United States Government Accountability Office

GAO

Report to Congressional Requesters

July 2009

MEDICARE PHYSICIAN PAYMENTS

Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together

GAO-09-647

July 2009

MEDICARE PHYSICIAN PAYMENTS

Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together

GAO Accountability•Integrity•Reliability

Highlights

Highlights of GAO-09-647, a report to congressional requesters

Why GAO Did This Study

Medicare's physician fees may not always reflect efficiencies that occur when a physician performs multiple services for the same patient on the same day, and some resources required for these services do not need to be duplicated. In response to a request from Congress, GAO examined (1) the Centers for Medicare & Medicaid Services' (CMS) efforts to set appropriate fees for services furnished together and (2) additional opportunities for CMS to avoid excessive payments when services are furnished together. GAO examined relevant policies, laws, and regulations; interviewed CMS officials and others; and analyzed claims data to identify opportunities for further savings.

What GAO Recommends

GAO recommends that the Acting Administrator, CMS, ensure that physician fees reflect efficiencies occurring when services are commonly furnished together. GAO suggests that Congress consider exempting any resulting savings from federal budget neutrality so that savings accrue to Medicare. The Department of Health and Human Services concurred with GAO, stating it plans to review these services. The American Medical Association disagreed with aspects of our report, including exempting savings from budget neutrality. GAO continues to believe that Congress should consider such an exemption to help ensure appropriate payments for Medicare physician services.

View GAO-09-647 or key components.
For more information, contact James C. Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

CMS has taken steps to ensure that physician fees recognize efficiencies that occur when certain services are commonly furnished together, that is, by the same physician to the same beneficiary on the same day, but has not targeted services with the greatest potential for savings. CMS is reviewing the efforts of a workgroup created by the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC) in 2007 to examine potential duplication in resource estimates for services furnished together. However, the RUC workgroup has not focused on services that account for the largest share of Medicare spending. For this and other reasons, its methodology to identify and review services furnished together likely will result in limited savings. The workgroup's process is also resource intensive because it depends on input and consensus from specialty societies. Independent of the RUC, CMS has implemented a multiple procedure payment reduction (MPPR) policy for certain imaging and surgical services when two or more related services are furnished together. Under an MPPR, the full fee is paid for the highest-priced service and a reduced fee is paid for each subsequent service to reflect efficiencies in overlapping portions of the practice expense component—clinical labor, supplies, and equipment. For example, a nurse's time preparing a patient for a medical procedure or technician's time setting up the required equipment is incurred only once. The MPPR produced savings of about $96 million in 2006 for imaging services. However, the scope of the policy is limited because the policy does not apply to nonsurgical and nonimaging services commonly furnished together, nor does it specifically reflect efficiencies occurring in the physician work component—the financial value of a physician's time, skill, and effort. For example, when two services are furnished together, a physician reviews a patient's medical records once, but the time for that activity is generally reflected in fees paid for both services.

CMS has additional opportunities to reduce excess physician payments that can occur when services are furnished together and Medicare's fees do not reflect the efficiencies realized. GAO's review found that expanding the MPPR to reflect practice expense efficiencies that occur when nonsurgical, nonimaging services are provided together could reduce payments for these services by an estimated one-half billion dollars annually. GAO's review also indicated that expanding the existing MPPR policy to reflect efficiencies in the physician work component of certain imaging services could reduce these payments by an estimated additional $175 million annually. Under the budget neutrality requirement, by law, savings from reductions in fees are redistributed by increasing fees for all other services. Thus, these potential savings would accrue as savings to Medicare only if Congress exempted them from the budget neutrality requirement, as was done in the Deficit Reduction Act of 2005 for savings from the changes to certain imaging services fees.

Contents

Abbreviations

AMA	American Medical Association
CMS	Centers for Medicare & Medicaid Services
CPT®	Current Procedural Terminology
CT	computed tomography
DRA	Deficit Reduction Act of 2005
HHS	Department of Health and Human Services
MedPAC	Medicare Payment Advisory Commission
MPPR	multiple procedure payment reduction
RBRVS	Resource-Based Relative Value Scale
RUC	AMA/Specialty Society Relative Value Scale Update Committee
RVU	relative value unit

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

July 31, 2009

The Honorable Frank Pallone
Chairman
The Honorable Nathan Deal
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable Dave Camp
Ranking Member
Committee on Ways and Means
House of Representatives

Spending on Medicare Part B physician services grew at an average annual rate of 6 percent from 1997 through 2008, more than twice the growth rate in the national economy over this period.[1] This rapid spending growth underscores the importance of ensuring that payments under Medicare's physician fee schedule, which includes fees for each of over 7,000 services, such as office visits, surgical procedures, and tests, are appropriate and encourage efficient use of resources.

Physician fee schedule payments may be excessive for some services because efficiencies that occur when two or more services are furnished together are not reflected in the fee schedule, and thus Medicare essentially pays twice for the portions of these services that overlap. In setting payments for services under the fee schedule, the Centers for Medicare & Medicaid Services (CMS)—the federal agency that administers the Medicare program—estimates resources required to provide three separate components of each service: the physician work component (which reflects the physician's time, skill, and effort); the practice expense

[1]Medicare Part B covers physician and other outpatient services.

component (which reflects operating expenses, such as rent, utilities, and the salaries of nurses, technicians, and administrative staff); and the malpractice component (which reflects the costs of obtaining professional liability insurance).[2] Each service is generally considered to be discrete and stand-alone. But when two or more services are furnished by the same physician to the same beneficiary on the same day, efficiencies may occur because some portions of the physician work component, the practice expense component, or both overlap and are incurred only once. For example, certain physician work activities—such as reviewing the patient's medical history or dictating a report for the medical record and following up with the referring physician after a medical procedure—occur only once. Similarly, certain practice expenses—such as a nurse's time spent in obtaining the patient's consent and preparing the patient for the procedure, or a technician's time in setting up the required equipment—are incurred only once. However, payment for these overlapping portions is generally included in each fee, resulting in excessive payments by Medicare.[3]

You asked us to explore options to ensure that the physician fee schedule appropriately reflects efficiencies occurring across all types of services that are commonly furnished together. This report examines (1) CMS's current efforts to ensure that Medicare physician fees reflect efficiencies in services commonly furnished together and (2) additional opportunities for CMS to avoid excessive payments for Medicare physician services commonly furnished together.

To determine how CMS ensures that Medicare physician fees reflect efficiencies for services commonly furnished together, we reviewed CMS's relevant payment policies and applicable laws and regulations. We interviewed officials from several organizations to discuss other instances where the physician fee schedule could better reflect efficiencies for these services. These organizations included CMS, the Medicare Payment Advisory Commission (MedPAC), and 7 of the 15 Medicare contractors

[2]On average, the physician work component accounts for about 52 percent of the total fee for each service, the practice expense component accounts for about 44 percent, and the malpractice component for about 4 percent.

[3]CMS also uses resource estimates for physician work and practice expenses to calculate indirect expenses—such as overhead, office equipment, and administrative staff salaries—for each service; thus, duplication of these resource estimates when services are commonly furnished together further contributes to excess payments.

that process and pay Part B claims.[4] We also met with representatives from the American Medical Association (AMA) and AMA-sponsored physician panels that assist CMS in developing estimates of resources required to deliver physician fee schedule services to discuss their initiatives to refine resource estimates for services commonly furnished together.

To determine additional opportunities for CMS to avoid excessive payments for services that are commonly furnished together, we conducted a systematic review of all pairs of services furnished by the same physician to the same beneficiary on the same day from 2006 Medicare claims data.[5] We excluded pairs subject to an existing Medicare billing or payment policy that reflected efficiencies when these services were furnished together. From the remaining service pairs, we selected the 350 that accounted for the highest share of Medicare spending and met with Medicare contractor Medical Directors and their staffs in five different states to determine whether efficiencies occurred in any of these service pairs. We also consulted with other experts from three medical specialty societies and reviewed AMA resource estimates of physician work and practice expenses.[6] On the basis of these discussions and analyses, we estimated resulting savings to the Medicare program if fees were adjusted to reflect efficiencies occurring in the service pairs identified by the contractors. Our estimate of savings is based upon the premise that providers do not change their practice patterns (for example, by scheduling services on different days) in response to these fee adjustments. Appendix I provides more detailed information on our methodology to estimate the potential for further savings from service pairs commonly furnished together.

[4]The seven contractors we interviewed together process claims in 28 states across the nation. CMS is in the process of integrating the administration of Medicare Part A (which covers hospital and other inpatient services) and Part B to new entities known as Medicare Administrative Contractors. The transition must be completed by October 2011.

[5]For this report, we will use "services commonly furnished together" to mean services performed by the same physician to the same beneficiary on the same day.

[6]We interviewed experts from the American College of Cardiology and American College of Radiology who had published articles on appropriate payments for Medicare physician services. We also interviewed an expert from the American Society of Interventional Radiology to understand how certain interventional radiology procedures are valued by the AMA-sponsored physician panels, since these procedures are commonly furnished on the same day with other services.

We examined the reliability of the claims data used in this report by performing appropriate electronic checks, including those for obvious errors, such as missing values and values outside of expected ranges. We also interviewed officials who were knowledgeable about the data, including CMS and Medicare contractor officials. We determined that the claims data we used were sufficiently reliable for purposes of our analysis because they are used by the Medicare program as a record of payments to health care providers. As such, they are subject to routine CMS scrutiny.

We conducted our work from May 2008 through July 2009 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicare's physician fee schedule includes payments for over 7,000 services, such as office visits, surgical procedures, and tests.[7] Most services are defined as discrete and stand-alone in that they may be furnished independently of other services, but a small number of services are defined as supplemental because they are commonly furnished along with other primary services.

Process for Defining Medicare Fee Schedule Services

Services under the Medicare fee schedule are described and defined by the AMA's Current Procedural Terminology (CPT) Editorial Panel, and each service is assigned a five-digit identifier, or code. The CPT Editorial Panel revises and modifies CPT codes based largely on suggestions from specialty societies and the CPT Editorial Panel's Advisory Committee.[8] Code revisions require research from both CPT staff and specialty society members who assist the CPT Editorial Panel in its work. According to

[7]Not all of the services included under the physician fee schedule are performed by physicians; some services (such as chemotherapy services or routine tests) may be performed by nurses or technicians.

[8]Primarily composed of physicians from the specialty societies, the Advisory Committee makes recommendations to the CPT Editorial Panel for either the creation of new codes or revisions to existing codes. The CPT Editorial Panel meets three times a year, and its actions can result in three outcomes: (1) a new or revised code is approved, (2) the proposal is postponed pending further information, or (3) the proposal is rejected.

AMA officials, the CPT process generally takes about 14 months from the time potential codes are first identified by specialty societies to the final revision or development of a new code.

Process for Developing and Updating Resource Estimates Used to Set Fees

CMS relies on the AMA/Specialty Society Relative Value Scale Update Committee (RUC)—an expert panel that includes members from national physician specialty societies—to develop and update on an ongoing basis the resource estimates upon which fees are based.[9] Specialty societies identify services for review, gather data on resource use, and make proposals to the RUC on resource estimates for services. Physician work estimates are developed using vignettes of each service furnished to a typical patient, where the specific physician activities are described for three phases—before, during, and after the service.[10] Practice expense estimates considered direct—clinical labor (that is, the nurse's or technician's time), equipment, and supplies—are developed similarly for each of these phases.[11,12] (App. II provides an example of a vignette and practice expense estimates for one service.) The RUC evaluates proposals submitted by the specialty societies and makes recommendations for final consideration by CMS. The RUC meets three times a year, and, on average, reviews approximately 300 codes annually. The RUC also assists CMS in the Five-Year Review process—a review of fees for all services that the

[9]Estimates for physician work are developed by the RUC, while estimates for practice expenses are first reviewed by a subcommittee of the RUC—the Practice Expense Subcommittee, then submitted to the RUC for final recommendation to CMS.

[10]These phases are referred to as preservice, intraservice, and postservice. The RUC maintains a database that includes vignettes and physician work estimates for services that it has reviewed.

[11]Indirect expenses—overhead, administrative labor, and office expenses—are calculated by CMS in proportion to direct expenses and the physician work or clinical labor involved in providing each service.

[12]Medicare's physician payment system ranks services on a common scale based on the amount of resources needed to provide each service relative to a benchmark service—defined as a midlevel office visit. These relative resources are expressed as relative value units (RVU). (Thus, if a midlevel office visit has an RVU value of 1.0, a service with an RVU of 1.5 is estimated to be 50 percent more costly to provide.) RVUs for each service are converted into fees by adjusting them to reflect geographic differences in resource costs, then multiplying by a dollar conversion factor. For further details on the process CMS uses to set fees, see GAO, *Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices*, GAO-08-452 (Washington, D.C.: June 13, 2008), and *Medicare Physician Fees: Geographic Adjustment Indices Are Valid in Design, but Data and Methods Need Refinement*, GAO-05-119 (Washington, D.C.: Mar. 11, 2005).

agency is required by law to conduct at least every 5 years to account for changes in medical practice.[13]

While CMS may reject or modify the RUC's recommendations, from 1993 through 2009, the agency accepted over 90 percent of the recommendations pertaining to 3,600 new and revised CPT codes. CMS may at times also make changes to fees for services independent of RUC recommendations.

Initiatives to Account for Efficiencies in Multiple Services

Efficiencies in multiple services that are furnished together may be factored into fees primarily in two ways. First, the RUC and specialty societies generally attempt to consider whether other services are typically furnished along with the service they are reviewing to avoid duplication of the resources associated with physician work and practice expenses that may be incurred only once. For example, certain activities included in the practice expense component, such as preparing the patient before a procedure and cleaning the room after the procedure, are performed only once when two services are furnished together. However, the RUC has not reviewed every service; therefore, estimates are outdated for a large portion of services and may no longer reflect current technology and medical practice. For example, resource estimates for certain image-guided surgeries were developed when a surgeon performed the surgery and a radiologist performed the related imaging, whereas in current medical practice, a single physician tends to do both tasks. Further, for supplemental services, the RUC ensures that the physician work and practice expense resources required before and after the service are not duplicated.

Second, CMS has, independent of the RUC and specialty societies, implemented its own policies to recognize efficiencies occurring in certain services. CMS has a long-standing policy called a multiple procedure payment reduction (MPPR) to avoid duplicate payments for portions of practice expenses that are incurred only once when two or more surgical services are furnished together by the same physician during the same operating session.[14] CMS expanded the MPPR to include certain diagnostic

[13]See 42 U.S.C. § 1395w-4(c)(2)(B)(i),(ii).

[14]Supplemental services are exempt from the MPPR.

imaging services in 2006.[15] Under the MPPR policy, the full fee is paid for the more expensive service, but a reduction is applied to the fees for each subsequent service. Generally, a 50 percent reduction is applied to fees for surgical services performed during the same operating session and a 25 percent reduction is applied to fees for certain imaging services that are furnished together.[16]

Budget Neutrality

By law, updates to fees are required to be budget neutral—that is, they cannot cause Medicare's aggregate payments to physicians to increase or decrease by more than $20 million.[17] As a result, any "savings" realized from reducing the fees for particular services do not accrue to the Medicare program but are redistributed across all services, resulting in a slight increase to the fees for all other services. In some instances, Congress has overridden budget neutrality to ensure that payment changes result in savings to Medicare. For example, through the Deficit Reduction Act of 2005 (DRA), Congress mandated that savings resulting from the MPPR for certain imaging services that were furnished together be exempted from budget neutrality.[18] As a result, annual savings of approximately $96 million were not redistributed across all services, but accrued as savings to the Medicare program in 2006.

CMS Has Recognized Efficiencies in Some Services, but Has Not Focused on High-Spending Services

CMS has taken steps to recognize efficiencies for services commonly furnished together through the use of the RUC process and the MPPR, but has not targeted services with the greatest potential for savings, and the RUC process depends on specialty societies. The MPPR is limited in scope because it does not apply to a broad range of services, nor does it capture efficiencies occurring in the physician work component.

[15]The MPPR applies only to the fee for the provision of the imaging test—generally performed by a technician. It does not apply to the fee for the interpretation of the imaging test—generally performed by a radiologist or other physician.

[16]Although the reduction is applied to the entire fee for each subsequent service, according to the rules we reviewed, the MPPR reflects duplication in practice expenses, not physician work. See 56 Fed. Reg. 59,502, 59,514-15 (Nov. 25, 1991); 62 Fed. Reg. 33,158, 33,171 (June 18, 1997); and 73 Fed. Reg. 69,726, 69,882 (Nov. 19, 2008).

[17]See 42 U.S.C. § 1395w-4(c)(2)(B)(ii).

[18]See 42 U.S.C. § 1395w-4(c)(2)(B)(v).

RUC Workgroup Examines Efficiencies in Services Commonly Furnished Together, but Does Not Target Services with Greatest Potential for Savings

CMS stated that it is reviewing the efforts of a workgroup recently created by the RUC to identify efficiencies in services that are commonly furnished together. In March 2006 MedPAC criticized the RUC for recommending more increases than decreases in resource estimates, largely because the RUC had focused on services that specialty societies believed were undervalued. In response, the RUC established the Five-Year Review Identification Workgroup in October 2006 to identify potentially misvalued services. The workgroup used several criteria to identify these services, one of which was to examine services commonly furnished together to determine if such services should be bundled to reduce duplication in the physician work component. The workgroup requested data from CMS on services commonly furnished together in 2007. CMS forwarded a list of over 2,200 service pairs that were furnished together more than 50 percent of the time, but did not tell the workgroup how to prioritize its review of the services. Instead, the workgroup developed its own methodology, targeting service pairs that were almost exclusively furnished together.

While the methodology represents a reasonable first step to identify potentially misvalued services, and the workgroup has expended considerable effort and resources in implementing it, the methodology will likely result in limited savings to Medicare. This is because the group did not systematically focus on services that accounted for a large share of Medicare spending, nor did it exclude supplemental services with limited potential for savings.

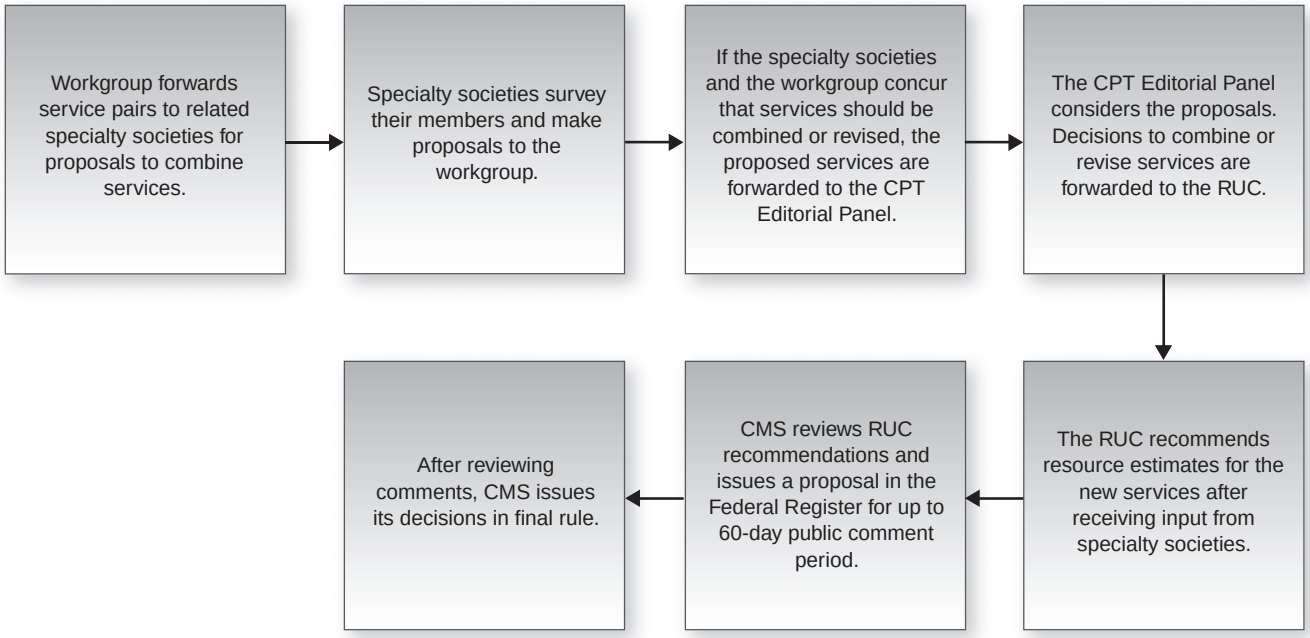
The workgroup focused on service pairs in which the two services were performed together at least 90 percent of the time. The workgroup classified service pairs into two types: type A, in which both services in the pair were performed together at least 90 percent of the time, and type B, in which one service was performed with another service at least 90 percent of the time in a unidirectional relationship (that is, when the first service was performed, the second service was also performed at least 90 percent of the time, but when the second service was performed, the first service was not performed at least 90 percent of the time). The workgroup identified 22 type A and 31 type B service pairs where possible duplication was occurring in physician work.[19]

[19]The workgroup told us that it intends to review pairs that are performed together at a threshold below 90 percent after it completes review of the type A and B pairs.

However, these service pairs would likely result in limited savings. First, 19 of the 22 type A pairs and 20 of the 31 type B pairs included supplemental services for which further reductions in fees would likely be small. For example, in performing a three-dimensional heart wall imaging study (also known as a myocardial perfusion imaging study), physicians may take additional measurements of blood flow or heart wall function. These additional services are supplemental to the primary service and are therefore already priced to exclude overlap in practice expenses incurred before and after the service. Second, spending for the lower-priced service in the remaining pairs was minimal: $27 million for the remaining 3 type A services and $117 million for the remaining 11 type B services. Thus, potential savings from combining the remaining service pairs would likely be no more than half these respective amounts, assuming a 50 percent discount was applied to the lower-priced service—a generous assumption, since that is the maximum discount that CMS has applied to services under the MPPR.

Another limitation of the workgroup's review of services commonly furnished together is that its process is resource intensive. This element is inherent in a process based on input and consensus from specialty societies. The workgroup follows the RUC's process in that it solicits proposals from specialty societies for potential revisions to the service pairs. The proposals must then be approved by the CPT Editorial Panel, the RUC, and CMS (see fig. 1).

Figure 1: Overview of Workgroup Process to Identify Misvalued Services Furnished by the Same Physician to the Same Beneficiary on the Same Day



Source: GAO analysis.

To date, the workgroup has identified only a limited number of misvalued services commonly furnished together. Since the review of service pairs that was started in 2007, the workgroup has identified three misvalued services; at the workgroup's recommendation, these (echocardiography) services were combined into a single code in 2009. The earliest any additional changes might be implemented for the type A and B service pairs first identified in 2007 would be 2010.[20]

[20]As of May 2009, specialty societies had recommended that each of the 22 type A and 31 type B service pairs be combined into single codes. The CPT Editorial Panel and the RUC have reviewed 25 of these proposals, and the RUC has forwarded its recommendations to CMS. CMS officials stated that they will publish these proposals and the agency's decisions in the proposed rule for 2010. (The proposed rule for 2010 was published on July 13, 2009.) The proposals on the remaining 28 service pairs are slated to be reviewed at upcoming CPT meetings.

Finally, the workgroup is required to undertake other tasks, including reviewing services because of technological changes or because of high growth, utilization, or intensity.[21] These reviews also require involvement from the specialty societies, in addition to their efforts to revise estimates of physician work and practice expenses an ongoing basis as well as for the Five-Year Reviews. Despite the demands of these tasks, the RUC has stated that CMS should continue to rely on the workgroup to identify opportunities for efficiencies, rather than implement an MPPR, which it perceives to be an imprecise tool for reducing duplicate payments for portions of services furnished only once.

CMS's MPPR Policy Reflects Efficiencies but Is Limited in Scope

CMS's MPPR policy reflects efficiencies for certain imaging and surgical procedures commonly furnished together, but it is limited in scope. CMS estimated that its use of the MPPR for certain imaging procedures produced savings of about $96 million in 2006.[22,23] In this instance, Congress exempted these savings from the budget neutrality provision; as a result, the $96 million was not redirected to other services but accrued as savings to the Medicare program.

In principle, an MPPR can be implemented quickly to reflect efficiencies for services performed together. In developing the list of services to be selected for an MPPR, CMS does not formally solicit opinion from specialty societies or others until the MPPR is published as a proposed rule. For example, in developing the imaging MPPR, CMS—acting independently of the RUC and specialty societies, on MedPAC's recommendation—identified imaging services that were commonly furnished together and determined an appropriate discount to account for efficiencies occurring in the practice expense component.[24] CMS then

[21]In addition to the workgroup's task of examining services commonly furnished together, the RUC is examining other misvalued services. For example, in June 2008, CMS forwarded a list of several hundred codes for its review. The list included codes in three different categories: (1) 114 services with the fastest growth, (2) 2,900 services with physician work estimates that had been developed over 20 years ago, and (3) over 320 services with rapid growth in practice expenses. The April 2009 RUC meeting agenda included over 2,000 pages of materials pertaining to these codes as well as other policies proposed by CMS.

[22]Estimates of excessive payments that were avoided for surgical services subject to the MPPR have not been available since this policy was implemented over 10 years ago.

[23]CMS recently expanded the imaging MPPR to include 10 additional services.

[24]MedPAC, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: 2006).

published these decisions in its August 2005 proposed rule for specialty society and public comment and finalized its decisions in November 2005 after evaluating and responding to stakeholder comments. These changes went into effect on January 1, 2006.

The MPPR as currently used by CMS does have limitations. First, the MPPR does not apply to nonsurgical and nonimaging services that are commonly furnished together. When CMS developed the MPPR for surgical services in 1996, it acknowledged that efficiencies likely also occur for nonsurgical services. However, other than the imaging MPPR, CMS has not implemented an MPPR policy for nonsurgical services.[25] Contractors we interviewed identified many opportunities to expand the MPPR policy to areas where services are commonly furnished together. For example, they stated that similar efficiencies occur when certain types of tests—such as nerve conduction studies or pulmonary function, vision, and hearing tests—are performed together. However, as of July 2009, CMS had not published proposals to systematically review services commonly furnished together by focusing on the most expensive services with the greatest potential for savings to Medicare.

Second, the MPPR only reflects efficiencies occurring in practice expenses, not in the physician work component, where certain physician activities may occur only once.[26] For example, a physician's review of a patient's medical history and prior imaging or other test results before the service, and dictation of the final report for the medical record, occur only once. Under the current payment methodology, the time spent on these activities is included in each service because the services are assumed to be furnished separately. Several organizations we interviewed stated that an MPPR for the physician work component was warranted to avoid duplicate payments to physicians for activities that they perform only once. In its 2006 report, MedPAC similarly recommended that CMS

[25]CMS stated, in the 2009 final rule, that it will conduct data analysis and seek input from the RUC, MedPAC, and specialty societies to determine if an MPPR should be expanded to other (nonsurgical and nonimaging) services. See 73 Fed. Reg. 69,726, 69,882 (Nov. 19, 2008). Officials also told us that they expect to publish proposals for expanding the MPPR to other services in the proposed rule for 2010. (The proposed rule for 2010 was published on July 13, 2009.)

[26]Although the reduction is applied to the entire fee for each subsequent service, according to the rules we reviewed, the MPPR reflects duplication in practice expenses, not physician work. See 56 Fed. Reg. 59,502, 59,514-15 (Nov. 25, 1991); 62 Fed. Reg. 33,158, 33,171 (June 18, 1997); and 73 Fed. Reg. 69,726, 69,882 (Nov. 19, 2008).

examine efficiencies that might be occurring in the physician work component but are not reflected in the fee schedule.[27] However, CMS has not conducted such a review.

CMS's MPPR Policy Could Be Applied to Other Services Commonly Furnished Together and Expanded to Reflect Efficiencies in Physician Work

Our review of Medicare claims data indicated the potential for reducing excessive physician payments by implementing an MPPR to reflect efficiencies generally occurring in the practice expense component of certain nonsurgical and nonimaging service pairs commonly furnished together. In addition, our analysis of certain imaging services indicated potential for further reducing excessive payments by implementing an MPPR to reflect efficiencies in the physician work component when these services are performed together.

Potential Exists for Reducing at Least One-Half Billion Dollars in Excessive Payments Annually through an MPPR to Reflect Efficiencies in the Practice Expense Component

Our systematic review of a sample of the most costly service pairs showed potential for annual savings of over one-half billion dollars with implementation of an MPPR to reflect efficiencies in the practice expense component. Contractor Medical Directors we met with determined that an MPPR was appropriate for 149 (over 40 percent) of the 350 most costly service pairs we reviewed with them. The contractor Medical Directors recommended these MPPRs to reflect efficiencies occurring in practice expenses for services that were furnished only once. The 149 service pairs included interventional radiology procedures, physical therapy services, and various tests, such as additional imaging, pulmonary function, vision, hearing, and pathology.[28] For example, a cardiovascular stress test is commonly furnished with a three-dimensional heart imaging test. However, the Medical Directors cautioned that CMS would need to

[27]MedPAC, *Report to the Congress: Medicare Payment Policy*.

[28]Interventional radiology procedures generally include one or more surgical procedures that are accompanied by imaging services. While the surgical procedures are subject to the surgical MPPR, the imaging services are not. Physical therapy services are generally valued as 15-minute sessions. Officials from the AMA explained that time spent on preservice and postservice activities is spread across the number of services in a "typical" session to avoid duplication of practice expenses. However, we found that there was duplication of certain activities in the intraservice period. For example, time spent testing range of motion or muscle flexibility was duplicated in the physical therapy service pairs that we examined.

carefully monitor utilization of these services to ensure that physicians did not change their behavior by scheduling services on different days to avoid reduced fees for those subject to an MPPR.

Potential Exists for Reducing about $175 Million Annually through Expanding the Current MPPR for Imaging Services to Reflect Efficiencies in the Physician Work Component

Our analysis of 118 imaging service pairs suggests that efficiencies in physician work occur when services are furnished together, and an MPPR policy that reflected these efficiencies could save Medicare over $175 million annually.[29] We sought the advice of contractor Medical Directors and other experts, who agreed that efficiencies occur in physician work when two or more services are furnished together and that an MPPR would be appropriate to account for these efficiencies. Our savings estimate is based on reducing fees for the lower-priced service in each service pair to reflect efficiencies in physician time spent on activities performed before and after the service that are already included in the higher-priced service. For example, the service pair that accounted for the largest share of spending across all imaging service pairs was the physician's interpretation of two computed tomography (CT) scans: CT of the abdomen with dye and CT of the pelvis with dye.[30] Of a total of 18 minutes allotted for interpretation of the second (lower-priced) service, 8 minutes were allotted for activities such as reviewing the patient's prior medical history before the service and reviewing the final report and following up with the referring physician after the service. Since time spent on these activities was already included in the first (higher-priced) service, we discounted the fee for the lower-priced service by 44 percent (that is, 8 minutes ÷ 18 minutes).[31] While the results of our analysis cannot be generalized to all service pairs, the concept of applying an MPPR for the physician work component could be applied to other services.

Our analysis focused on efficiencies in activities performed before and after each service, but there are also likely efficiencies occurring during, or within, the intraservice phase. For example, a practicing radiologist we interviewed stated that when two CT scans of contiguous body areas (e.g.,

[29]We could not estimate savings from an MPPR for the physician work component of all service pairs because the RUC had not reviewed these services and the data required for this analysis were missing.

[30]AMA officials informed us that the RUC has recommended changes for this service pair that CMS could incorporate into the 2011 physician fee schedule.

[31]Experts we interviewed agreed that this methodology was a reasonable way of estimating efficiencies in physician work.

the abdomen and pelvis) are taken at the same time, the total number of actual CT images reviewed is lower than if each scan were performed separately. This is because an abdominal CT generally includes margins of the pelvis and vice versa, and the images of these overlapping margins are examined only once by the radiologist. Other efficiencies relating to technology advances, such as digital storage and retrieval of imaging, may also be realized during the intraservice phase.

Conclusions

The RUC and specialty societies may be limited in their ability to help CMS quickly identify opportunities for further savings from efficiencies occurring when services are commonly furnished together. The RUC's methodology for identifying additional services is not focused on finding savings for the Medicare program. Moreover, the RUC workgroup's dependence on specialty societies limits its ability to make progress. CMS, on the other hand, has the tools in place to readily expand its MPPR policy to reflect efficiencies occurring in the practice expense and physician work components of services that are commonly furnished together. However, as of July 2009, the agency did not appear to have conducted a systematic review of claims data to identify opportunities with the greatest potential for further savings. Further, unless specifically exempted by Congress (as was done in the DRA for fee changes for certain imaging services), savings would be redistributed to other services in accordance with the budget neutrality provision, and the Medicare program would not realize savings.

Recommendation for Executive Action

The Acting Administrator of CMS should take further steps to ensure that fees for services paid under Medicare's physician fee schedule reflect efficiencies that occur when services are performed by the same physician to the same beneficiary on the same day. These efforts could include

- systematically reviewing services commonly furnished together and implementing an MPPR to capture efficiencies in both physician work and practice expenses, where appropriate, for these services;
- focusing on service pairs that have the most impact on Medicare spending; and
- monitoring the provision of services affected by any new policies it implements to ensure that physicians do not change their behavior in response to these policies.

Matter for Congressional Consideration

To ensure that savings are realized from the implementation of an MPPR or other policies that reflect efficiencies occurring when services are furnished together, Congress should consider exempting these savings from budget neutrality.

Agency and Professional Association Comments and Our Evaluation

We obtained written comments on a draft of this report from the Department of Health and Human Services (HHS), which are reprinted in appendix III. We obtained oral comments from representatives of the AMA.

HHS Comments

HHS concurred with our recommendation and stated that CMS plans to perform an analysis of nonsurgical codes that are furnished together between 60 and 70 percent of the time to determine whether efficiencies occur in the physician work and practice expense component of these services. HHS stated that it would implement policies to reflect these efficiencies, as appropriate, and agreed that CMS should focus on service pairs that have the most impact on Medicare spending. HHS also agreed on the need to monitor physician utilization of services if the MPPR is expanded. HHS suggested that we include in an appendix to the report the specific service pairs that we identified.

We did not include such an appendix because our report focuses on illustrating the value of CMS's taking a more systematic approach, rather than focusing on specific service pairs, to ensure that the fee schedule reflects efficiencies when services are provided together. However, we will work with CMS officials and share information to aid in the agency's efforts.

AMA Comments

AMA representatives expressed three broad concerns about the draft report. First, they disagreed with our assessment of the RUC workgroup's efforts to ensure that services are appropriately coded and valued. Second, they stated that a broad application of the MPPR to account for efficiencies in practice expenses and physician work was not appropriate. Third, they opposed our matter for congressional consideration that suggests that any savings from implementing the report's recommendations be exempted from budget neutrality requirements.

RUC Workgroup's Efforts

AMA representatives disagreed with the report draft's characterization of the efficacy of the RUC workgroup, noting that the RUC workgroup's efforts have been aggressive, timely, and efficient. They also stated that the specialty societies had developed proposals to combine the type A and B service pairs that would result in significant savings should CMS implement them in 2010 or 2011. As an example, they projected that the proposals to combine 14 myocardial perfusion services of the workgroup's 53 type A and type B service pairs would result in annual savings of about $40 million from efficiencies occurring in the physician work component. In addition, they said that while they did not have an estimate, they believed that savings for the practice expense component would also likely be significant. Finally, representatives stated that in its review of potentially misvalued services, the workgroup may have already identified and made recommendations on some of the unique codes or pairs included in our list of 149 code pairs.

We acknowledge in the draft the time and effort the workgroup has expended in identifying potentially misvalued services. However, based on our review of the workgroup's processes and progress to date, we continue to believe that these processes are resource intensive and will likely limit CMS's ability to quickly identify opportunities for savings from those service pairs that account for a high share of Medicare spending. In addition, as stated in the draft, the workgroup has not prioritized its review to systematically focus on services with the greatest potential savings for Medicare. While it is possible that some of the type A and type B service pairs the workgroup identified may be relatively costly, its methodology does not systematically focus on such services. We believe our assessment of the workgroup's progress remains accurate—as of 2009 the workgroup had identified only three misvalued services that were combined. Finally, from our list of 149 code pairs (which included 116 unique codes), the workgroup had identified only one code pair and 21 unique codes in its review of potentially misvalued codes.

Broader Application of MPPR

AMA representatives stated that a "blanket reduction" of 25 percent for the 149 code pairs based on duplication in time spent on certain preservice and postservice tasks was not appropriate. They contended that for an average service, the intensity of time spent on tasks in the preservice and postservice phases is less than the intensity of time spent on intraservice tasks. AMA representatives added that in some instances a 25 percent reduction may be too high, whereas in other instances it might be more appropriate. They said that for some of the newer codes, the RUC had already taken any potential efficiencies into account, but for some of the old codes, which have not been revalued by the RUC, the 25 percent

discount may be more reasonable. The AMA representatives also stated that the RUC workgroup's efforts result in a more accurate and credible system of coding and valuation of services and thus is more effective than the application of "arbitrary policies" such as an MPPR.

In the draft report, we acknowledge the limitations of our approach and state that the results of our analysis cannot be generalized to all service pairs. Our draft also states that the discount of 25 percent we applied to the 149 code pairs is consistent with the imaging MPPR that reflects efficiencies in the practice expense component. We do not recommend that CMS adopt our specific methodology; rather we present it as an illustration of potential efficiencies occurring in the physician work component that can be uncovered through a systematic review of service pairs. However, we continue to believe that CMS should undertake a systematic review of services and, where appropriate, expand the MPPR to ensure that physician fee schedule payments reflect efficiencies when services are performed by the same physician to the same beneficiary on the same day.

Exempting Savings from Budget Neutrality Requirement

AMA representatives disagreed with the draft's statement that spending on physician services has recently grown at an average annual rate of 6 percent, and opposed our suggestion that Congress consider exempting any savings from implementation of the report's recommendations from federal budget neutrality requirements. AMA representatives told us that the growth rate of per beneficiary spending on Part B physician services has slowed to an annual rate of 3 percent in 2006 and 2007. Regarding our suggestion that Congress consider exempting any savings from budget neutrality, AMA representatives expressed concern that the exemption would have an adverse effect on primary care services that could benefit from the redistribution of savings and stated that savings would be spent on other programs.

We agree that the annual rate of growth in per beneficiary spending on physician services slowed somewhat in 2006 and 2007, but even taking this into account, annual spending from 1997 to 2008 grew an average of 6 percent. We recommend that Congress consider exempting potential savings from budget neutrality to help ensure the fiscal health of the Medicare program. As we noted in the draft, there is recent precedent for exempting savings from budget neutrality. We agree that primary care services are important, but Congress has other mechanisms for altering payment for these services.

AMA representatives also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Acting Administrator, CMS, and relevant congressional committees. This report also will be 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) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IV.

James C. Cosgrove
Director, Health Care

Appendix I: Estimating Potential for Further Savings from Efficiencies in Multiple Services

In this appendix, we describe the processes we used to determine opportunities for the Centers for Medicare & Medicaid Services (CMS) to avoid excessive payments for services commonly furnished together.

Estimating Potential for Further Savings from Efficiencies in the Practice Expense Component of Multiple Services through Systematic Review of Medicare Claims Data

To determine additional opportunities for CMS to avoid excessive payments for services that are commonly furnished together, we conducted a systematic review of Medicare claims data using the 2006 Medicare Physician/Supplier Part B 5 Percent Standard Analytic File.[1] To conduct this review, we selected physician services that were paid under the resource-based payment methodology.[2] We generated a list of all service pairs that were furnished by the same physician to the same beneficiary on the same day and made the following exclusions:

- service pairs with low utilization—those that were billed fewer than 5,000 times annually;
- service pairs containing only the professional portion of a service;[3]

[1]The 5 Percent Standard Analytic File contains final action claims data submitted by noninstitutional providers, including physicians, physician assistants, clinical social workers, nurse practitioners, independent clinical laboratories, ambulance providers, and stand-alone ambulatory surgical centers.

[2]Thus, we excluded Part B services provided or ordered by physicians but paid under other fee schedules, such as prescription drugs, laboratory, and Durable Medical Equipment. We estimated that these services account for approximately one-third of total Medicare spending on physician-billed services.

[3]Certain services, including imaging tests, have two separate portions—a professional portion that represents the physician's interpretation of the test, and a technical portion that represents the actual performance of the test, generally by a technician. As such, the professional portion reflects the physician's work. We excluded services with a professional portion since CMS currently does not have policies in place to recognize efficiencies in physician work.

- service pairs that were already subject to payment policies that reduced payments for one of the services in the pair;[4]
- service pairs containing supplemental services, which are priced to exclude duplication of physician work and practice expenses that are already included in the primary service;[5] and
- service pairs containing duplicate services.

The remaining list of service pairs was our universe of pairs that represented opportunities for savings from efficiencies that resulted when the two services were furnished together.[6] To target our review to the service pairs that accounted for a large share of Medicare spending, we ranked the service pairs based on spending for the lesser-priced service (since the multiple procedure payment reduction (MPPR) and other policies usually apply to that service) and selected the 350 costliest service pairs based on total spending. We met with contractor Medical Directors and their staffs in five different states to determine if there were efficiencies taking place in the practice expense component when these service pairs were furnished together. To ensure consistency of review across the five contractors, we developed a standard set of questions that each contractor followed in evaluating the service pairs. We asked contractors to examine service descriptions and definitions, as well as coding instructions from the Current Procedural Terminology (CPT)

[4]These policies fell into three broad categories: (1) the National Correct Coding Initiative, which disallows payment for the second service because it is either a component of the first service or cannot reasonably be performed with the first service; (2) the global surgery payment policy, which generally disallows separate payment for certain services—such as evaluation and management—performed before and after a surgical service over a defined period of time, because reimbursement for these evaluation and management services is included in the surgical fee; and (3) the multiple procedure payment reduction (MPPR), which reduces payment for the second and subsequent services for certain surgical and imaging services. CMS officials we met with concurred that while they routinely issue payment policies on other individual services that are performed together, the three policies that we identified are the most comprehensive.

[5]We identified supplemental services as those listed in Appendix D: "Summary of CPT Add-on Codes" and Appendix E: "Summary of CPT Codes Exempt from Modifier 51", of the 2008 *AMA CPT Manual*.

[6]The total list of service pairs generated before any exclusions was approximately 165,000 pairs. After the exclusions, that number dropped to approximately 64,000. We then selected the top 350 service pairs that accounted for at least one-half of 1 percent of the total savings potential from the 64,000 service pairs.

manual and from CMS, and use their clinical judgment and knowledge to assess whether there were efficiencies occurring because certain practice expenses were incurred only once before and after each service in the service pairs. We also asked contractors to determine the payment policy that best captured these efficiencies. For example, contractors determined whether the services in each pair should be combined into a single code, there should be no payment for one service in the service pair because it was inherently included in the other, or an MPPR should be applied. If an MPPR should be applied, contractors determined the approximate discount that was most appropriate. Since all five contractors determined that an MPPR was the most appropriate payment policy to reflect efficiencies in all 149 of the 350 service pairs they identified as having potential, we estimated total savings to the Medicare program by applying the appropriate discount to spending for the lower-priced service in each pair.

Our estimate of savings is conservative for several reasons. First, we excluded services that were billed multiple times on the same day by the same physician, since our focus was on potential savings when two unique services were furnished together. To the extent that there is overlap of physician work and practice expenses in the preservice and postservice phases of these duplicate services, an MPPR should be applied to account for this overlap. Second, we generally applied a discount of 25 percent or less to the service pairs to mirror CMS's discount on imaging service pairs, although, in certain instances, a higher discount was warranted based on the extent of duplication in practice expenses.

Estimating Potential Savings from an MPPR to Reflect Efficiencies in Physician Work Component

To estimate potential savings from applying an MPPR to account for duplication of physician work activities occurring before and after each service in the service pairs, we first examined the American Medical Association (AMA) database—the Resource-Based Relative Value System (RBRVS) Data Manager—to determine if data on these activities were available for all service pairs. The RBRVS Data Manager contains vignettes describing the physician's work for a specific procedure for a typical patient in three phases: preservice, intraservice, and postservice.[7] The AMA/Specialty Society Relative Value Scale Update Committee (RUC) bases its estimates of physician work and practice expenses on these vignettes. Because we found that vignettes were missing for a large proportion of services, we used physician time—the amount of time it takes a physician to perform a service—as a proxy for physician work, and discounted the fee for the lesser-priced service in each service pair for the extent of overlap in physician time spent on the preservice and postservice phases across the two services.[8] Using the physician time file on the CMS Web site, we calculated this discount as the sum of time spent on the preservice and postservice phases of the lesser-priced service divided by total time for that service.[9] We limited our analysis to the imaging service pairs that we had identified from our review of Medicare claims data because we wanted to examine a homogenous group of services where the activities included in the pre- and postservice phases were generally the same across different imaging services, and therefore the time spent on pre- and postservice phases was also likely to be relatively uniform across this group of services. We applied the discount to the professional fee of imaging services, since the professional fee captures the physician's work in interpreting the imaging service. We discussed our approach with several experts in the Medicare physician payment system. These included an experienced contractor Medical Director; a Medicare Payment Advisory

[7]Preservice describes the activities involved prior to performing a specific procedure, such as obtaining a patient history; intraservice reflects the primary service performed, such as interpretation of an imaging test; and postservice includes activities performed following a procedure, such as signing a final report and discussing the findings with the referring physician.

[8]Physician time does not account for either the complexity and intensity of a procedure and the risk to the patient or the physician's skill required, but the time spent on activities in both the preservice and postservice phases is likely to be duplicated for procedures performed together by the same physician on the same patient on the same day.

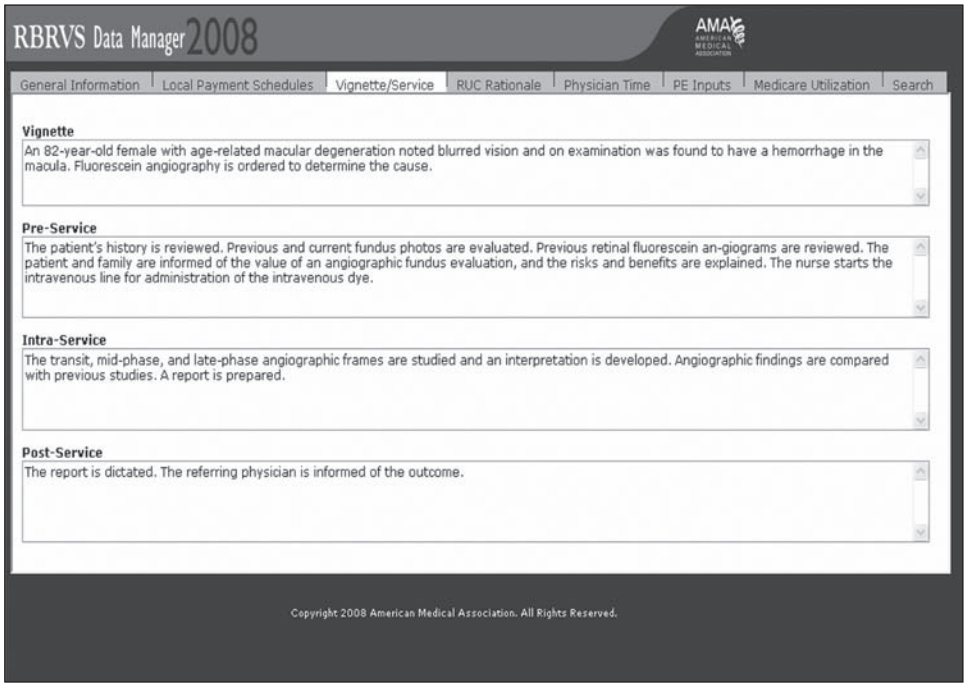
[9]For example, if a service takes a total of 20 minutes, and the time spent on the preservice and postservice phases was 3 minutes and 2 minutes, respectively, the discount would be 25 percent.

Commission (MedPAC) official who is an expert in Medicare physician payment policy; and a practicing radiologist and leading expert in the field who has written extensively on Medicare payment policy and reimbursement issues. They concurred that our methodology was a reasonable approach to estimating potential savings from an MPPR for physician work.

Appendix II: Examples of Vignette and Practice Expense Estimate

This appendix contains examples of a vignette and a practice expense estimate. The vignette (fig. 2) is used by specialty societies to develop estimates of physician work resources for a service. The practice expense estimate (fig. 3) describes the nonphysician clinical labor, supplies, and equipment resources required for each service.

Figure 2: Example of AMA Vignette for CPT Code 92235, Eye Exam with Photos



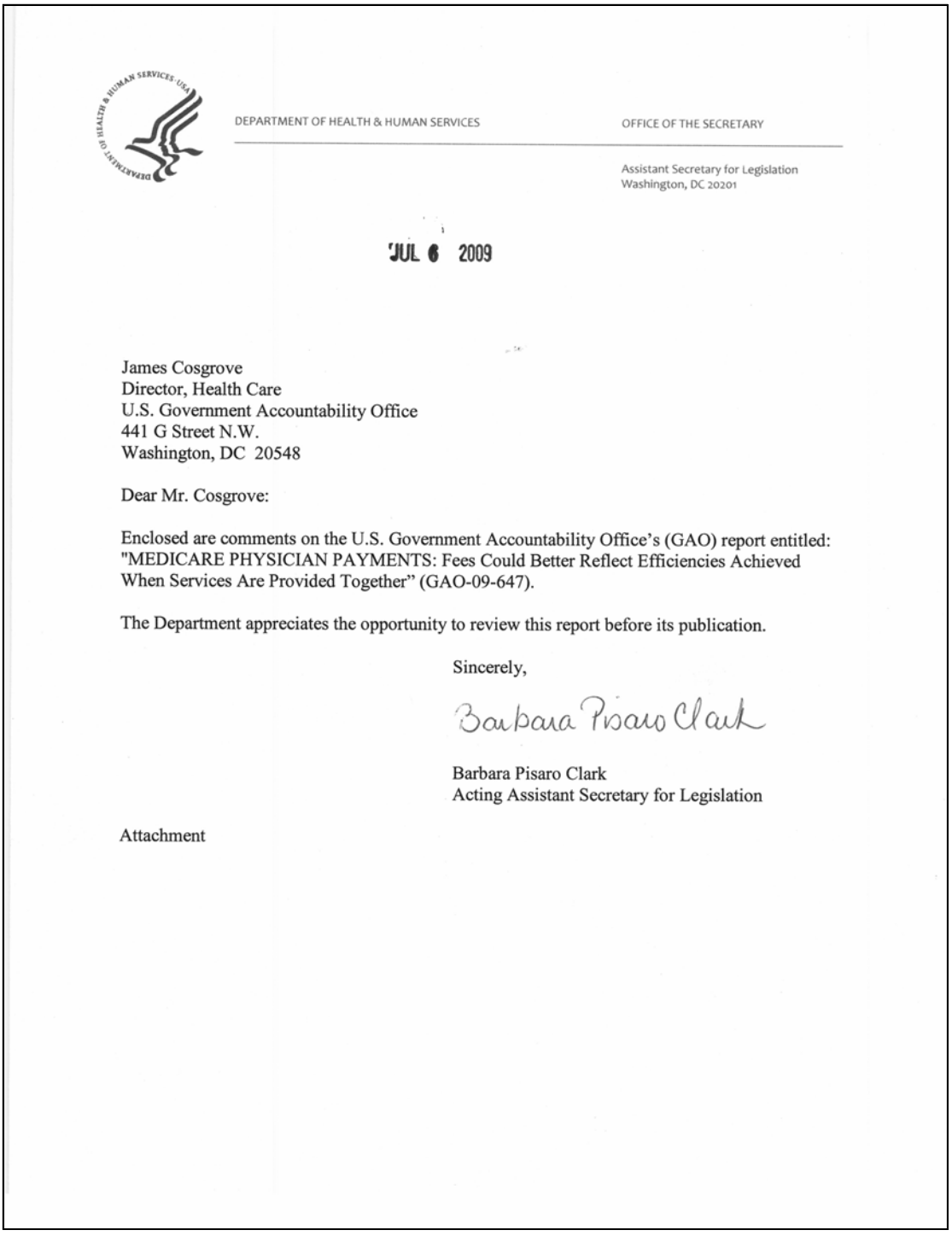
Source: 2008 American Medical Association.

Figure 3: Example of AMA Practice Expense Estimates for CPT Code 92235, Eye Exam with Photos

AMA/Specialty Society RVS Update Committee Recommendations		
LOCATION: In-office	CMS STAFF TYPE, MEDICAL SUPPLY, OR EQUIPMENT CODE	**CPT code: 92235 Code Descriptor: Eye Exam with Photos**
TOTAL CLINICAL LABOR TIME		67
SERVICE PERIOD		
Start: When patient enters office for surgery/procedure		
Pre-service:		
Review charts	Certified Retinal Angiographer	2
Greet patient and provide gowning	Certified Retinal Angiographer	2
Obtain vital signs		
Provide pre-service education/obtain consent	Certified Retinal Angiographer	5
Prepare room, equipment, supplies		
Prepare and position patient/monitor patient/set up IV	RN/Other	10
Sedate/apply anesthesia		
Intra-service		
Assist physician in performing procedure	Certified Retinal Angiographer	40
Post-service		
Monitor patient following service/check tubes, monitor drains	RN/Other	5
Clean room/equipment by physician staff		
Complete diagnostic forms, lab and X-ray requisitions		
Review/read X-ray, lab and pathology reports		
Label and file photos/slides with patient chart	Certified Retinal Angiographer	3
Other clinical activity (please specify)		
End: Patient leaves office		
MEDICAL SUPPLIES		
Pack, ophthalmology visit (w-dilation)	SA082	**1**
Applicator, cotton-tipped, non-sterile 6in	SG008	**2**
IV infusion set	SC018	**1**
18 gauge filter needle	SC027	**1**
Needle, butterfly 20 to 25 gauge	SC030	**1**
Syringe 5-6 ml	SC057	**1**
Band aid 3/4"x3"	SG021	**2**
Fluorescein inj (5ml uou)	SH033	**1**
Povidone soln, (Betadine)	SJ041	**10**
Film, Tri-x 35mm BW (per exposure)	SK030	**24**
Paper, photo printing (8.5 x 11)	SK058	**2**
Photographic stop bath	SK065	**8**
EQUIPMENT		
Electric table	EF030	1
Exam Lane	EL005	1
Topcon Retinal Camera, incl. monitor, printer, etc. ($78,000)	ED008	1

Source: American Medical Association.

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUL 6 2009

James Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

Dear Mr. Cosgrove:

Enclosed are comments on the U.S. Government Accountability Office's (GAO) report entitled: "MEDICARE PHYSICIAN PAYMENTS: Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together" (GAO-09-647).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

Barbara Pisaro Clark

Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: JUL 0 2 2009

TO: Barbara Pisaro Clark
Assistant Secretary for Legislation

FROM: Charlene Frizzera
Charlene Frizzera
Acting Administrator

SUBJECT: Government Accountability Office's Report: "MEDICARE PHYSICIAN PAYMENTS: Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together" (GAO-09-647)

Thank you for the opportunity to review and comment on the Government Accountability Office's (GAO) draft report entitled "MEDICARE PHYSICIAN PAYMENTS: Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together."

Medicare has a longstanding policy of reducing payment for multiple surgical procedures performed on the same patient, by the same physician, on the same day. The multiple procedure payment reduction (MPPR) for surgery is largely based on the efficiencies recognized in practice expenses for pre and post-surgical services.

In 1995, the MPPR was extended to six nuclear medicine diagnostic procedures performed on the same patient on the same day. For surgical and nuclear medicine diagnostic procedures, payment is made in full for the highest priced procedure, and at 50 percent for the second procedure.

In 2006, the MPPR was extended to certain diagnostic imaging procedures performed on contiguous areas of the body in the same session. In such cases, most clinical labor activities and most supplies are not performed or furnished twice. The payment reduction applies to over 100 procedure codes within 11 families of codes. When 2 or more procedures within a family are performed on the same patient in a single session, the technical component (TC) of the highest priced procedure is paid at 100 percent; the TC of each subsequent procedure is paid at 75 percent. The reduction does not apply to the professional component.

The GAO estimates that considerable additional savings may be realized by expanding the MPPR to additional non-surgical, non-imaging procedures and by applying the MPPR to physician work, as well as to practice expense.

GAO Recommendation

The Centers for Medicare & Medicaid Services should take further steps to ensure that fees for services paid under Medicare's physician fee schedule reflect efficiencies that occur when services are performed by the same physician to the same beneficiary on the same day.

CMS Response

We concur with GAO's recommendation. In the 2009 Physician Fee Schedule final rule (73 FR 69882) we indicated that we plan to perform a data analysis of non-surgical Current Procedural Terminology codes that are often billed together (e.g., 60-70 percent of the time) to determine whether there are efficiencies that would justify a payment reduction. We further indicated that we plan to review physician work as well as practice expense inputs. We agree that we should focus on code pairs that have the most impact on Medicare spending. We also agree that monitoring physician behavior will be necessary if the MPPR is expanded.

If reductions are warranted, we may propose either to expand the application of the MPPR or bundle additional services, as appropriate. Any proposed changes in our payment policy will be made through rulemaking and be subject to public comment.

In order to facilitate analysis of the issues raised by the GAO, we strongly urge GAO to include, as an appendix to this report, all the specific code pairs identified and used by the GAO in preparation of this report.

The Centers for Medicare & Medicaid Services appreciates GAO's analysis of the effects of expanding the MPPR, both in terms of the range of procedures and in applying it to physician work as well as to practice expense.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

James C. Cosgrove, (202) 512-7114 or cosgrovej@gao.gov

Acknowledgments

In addition to the contact named above, Phyllis Thorburn, Assistant Director; William A. Crafton; Iola D'Souza; Richard Lipinski; and Elizabeth T. Morrison made key contributions to this report.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday afternoon, GAO posts on its Web site newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to www.gao.gov and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's Web site, http://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Ralph Dawn, Managing Director, dawnr@gao.gov, (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548