims; and a representative of a trade association that represents the medical malpractice insurance industry. We also attempted to obtain Medicare claims data to determine whether patients who had endoscopic procedures later encountered medical complications. However, such data are not readily available. To assess whether the practice expense site-of-service differential has served as an incentive for physicians to conduct office-based procedures, we analyzed CMS data on the percentage of endoscopic procedures performed in physicians' offices, hospitals, and ASCs from 1996 through 2001. To determine whether access to care by Medicare beneficiaries would be affected if these procedures were no longer reimbursed by Medicare when conducted in physicians' offices, we analyzed CMS data on a geographic basis, leading to a focus on the New York City area, which has a high utilization rate of physician office-based endoscopic procedures. For this metropolitan area, we analyzed CMS medical setting data and interviewed Medicare carrier directors and New York state officials. We conducted our work from February 2001 through October 2002 in accordance with generally accepted government auditing standards. (See app. I for more information on our scope and methodology.)

Results in Brief

For the 20 procedures we reviewed, we found no evidence to suggest that there is any difference in the level of safety of gastroenterological and urological endoscopic procedures performed on Medicare beneficiaries in either physicians' offices or health care facilities, such as hospitals and ASCs. We also found no indication in the literature that physician office-

[5]We defined "ordinarily performed" in health care facilities as procedures performed at least 90 percent of the time in health care facilities and less than 10 percent of the time in physicians' offices. We have included all gastroenterological and urological procedures that have been ordinarily performed in health care facilities. See app. I for a list of these procedures.

based gastroenterological or urological procedures are less safe than those provided in health care facilities. In addition, Medicare carrier directors, physicians, and physician specialty society representatives told us that there is no indication that physician office-based endoscopy is unsafe. According to a major trade association that represents the malpractice insurance industry, office-based endoscopy is not considered riskier than endoscopy conducted in medical facilities. For example, the two largest malpractice insurance companies in the New York City area—a locality with a high proportion of physician office-based procedures—do not impose a surcharge on physicians who perform any type of endoscopy in the office.

We also found no evidence to suggest that the resource-based site-of-service payment differential has caused physicians to conduct a greater proportion of gastroenterological or urological endoscopic procedures in their offices for Medicare beneficiaries. Since 1996, the proportion of these endoscopic procedures performed in physicians' offices for Medicare beneficiaries has not increased. At the same time, practice expense payments in 2002 for these office-based endoscopic procedures have increased to five times greater than payments for the procedures performed in a health care facility. However, because full implementation of the practice expense component did not occur until 2002, it is too early to tell whether that the percentage of these procedures performed in physicians' offices will increase in the future.

If Medicare coverage for the office procedures in our study were terminated, few access problems would occur in most of the country because physicians perform the vast majority of the procedures that we studied in health care facilities. However, our analysis of CMS data demonstrated that the New York City area has a much higher rate of utilization of physicians' offices for these procedures than the rest of the nation. As noted by state Medicare carrier directors, health care facility capacity in the New York City area might be initially inadequate because about 35 percent of the gastroenterological procedures in our study were performed in physicians' offices in this region. If these gastroenterological procedures could no longer be provided in offices, medical facilities in the area might not be able to absorb all the displaced patients in the short term. The effect on patient access of such a change might be mitigated somewhat over time, however, by a March 1998 New York State Department of Health rule change that is causing the numbers of ASCs in the state to increase. Relatively few of the urological procedures in our study (about 8 percent) are performed in physicians' offices in the New

York City area, so if Medicare coverage for office-based procedures was eliminated, the impact for these procedures would likely be minimal.

CMS provided written comments on a draft of this report, and concurred with the general findings of the study.

Background

In 2001, there were about 4.8 million gastroenterological procedures and about 306,000 urological procedures performed on Medicare beneficiaries nationwide that were conducted at least 90 percent of the time in health care facilities and less than 10 percent of the time in physicians' offices. About 3.3 percent (or about 156,000) of these gastroenterological procedures and 3.8 percent (or about 12,000) of these urological procedures were conducted in physicians' offices. About 35 percent of all office-based gastroenterological endoscopic procedures were conducted in the New York City metropolitan area.[6]

Regulations and Guidelines for Endoscopic Procedures

Medicare regulates ASCs and other health care facilities that conduct endoscopic procedures by requiring that they satisfy conditions related to safety, facility design, staff expertise, and other factors in order to treat Medicare beneficiaries. [7] If an ASC is accredited by a national accrediting body or licensed by a state agency that provides reasonable assurances that the conditions are met, CMS may deem it to comply with most requirements. These conditions include, for example, the following:

- Compliance with state licensure requirements.
- An effective procedure for immediate transfer to hospitals of patients needing emergency medical care beyond the capabilities of the ASC.
- Safe performance of surgical procedures by qualified physicians granted clinical privileges by the ASC under Medicare-approved policies and procedures.
- Ongoing comprehensive self-assessment of the quality of care with active participation of the medical staff.
- Use of a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.

[6]This pattern does not exist for the urological procedures. Only about 8 percent of the office-based procedures were conducted in the New York City area.

[7]42 C.F.R. §§ 416.40 – 416.48 (2001).

- Provision of adequate management and staffing of nursing services to ensure that nursing needs of all patients are met.
- Maintenance of complete, comprehensive, and accurate medical records to ensure adequate patient care.
- Safe and effective provision of drugs and biologicals under the direction of a responsible individual.

According to the American College of Surgeons, nine states have guidelines or regulations[8] pertaining to the safety of office-based surgical procedures (including endoscopy) that address issues of Medicare certification, state licensure, accreditation,[9] and inspection of physicians' offices:

- In California, state licensure, Medicare certification, or accreditation is required for all outpatient settings where anesthesia is used.
- In Connecticut, state regulations require any office or facility operated by a licensed health care practitioner or practitioner group to be accredited by a nationally recognized body if sedation or anesthesia is used.
- In Florida, the state is required to inspect a physician's office where certain levels of surgery (including endoscopy) are performed, unless a nationally recognized accrediting agency or another accrediting organization approved by the Board of Medicine accredits the office.
- In Illinois, state regulations allow the delivery of anesthesia services by a certified registered nurse anesthetist in the office only if the physician has training and experience in these services.
- In Mississippi, physicians conducting office procedures must register with the state, maintain logs of surgical procedures conducted, follow federal standards for sterilization of surgical instruments, and report any surgical complications to a state board.
- In New Jersey, state regulations have been developed to establish training programs for physicians who utilize anesthesia in their office practices.
- In Rhode Island, state regulations require licensure for offices in which surgery, other than minor procedures, is performed. Accreditation by a nationally recognized agency or organization is also required.

[8]These state guidelines and regulations cover a wide range of office-based procedures, of which gastroenterological and urological endoscopy are only a portion.

[9]The application of safety and quality standards to offices that conduct surgery may result from their seeking accreditation by the Accreditation Association for Ambulatory Health Care, American Association for Accreditation of Ambulatory Surgery Facilities, or the Joint Commission on Accreditation of Healthcare Organizations.

- In South Carolina, guidelines address the safe delivery of anesthesia, the presence of emergency equipment, procedures to transfer emergency cases to hospitals, and physician training.
- In Texas, regulations govern physicians in outpatient settings providing general or regional anesthesia.

In addition, organizations such as the American Society for Gastrointestinal Endoscopy and the Society of American Gastrointestinal Endoscopic Surgeons publish safety guidelines that are similar to the Medicare guidelines for ASCs. These guidelines are designed to ensure that endoscopies are conducted safely regardless of whether they are conducted in health care facilities or physicians' offices. However, the Medicare program does not regulate physicians' offices and does not make judgments about the safety of procedures conducted there.

Medicare's Practice Expense Payments and Site-of-Service Differentials

In 1992, the Health Care Financing Administration (HCFA) began the implementation of a resource-based physician fee schedule for the Medicare program. The physician fee schedule is applicable to procedures conducted in a variety of health care settings, including hospitals, ASCs, and physicians' offices.[10] Under this fee schedule, physician payments are based on relative amounts of resources needed to provide procedures regardless of the health care setting.[11] The physician fee schedule includes three components. The physician work component (implemented in 1992) provides payment for the physician's time, effort, skill, and judgment necessary to provide a service. The malpractice insurance component reimburses physicians for the expense of their professional liability insurance. The practice expense component compensates physicians for direct expenses, such as clinical staff salaries, medical supplies, and medical equipment and indirect expenses, such as administrative staff salaries and other office expenses incurred in providing services.

[10]42 U.S.C. § 1395w-4 (2000).

[11]Prior to 1992, fees were based on charges physicians billed for their services.

Unlike the other two components, physician practice expenses can differ depending on where the procedure is performed.[12] In the office setting, the physician is responsible for providing clinical staff, supplies, and equipment needed to perform a service. In the facility setting, such as a hospital or ASC, these are the responsibility of the facility. Medicare's practice expense payments to physicians can differ depending upon the medical setting to reflect these differences. For medical facilities, practice expense payments to physicians are generally lower, because Medicare pays for nursing support, equipment, and supplies needed with a separate facility fee. However, when these procedures are performed in an office, Medicare pays physicians for these expenses in the practice expense portion of the physician fee schedule.[13] The differences in practice expense payments for the same procedure are referred to as the site-of-service differential.[14] In 1999, HCFA began a now completed 3-year phase-in of the site-of-service payment differential, as a part of the resource-based practice expense system. In previous work, we found that HCFA used acceptable methodology and relied on the best data available to develop the practice expense component of its Medicare payment system of which

[12]HCFA convened clinical practice expense panels composed of physicians, non physician clinicians, and practice administrators to review the types and quantities of practice expense components used for medical procedures. A contractor used the resulting data to develop dollar cost estimates. These estimates resulted in practice expense amounts assigned to different medical settings. There has been an ongoing multi specialty panel review of these estimates since 1999. According to CMS, this review has changed the estimates for more than 1,000 procedure codes. See 66 *Fed. Reg.* 55,245 (Nov. 1, 2001) for the most recent Medicare physician fee schedule.

[13]The payment schedule for diagnostic colonoscopy, a common gastroenterological procedure, illustrates how payments to physicians differ by medical setting. In 2002, the practice expense payment to physicians who provide the procedure in an office, $318, is about five times greater than the practice expense payment of $64 to physicians who conduct the procedure in a medical facility, such as a hospital or an ASC. However, when this procedure is conducted in a hospital or ASC, Medicare also pays a facility fee of $372 to hospital outpatient departments and $433 to ASCs. These are national reimbursement rates. The rates differ for specific geographic areas.

[14]App. I lists the practice expense relative value units for each procedure included in our sample listing those for health care facilities and the physicians' offices separately. The Medicare program translates the relative value units for practice expense (as well as those for physician work and malpractice insurance) into dollars by multiplying them by a single conversion factor. Since the practice expense relative value units are higher for physicians' offices than for health care facilities, they result in higher reimbursement amounts for the physicians' offices, hence a payment differential.

this payment differential is a result.[15] Medicare's higher payment for office-based procedures reflects the higher expenses to the physicians of providing those procedures, but this payment may not cover all of their expenses.[16]

Level of Safety of Endoscopy Does Not Appear to Differ by Medical Setting

We found no evidence to suggest that the level of safety of gastroenterological or urological endoscopy conducted on Medicare beneficiaries differs by medical setting. In our search of the relevant scientific literature maintained by the National Library of Medicine and in discussions with Medicare carrier medical directors, physicians, and physician specialty societies, we found no evidence of a higher occurrence of medical complications from office-based gastroenterological and urological endoscopic procedures relative to other medical settings.[17] Furthermore, according to a major trade association representing medical malpractice insurance companies, the pricing policies of insurance companies indicate that those companies do not believe that office-based endoscopy poses additional safety risks.

Available Evidence Suggests Complications Are Few with Office-Based Endoscopy

Our search of relevant scientific literature maintained by the National Library of Medicine and discussions with physicians revealed little evidence of complications associated with office-based endoscopy for gastrointestinal and urological procedures. The scientific literature on the safety of office endoscopy is sparse; we were able to locate only one published study. This study of upper gastrointestinal procedures conducted in France showed very few complications over the course of nearly 18,000 endoscopic procedures.[18] In this study, there was one death (the patient had previously diagnosed heart disease), one case of breathing

[15]See U.S. General Accounting Office, *Medicare Physician Payments: Need to Refine Practice Expense Values During Transition and Long Term*, GAO/HEHS-99-30 (Washington, D.C.: Feb. 24, 1999).

[16]See U.S. General Accounting Office, *Medicare Physician Fee Schedule: Practice Expense Payments to Oncologists Indicate Need for Overall Refinements*, GAO-02-53 (Washington, D.C.: Oct. 31, 2001).

[17]The Medicare program does not routinely collect safety data for endoscopic procedures performed in offices or other medical settings.

[18]B. Maroy and P. Moullot, "Safety of Upper Gastrointestinal Endoscopy with Intravenous Sedation by the Endoscopist at Office: 17,963 Examinations Performed in a Community Center by Two Endoscopists over 17 Years," *Journal of Clinical Gastroenterology*, vol. 27, no. 4 (1998): 368-69.

difficulty (considered avoidable by the authors), and five other minor incidents. During the 10,000 exams performed over the last 12 years of this 17-year study, no clinically significant incidents occurred.

We discussed the safety of office-based endoscopy with physicians, including representatives of three organizations critical of the CMS practice expense site-of-service differential policy. We also discussed in-office safety issues with four Medicare carrier medical directors, including those in New York where there is a relatively high proportion of office procedures conducted. All of these officials, including the critics of the policy, emphasized that the procedures as currently conducted are safe and that complications are extremely rare.

Major Malpractice Insurance Companies Do Not Levy Surcharge on Physicians Who Conduct Office-Based Endoscopy

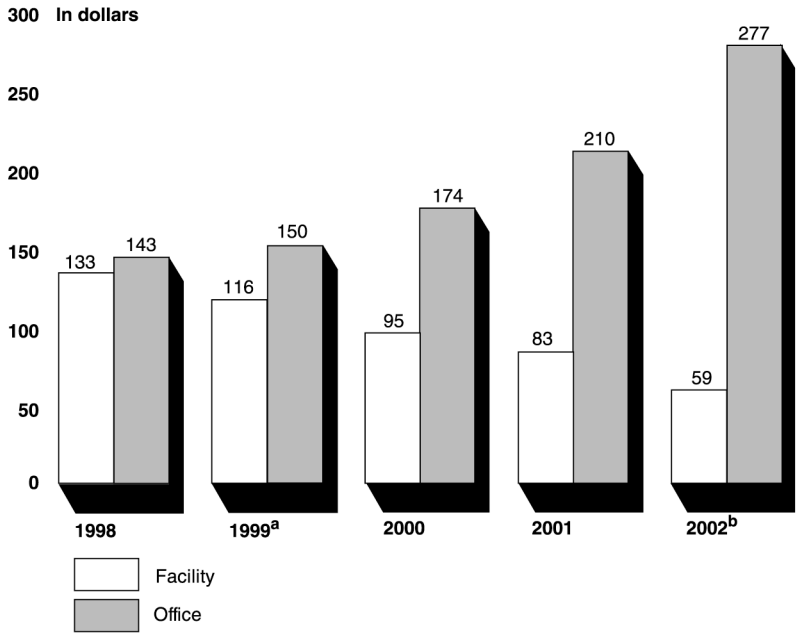
According to the Physician Insurers Association of America, a trade association that represents the malpractice insurance industry, office-based endoscopy is not riskier than endoscopy conducted in health care facilities. For example, two large New York malpractice insurance companies do not levy a surcharge on physicians who conduct office-based surgery, including the endoscopic procedures included in our study. One of these New York companies, which has the largest market share nationwide (and 57 percent of the malpractice insurance market in New York) does not consider office-based surgery an issue when setting rates for its clients. The other New York company requires physicians who conduct surgery in their offices to follow its company standards for equipment and safety backup procedures, and it reserves the right to conduct unannounced inspections of their offices. It does not, however, impose a surcharge on physicians for office-based procedures. It does require a surcharge for endoscopic procedures, but the amount does not differ by medical setting.

Payment Differential Has Increased but Proportion of Office Procedures Has Not Increased

Although the site-of-service Medicare payment differential for the 12 common gastroenterological endoscopic procedures in our study has increased since the practice expense component of the resource-based fee schedule began to be implemented in 1999, the percentage of these procedures performed in the office has not increased. The average Medicare practice expense payments for the 12 gastroenterological endoscopic procedures are presented in figure 1.[19] The figure shows that the payment differential has increased both because the average practice expense payments for procedures performed in health care facilities have decreased substantially (from $133 in 1998 to $59 in 2002) and because the payment for office-based procedures has nearly doubled (from $143 in 1998 to $277 in 2002). The payment differential for urological procedures has similarly increased since the average practice expense payments for such procedures performed in health care facilities have decreased by more than half (from $218 in 1998 to $83 in 2002) and because the average payments for office-based procedures have more than doubled (from $218 in 1998 to $448 in 2002.)

[19]These calculations are based on practice expense reimbursement data for 12 gastroenterological endoscopic procedures as detailed in app. I. Each procedure is assigned a specific dollar payment amount by CMS for practice expense reimbursement. The payment amounts reported reflect national reimbursement rates; the rates differ for specific geographic areas.

Figure 1: Average Physician Practice Expense Reimbursements for 12 Gastroenterological Procedures for Medicare Beneficiaries by Medical Setting, Nationwide



Note: See app. I for a list of included procedures.

[a]Practice expense site-of-service differential phase-in begins.

[b]Practice expense site-of-service differential phase-in completed.

Source: GAO analysis of CMS data.

The nationwide percentage of common office-based gastroenterological and urological endoscopic procedures conducted on Medicare beneficiaries has not increased (see fig. 2).[20] For example, the percentage of the gastroenterological procedures in our study conducted in the office nationwide declined from about 4.8 percent in 1996 to 3.9 percent in 1998, the last year of the old practice expense payment system, and to 3.3 percent in 2001 as the phase-in of the new practice expense system approached completion. Similarly, the percentage of the urological

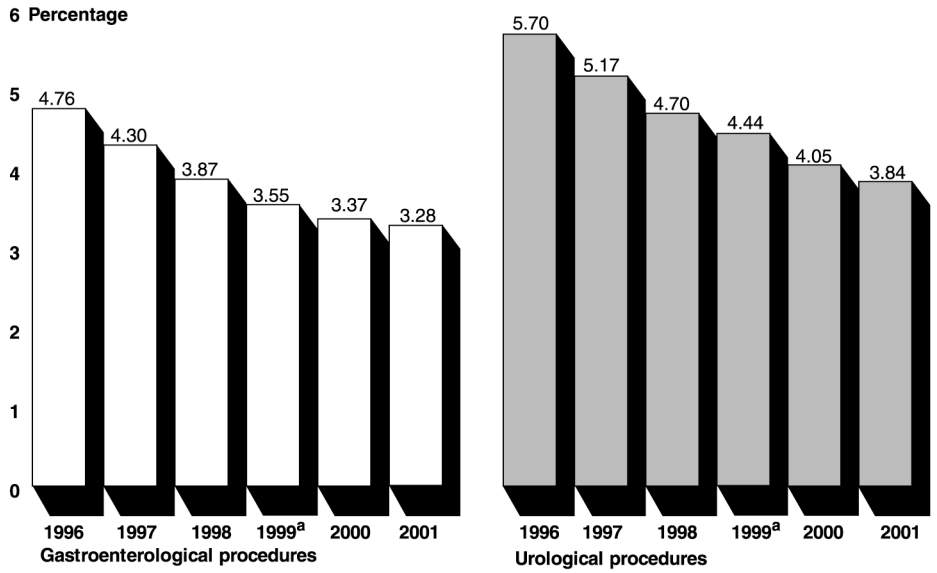
[20]See app. II for more information on site-of-service usage from 1996 through 2001 for the endoscopic procedures in our study.

procedures in our study declined from about 5.7 percent in 1996 to 4.7 percent in 1998 to 3.8 percent in 2001.

From 1996 through 2001 in the New York City metropolitan area, where about 35 percent of the nationwide Medicare-covered office procedures were conducted, the proportion of office-based endoscopic procedures for gastroenterology has remained fairly constant at slightly less than 30 percent. During the same period, the proportion of office-based urological procedures in our study has declined from 11 percent to 8 percent.

However, regardless of geographic area, these findings must be interpreted with caution. It is too early to determine the full effects of the new practice expense system's payment differential, as it was not fully implemented until 2002.

Figure 2: Percentage of 12 Common Gastroenterological and 8 Urological Endoscopic Procedures Provided in Physicians' Offices, Nationwide



Note: See app. I for a list of included procedures.

[a]Practice expense site-of-service differential begins phase-in.

Source: GAO analysis of CMS data.

If Office Procedures Were Not Reimbursed by Medicare, Access to Endoscopy Might Be Most Affected in the New York City Area

We were directed by BIPA to assess whether the access to care by Medicare beneficiaries would be adversely affected if gastroenterological procedures conducted in physicians' offices were no longer reimbursed by Medicare. If this occurred, patients in most of the nation would not likely experience access problems for the procedures in our study, given that relatively few procedures are performed in the office setting. However, some New York City metropolitan area Medicare patients might have initial difficulty obtaining care. In 2001, 28 percent, or about 54,000, of the gastroenterological procedures for Medicare patients in the New York City area were conducted in physicians' offices, accounting for about 35 percent of these office procedures nationwide. According to CMS data, the New York City area has the largest proportion and total number of office-based gastroenterological procedures of any geographic area in the nation. In our review of CMS data on the geographic dispersion of office procedures, we have been unable to locate other areas of the country with such a major reliance on the availability of office-based gastroenterological endoscopy. If Medicare coverage for the common endoscopic office procedures included in our study were withdrawn, medical facilities might not have the capacity to absorb the displaced patients in the short term, according to a New York State Department of Health official and Medicare carrier directors.

However, in 1998, New York State eased requirements for approval of new ASCs, and, as a result, medical facility capacity has recently begun to increase in the state and in the New York City area. New York requires an approved certificate of need (CON) in order to approve a new ASC. To obtain a CON, the need for the services of a proposed ASC must be demonstrated for specific geographic areas. According to a New York State Department of Health official, the rules for CON approval were relaxed significantly in March 1998, and nearly all applications are currently being approved. Since March 1998, there has been an increase of almost 200 percent in the number of ASCs in New York, including major increases in the New York City area. CON approvals can be obtained in the New York City area because most area hospitals are operating at capacity. In the future, if ASCs are equipped to offer the gastroenterological procedures included in our study, it is possible that they could accommodate displaced patients, if they are located in areas accessible to these patients. In contrast, only about 8 percent of the urological procedures in the New York City area were conducted in offices, so the elimination of Medicare reimbursement would likely have a minimal effect on the delivery of these procedures.

Concluding Observations

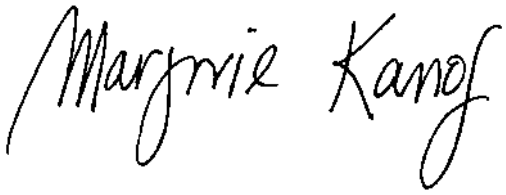
Some critics of the Medicare site-of-service payment differential for endoscopic procedures have questioned the practice of conducting them as office procedures because of concerns about patient safety. They have suggested that the differential provides an incentive to the physician to provide endoscopic procedures in a setting—the physician's office—that is less safe than another setting, such as a hospital or an ASC. But in our review of common gastroenterological and urological endoscopic procedures, we found no evidence that safety problems are greater for these procedures conducted in physicians' offices. Furthermore, we found that the proportion of common office-based gastroenterological and urological endoscopic procedures included in our study has not increased as the site-of-service differential has been phased in. However, because the payment differential has been in effect only since 1999 and was not fully implemented until 2002, it is too early to tell whether it will affect the percentage of procedures conducted in the office in the future. If the common office-based endoscopic procedures included in our study were no longer reimbursed by Medicare, most areas of the country would not develop patient access problems. However, the initial effects in the New York City metropolitan area—where there is a predominance of office-based procedures—could be problematic, although the increase in ASCs in the New York City area could mitigate patient access problems in the future.

Agency Comments

CMS provided written comments on a draft of this report, and concurred with the general findings in the study (see app. III). The agency provided technical comments, which we have addressed where appropriate.

We are sending this report to the CMS Administrator and interested congressional committees. We will also make copies available to other interested parties on request. In addition, the report available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staffs have any questions, please contact me at (202) 512-7101. Major contributors to this report are listed in appendix IV.



Marjorie Kanof
Director, Health Care—Clinical
and Military Health Care Issues

Appendix I: Scope and Methodology

This appendix provides detailed information on the gastroenterological and urological procedures that we selected for our study. It also describes the methods that we used to address the study's main objectives.

We selected the 12 gastroenterological and 8 urological endoscopic procedures that are ordinarily performed in health care facilities and that we defined as being conducted at least 90 percent of the time in health care facilities and less than 10 percent of the time in offices. These gastroenterological and urological procedures are common types of endoscopy. These procedures have a practice expense site-of-service differential. The procedures included in our study accounted for about 30 percent of the total number of gastroenterological and urological endoscopic procedures conducted for Medicare beneficiaries in 2001; about 3.5 percent of the procedures in our study were conducted in offices. Many of these procedures require the use of sedation and entail some risks for patients. Our results are not generalizable to other endoscopic procedures. Tables 1 and 2 provide detailed information on the 20 procedures included in our study.

Table 1: GAO Sample of Gastroenterological Endoscopic Procedures for Medicare Beneficiaries, 2001

Procedure name (Current Procedural Terminology [CPT] code[a])	Total performed	Percentage in office	Practice expense reimbursement[b]	
			Health care facility	Physician's office
Esophagus endoscopy (43200)	16,636	5.96	$52	$215
Esophagus endoscopy with biopsy (43202)	6,573	2.40	54	179
Upper GI—examination (43234)	3,492	2.21	53	132
Upper GI—diagnostic (43235)	507,438	2.50	61	169
Upper GI—biopsy (43239)	1,246,051	3.09	67	178
Change gastronomy tube (43760)	73,779	7.59	20	46
Diagnostic colonoscopy (45378)	1,211,962	3.59	91	232
Colonoscopy and biopsy (45380)	572,206	3.09	98	244
Colonoscopy and control bleeding (45382)	20,037	1.62	125	289
Colonoscopy and lesion removal (45383)	66,250	2.97	133	286
Colonoscopy and lesion removal—with forceps or bipolar cautery (45384)	337,139	2.62	113	266
Colonoscopy and lesion removal—with snare technique (45385)	694,714	3.46	126	286
Total	**4,756,277**	**3.25**		

[a]CPT codes, which are maintained and copyrighted by the American Medical Association, are descriptive terms and identifying codes for reporting physician services and other medical services, including outpatient hospital procedures. CPT codes are used by health care providers to bill Medicare for covered services.

[b]These are national reimbursement rates. The rates differ for specific geographic areas.

Source: GAO analysis of CMS data.

Table 2: GAO Sample of Urological Endoscopic Procedures for Medicare Beneficiaries, 2001

Procedure name (CPT code[a])	Total performed	Percentage in office	Practice expense reimbursement[b]	
			Health care facility	Physician's office
Kidney stone fragmentation (50590)	40,666	2.86	$248	$397
Cystoscopy with ureteral catherization (52005)	69,293	7.84	46	162
Cystoscopy with fulguration and/or resection of small bladder tumor(s) (52234)	34,522	5.96	93	241
Cystoscopy with fulguration and/or resection of medium bladder tumor(s) (52235)	33,230	1.67	114	263
Cystoscopy with fulguration and/or resection of large bladder tumor(s) (52240)	25,419	1.38	204	352
Cystoscopy with direct vision internal urethrotomy (52276)	14,817	6.60	95	246
Remove bladder stone (52317)	6,832	4.00	129	792
Cystoscopy with insertion of stent (52332)	80,925	1.13	60	841
Total	**305,704**	**3.84**		

[a]CPT codes, which are maintained and copyrighted by the American Medical Association, are descriptive terms and identifying codes for reporting physician services and other medical services, including outpatient hospital procedures. CPT codes are used by health care providers to bill Medicare for covered services.

[b]These are national reimbursement rates. The rates differ for specific geographic areas.

Source: GAO analysis of CMS data.

To assess the safety of office-based endoscopy, we reviewed the scientific literature and interviewed physicians; four Medicare carrier medical directors in the New York City area; North Dakota; and Wyoming; a representative of Physicians Insurance Association of America; an official from a trade association that represents the medical malpractice insurance industry; and representatives of two large New York malpractice insurance companies. We also interviewed interest group representatives, including members of the American College of Gastroenterology, American Society for Gastrointestinal Endoscopy, American College of Surgeons, American Gastroenterology Association, and American Urological Association. We also reviewed regulations and guidelines on physician office-based endoscopy in the nine states that have such regulations and guidelines.

These states are California, Connecticut, Florida, Illinois, Mississippi, New Jersey, Rhode Island, South Carolina, and Texas.

To assess whether the practice expense site-of-service payment differential acts as an incentive for physicians to conduct gastroenterological and urological endoscopic procedures in their offices, we analyzed data from the Centers for Medicare & Medicaid Services (CMS) using the Part B Extract and Summary System on the medical settings (office, inpatient hospital, outpatient hospital, and ambulatory surgical center) for relevant procedures for 1996 through 2001. For the gastroenterological and urological procedures in our analysis, we developed averages of practice expense reimbursements for health care facilities and offices for each year from 1998 through 2002.

To determine whether access to care by Medicare beneficiaries would be affected if endoscopic procedures in physicians' offices were no longer reimbursed by Medicare, we analyzed CMS data (using the Part B Extract and Summary System) on office-based endoscopy for the nation as a whole and for the New York City area, which has the highest proportion of office-based procedures in the nation. We interviewed Medicare carrier medical directors in several locales with a range of population size and density, including the New York City area, North Dakota, and Wyoming.

Appendix II: Medical Settings for Endoscopic Procedures in GAO Sample

Tables 3 and 4 summarize the percentages of gastroenterological and urological endoscopic procedures in our sample performed in physicians' offices, hospitals (both inpatient and outpatient), and ASCs for 1996 through 2001. In the data provided to us by CMS, there was another medical setting category ("other") that captured a broad variety of medical settings, including nursing facilities, rural health clinics, and military treatment facilities. The proportion of procedures conducted in these settings was very low, about 1 percent or less. In 1999, some of the claims data were coded incorrectly, and the Health Care Financing Administration inaccurately assigned larger proportions to the "other" category (from 5 to 9 percent). Because of this confusion, we have eliminated the "other" category from the analysis for 1999 and the other years to ensure consistency in comparisons. Our reanalysis affects the results for 1999 because it is unclear where the claims categorized as "other" should have been categorized. However, because of the relatively few cases affected, we do not believe that this error affects our analyses or conclusions.

Table 3: Medical Setting Usage Trends for 12 Gastroenterological and 8 Urological Procedures, Nationwide, Calendar Years 1996-2001

	Year					
	1996	1997	1998	1999	2000	2001
Gastroenterological procedures[a]	Percentages					
Office	4.76	4.30	3.87	3.55	3.37	3.25
Inpatient hospital	26.63	25.97	24.35	23.02	21.35	19.93
Outpatient hospital	49.49	48.94	49.33	48.89	48.73	47.15
ASC	19.11	20.79	22.45	24.54	26.54	29.64
Urological procedures[b]	Percentages					
Office	5.70	5.17	4.70	4.44	4.05	3.84
Inpatient hospital	32.74	31.32	29.19	27.48	26.33	25.76
Outpatient hospital	54.52	56.06	57.48	58.80	59.33	59.16
ASC	7.04	7.46	8.63	9.28	10.29	11.24

[a]Includes 12 procedures. See app. I for complete list.

[b]Includes 8 procedures. See app. I for complete list.

Source: HCFA Part B Extract and Summary System (1996-2001).

Table 4: Medical Setting Usage Trends for 12 Gastroenterological and 8 Urological Procedures, New York City Area and the Remainder of the United States, Calendar Years 1996-2001

	Year					
	1996	1997	1998	1999	2000	2001
New York City metropolitan area						
Gastroenterological procedures[a]			Percentages			
Office	29.19	28.45	29.22	28.70	27.87	28.11
Inpatient hospital	33.45	32.49	30.15	27.38	24.56	22.72
Outpatient hospital	28.63	30.39	32.21	34.37	36.82	38.08
ASC	8.73	8.67	8.42	9.55	10.75	11.09
Urological procedures[b]						
Office	11.49	9.28	9.36	9.71	8.61	8.05
Inpatient hospital	62.40	62.04	57.70	53.69	48.26	45.17
Outpatient hospital	21.80	24.37	28.86	31.84	38.19	42.08
ASC	4.30	4.30	4.08	4.76	4.94	4.70
Rest of United States						
Gastroenterological procedures[a]			Percentages			
Office	3.63	3.21	2.74	2.47	2.28	2.22
Inpatient hospital	26.32	25.67	24.10	22.84	21.21	19.82
Outpatient hospital	50.46	49.78	50.09	49.51	49.26	47.53
ASC	19.59	21.33	23.07	25.18	27.25	30.43
Urological procedures[b]						
Office	5.45	4.99	4.51	4.23	3.85	3.66
Inpatient hospital	31.45	29.99	28.01	26.45	25.40	24.96
Outpatient hospital	55.95	57.43	58.67	59.86	60.23	59.86
ASC	7.16	7.60	8.81	9.46	10.52	11.51

[a]Includes 12 procedures. See app. I for complete list.

[b]Includes 8 procedures. See app. I for complete list.

Source: HCFA Part B Extract and Summary System (1996-2001).

Appendix III: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

OCT - 4 2002

TO: Marjorie E. Kanof
Director, Health Care—Clinical
and Military Health Care Issues
General Accounting Office

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: General Accounting Office (GAO) Draft Report, "*MEDICARE PHYSICIAN PAYMENTS: Medical Settings and Safety of Endoscopic Procedures*," (GAO-02-885)

We appreciate the opportunity to review GAO's above-subject draft report to Congress. This study was completed to meet the requirements of section 411 of the Medicare, Medicaid, and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA). We agree with the GAO's general findings in this study. The report is very helpful in addressing long-standing questions raised by specialty groups.

We have provided specific editorial comments.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Marjorie Kanof, (202) 512-7101

Acknowledgments

Lawrence S. Solomon, Martin T. Gahart, Vanessa Taylor, Wayne Turowski, Roseanne Price, and Mike Thomas made major contributions to this report.

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