REPORT NUMBER SIXTY-EIGHT

to the

Secretary

U.S. Department of Health and Human Services

(Re: Physicians Regulatory Issues Team, Value-Based Purchasing, Recovery Audit Contractors, Inpatient Prospective Payment System, Medicare Part C and Part D, Durable Medical Equipment, Prosthetics, Orthotics, Supplies Surety Bond Policy and Implementation, and other matters)

From the

Practicing Physicians Advisory Council

(PPAC)

Hubert H. Humphrey Building

Centers for Medicare & Medicaid Services

Washington, DC

June 1, 2009

Magnificent Publications, Inc. P.O. Box 77037, Washington, DC 202-544-5490 www.magpub.com

SUMMARY OF THE JUNE 1, 2009, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the Hubert H. Humphrey Building in Washington, DC, on Monday, June 1, 2009 (see Appendix A). Vincent Bufalino, M.D., chair, welcomed the Council members and thanked them for making time to attend the meeting.

Agenda Item B — Welcome

Jonathan D. Blum, Director of the Center for Medicare Management (CMM) in the Centers for Medicare & Medicaid Services (CMS), pointed out that health care reform starts with reform of the Medicare and Medicaid systems. Among the issues under consideration to contain costs are bundling services, promoting integrated care and care coordination, and providing more direct incentives for hospitals to improve care and care management. Mr. Blum said CMS would continue to focus on eliminating fraud and abuse in the Medicare and Medicaid systems as well as promoting better payment accuracy. He anticipated CMS developing new demonstration projects to test new payment methods.

Council members introduced themselves and indicated their primary areas of interest in Medicare policy.

OLD BUSINESS

Agenda Item C — PPAC Update

Ken Simon, M.D., M.B.A., Executive Director of PPAC, presented the responses from CMS to PPAC recommendations made at the March 9, 2009, meeting (Report Number 67).

Agenda Item E — Value-Based Purchasing Final Rule

67-E-1: PPAC recommends that in CMS' future planning for value-based purchasing programs, the following be included:

- Measurement of physician participation in quality-enhancement processes
- Recognition that a patient population's socioeconomic factors have an impact on achieving ideal patient outcome goals
- Recognition that a patient population's comorbidity has an impact on achieving ideal patient outcome goals
- Continuation of the use of recognized, reasonable consensus guidelines. The best source at present is the American Medical Association's Physician Consortium for Performance Improvement (PCPI)
- Initiation of a discussion on enhancing patient education, activation, and motivation for participation in care

CMS Response: CMS appreciates PPAC's recommended principles for Medicare value-based purchasing programs. We believe that these principles are consistent

with the goal, objectives, assumptions, and design principles presented for stakeholder comment in the Physician and Other Professional Value-Based Purchasing (PVBP) Plan Issues Paper (http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Paper.pdf). We plan to continue to base the development of the PVBP Plan on those principles.

67-E-2: PPAC recommends that in CMS' value-based purchasing programs, PCPI be recognized as the leading developer of physician-level measures of quality.

CMS Response: CMS has recognized the PCPI as a leading developer of physician quality measures in our value-based purchasing programs to date. In fact, the majority of the measures that CMS has selected for the Physician Quality Reporting Initiative (PQRI) have been developed by the PCPI.

67-E-3: PPAC recommends that in CMS' value-based purchasing programs, incentive payments be funded with new money and that payments not be made on a budget-neutral basis within the Medicare physician payment system.

CMS Response: CMS is in the early stages of developing the PVBP Plan. No options have been precluded at this time. For example, the PVBP Plan Issues Paper presents the possibility of funding professional incentives out of savings from more efficient use of institutional care.

67-E-4: PPAC recommends to CMS that physicians and other providers involved in the treatment of a patient must have an opportunity for prior review and comment and the right to appeal with regard to any data that are part of the public review process. Any such comments should also be included with any publicly reported data.

CMS Response: CMS is in the early stages of developing the PVBP Plan, which will address both financial incentives and the non-financial incentive of public reporting. More specifically the Plan is expected to address the possibility of review, comment, and appeal of performance results prior to use for payment or public reporting.

Agenda Item H — Recovery Audit Contractors (RACs)
67-H-1: Whenever a particular procedure or service has been questioned as unnecessary by a RAC after service has been delivered, all downstream medical services, including consultant services, have been called into question. Requests for repayment during the period of investigation have been made of consulting physicians (such as pathologists, radiologists, and anesthesiologists). These hospital-based specialists rendered their services in good faith in response to a request from another physician and have no way of determining at the time they are asked to participate in the care of a patient whether the underlying procedure or service may be questioned or determined to be medically unnecessary by a

RAC at some time in the future. Therefore, PPAC recommends that the RAC process be modified to exclude extending demands for repayment to subsequent consulting physicians for an index case for a particular surgery, procedure, or consultation.

CMS Response: CMS appreciates the Council's concern that downstream practitioners not be held liable when an underlying/precipitating service has been deemed not medically necessary or otherwise ineligible for payment. CMS staff are researching applicable statutes, regulations, policy statements and precedents.

67-H-2: PPAC recommends that the RACs only be allowed to request and review three records per physician per 45 days, regardless of whether the physician is a solo practitioner or part of a group of any size.

CMS Response: CMS has received a number of comments on the medical record request limits, which were set in an effort to minimize clinician burden while ensuring that the RACs have access to sufficient claims to carry out their CMS-ordained mission.

The requested limit of three records per clinician would potentially reduce the burden on solo practitioners and small groups. We appreciate and share the desire to protect small practices from undue burden.

We are committed to reviewing the medical record request limits annually and are considering several potential revisions for the fiscal year starting in October 2009. The RACs have only recently begun receiving claims data and the first medical record request letters are unlikely to be sent for several more weeks. To ensure that RACs respect the request limits, CMS has developed a number of internal compliance reports. This information, as well as overall request volumes, will be included in our annual public reports. We will closely monitor RAC activity and will take the Council's recommendation under careful advisement.

67-H-3: PPAC recommends that the RACs be required to reimburse providers for the cost of copies of requested medical records prior to commencement of a RAC audit.

CMS Response: CMS will take this recommendation under advisement.

67-H-4: PPAC recommends that CMS clarify for the RACs, in writing, that the 30-day deadline for filing an appeal should be flexible if there are extenuating circumstances and that such information should be included in the RACs' letter to the provider.

CMS Response: Physicians have the same appeal rights for RAC-initiated claim adjustments as for any other Medicare adjustment: A request for redetermination must be filed within 120 days after the date of receipt of the notice of the initial

determination, and the notice of initial determination is presumed to be received 5 days from the date of the notice unless there is evidence to the contrary (Medicare Claims Processing Manual, Chapter 29, Section 220).

Following completion of RAC reviews (including a results letter and subsequent discussion period for complex reviews), the RAC will issue a demand letter concurrent with a remittance advice issued by the clinician's claims processing contractor. The demand letter will include the amount due, along with a complete description and timeline of the physician's appeal rights.

Agenda Item O — Wrap Up and Recommendations
67-O-1: PPAC recommends to CMS that physicians and licensed health care providers not be subject to costly and burdensome durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) accreditation requirements, as they are already licensed and trained to provide durable medical equipment supplies to patients.

CMS Response: The Medicare Improvements for Patients and Providers Act (MIPPA), Section 154(b), states that eligible professionals are exempt from meeting the October 1, 2009, accreditation deadline unless CMS determines that the quality standards are specifically designed to apply to such professionals and persons.

The eligible professionals, as defined in section 1848(k)(3)(B) of the Social Security Act (the Act) include the following practitioners and other persons:

Physicians (as defined in section 1861(r) of the Act),
Physical therapists,
Occupational therapists,
Qualified speech-language pathologists,
Physician assistants,
Nurse practitioners,
Clinical nurse specialists,
Certified registered nurse anesthetists,
Certified nurse-midwives,
Clinical social workers,
Clinical psychologists,
Registered dietitians, and
Nutritional professionals.

CMS did exempt these licensed professionals. Other persons that MIPPA gave the Secretary discretion to exempt included orthotists and prosthetists. CMS exempted opticians and audiologists, as these providers furnish only one-time items that have no fraud or abuse history.

CMS announced these exemptions: at a Special Open Door Forum on September 3, 2008, and on the CMS listserv September 25, 2008, and posted the fact sheet with frequently asked questions on September 16, 2008, at www.cms.hhs.gov/medicareprovidersupenroll.

The National Supplier Clearinghouse announced these exemptions via listserv messages on September 22 and December 18, 2008, and in its October 10th, March 20th, and May 27th newsletters.

67-O-2: PPAC recommends that CMS provide data to determine whether there is a decrease in care to Medicare beneficiaries as a result of a "brown-out" (i.e., providers seeing fewer beneficiaries as opposed to opting out of Medicare).

CMS Response: CMS is sensitive to the implications of the potential negative updates on access to care. CMS periodically monitors beneficiary-reported experiences on their ability to access needed care. Using longitudinal data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Medicare Health Plans, we will be able to examine and monitor at the state level whether beneficiaries are reporting changes in their access to care. In addition, we would note that the Medicare Payment Advisory Commission (MedPAC) examines patient access to physician care in their annual March Report to the Congress. In its recent March 2009 report, MedPAC indicated that results from its 2008 survey indicate that most beneficiaries have reliable access to physician services, with most beneficiaries reporting few or no access problems. MedPAC also indicated that other national surveys show results comparable to MedPAC's surveys.

Following Dr. Simon's update, Council members discussed continued confusion about who must be accredited to provide DMEPOS and concerns about how such accreditation is addressed on Medicare provider enrollment forms.

NEW BUSINESS

Agenda Item D — Physicians Regulatory Issues Team (PRIT) Update

William Rogers, M.D., Director of PRIT, outlined the active PRIT issues (Presentation 1). For example, PRIT clarified that retroactive billing is not prohibited; however, Medicare providers can only bill for services provided up to 30 days before submission of a successful enrollment application. PRIT continues to work with States to ensure Medicare claims cross over to Medicaid programs automatically. Finally, CMS withdrew the proposal to limit electronic funds transfers to the State in which a given practice is located because of the logistic complexity and questionable value. Dr. Rogers said he sits on the Healthcare Administrative Simplification Coalition, a group that has proposed some effective methods to simplify medical billing and claims adjudication.

Agenda Item E — Value-Based Purchasing

Thomas Valuck, M.D., J.D., CMM Medical Officer and Senior Advisor, noted that MIPPA allows CMS to use Medicare data to identify providers who treat high-cost events and identify outliers and to use the data for quality measurement (Presentation 2). The physician resource use reports (RURs) were developed toward those ends, and Dr. Valuck sought input from PPAC on the structure and content of the RURs. Lisa Grabert, M.P.H., Health Insurance Specialist, walked the Council through a sample report.

Council members raised questions about the accuracy of the data and the appropriateness of the methodologies used. Dr. Valuck said plans are underway to increase the precision of the reports over time; he emphasized that the reports are confidential and are not connected to payment. Council members reiterated concerns that poor data are more harmful than no data. Council members were concerned about the accuracy of attribution of care to a given physician, as well as attribution of costs. Dr. Valuck said it may be possible to apply different attribution methodologies for different settings or conditions. He added that concerns about transparency of the methodology must be weighed against calls to shorten and simplify the reports. Dr. Valuck hoped the reports would encourage physicians and hospitals to collaborate to provide the most cost-efficient patient care.

Agenda Item G — Inpatient Prospective Payment System Update

Marc Hartstein, Deputy Director of the Hospital & Ambulatory Policy Group, summarized proposed changes to the Inpatient Prospective Payment System for 2010 (Presentation 3). He described the formula for calculating payment adjustments resulting from substantial changes in documentation and coding that were adopted in 2008. Mr. Hartstein said more than 90 percent of hospitals were reporting complete quality data, and hospitals appear to be very engaged in the effort to prevent hospital-acquired conditions. He added that CMS is transitioning to a new method for calculating wage indexes that would result in Statewide instead of national payment adjustments.

Agenda Item H — RAC Update

CDR Marie Casey, R.N., Nurse Consultant for the RAC program, described the rollout of the permanent RAC program, pointing out that RACs may not conduct widespread reviews of medical records on a given issue without review and approval by CMS (Presentation 4). However, RACs may seek up to 10 records per physician for a given issue to determine whether it would like to seek CMS approval for a widespread review. CMS has selected an independent contractor to evaluate the accuracy of the RACs' determinations.

LT Terrence Lew, Health Insurance Specialist in the Division of Recovery Audit Operations, Provider Compliance Group, Office of Financial Management, summarized the process RACs use to notify a provider of improper payments and request repayment. He emphasized that RACs must follow the same procedures for recovering money as other CMS contractors, and providers have the same appeals rights as they do for other CMS programs.

CDR Casey noted that the demonstration RACs performed very few medical necessity determinations involving individual physicians, so there are few data of relevance about physicians and improper payment recovery. She added that the permanent RACs have not proposed new issues for review to CMS related to physicians.

It was noted that hospitals can charge for the cost of providing medical records for review, but CMS maintains that for physicians, those costs are captured in the practice expense calculation. Council members recounted some confusion about payment demand letters that appeared to come from RACs.

LT Lew agreed to ask the RAC medical directors to come to a future Council meeting to discuss potential topics of physician review.

Recommendations

68-H-1: PPAC recommends that CMS assess the time required of physicians and other providers, the resources involved, and, hence, the cost per physician or provider to comply with the existing regulatory burdens posed by the PQRI, electronic prescribing, and RAC medical records requests.

68-H-2: PPAC recommends that CMS be required to assess the time required of physicians and other providers, the resources involved, and, hence, the cost per physician or provider to comply with a proposed regulation before implementation.

68-H-3: PPAC recommends that CMS reconsider its decision not to pay physicians for the costs of copying medical records in response to RAC requests.

68-H-4: PPAC recommends that CMS require the RACs to provide data on CMS overpayments for DMEPOS that distinguish between overpayments to physicians versus DMEPOS suppliers and that such data be provided by January 1, 2010, and reported at the subsequent PPAC meeting.

Agenda Item J — Medicare Part C and Part D Update

Jeffrey Kelman, M.D., Chief Medical Officer for the Center for Drug and Health Plan Choice, described the Part D drug benefits and findings since Part D began. He said about 67 percent of prescriptions are filled using generic drugs, which he considered a high rate. CMS sees the potential to increase that percentage through increased use of therapeutic interchange of drugs (i.e., when less costly drugs can be substituted for more expensive ones); Dr. Kelman proposed a patient drug report that would identify alternative prescriptions for the physician's consideration.

Dr. Kelman reported high satisfaction among beneficiaries with Part D and said the lower cost of drugs has improved patient compliance with drug regimens. He added that the quality ratings for the Part C and Part D programs are included on the enrollment tool that beneficiaries use to select plans. The use of computerized formularies has resulted in a

sort of personal health record for drugs, because they provide lists of medications that a beneficiary uses as well as related health data across pharmacies and providers, which can protect beneficiaries, said Dr. Kelman.

In Part C, CMS is exploring the benefits of disease management for certain complicated conditions. Dr. Kelman said CMS hopes to assess whether coordinated care results in meaningful improvements in outcomes.

Dr. Kelman noted that Part D plans may offer to pay the full cost of some over-the-counter drugs. Janice Ann Kirsch, M.D., said she was not aware of such benefits, and Dr. Kelman said more outreach may be needed. Dr. Kirsch added that while a list of drugs appropriate for therapeutic interchange may be well intentioned, it would likely cause a lot of extra work for doctors. Council members discussed the drawbacks associated with generic drugs and general concerns about drug safety.

Agenda Item K — DMEPOS Surety Bond Policy and Implementation

Frank Whelan, Health Insurance Specialist in the Division of Provider/Supplier Enrollment of the Office of Financial Management, outlined the requirements and exemptions for DMEPOS suppliers to secure surety bonds (Presentation 5). He reported that implementation of the program was relatively smooth. The requirement is intended to stem fraud and abuse in the supply of DMEPOS to Medicare beneficiaries. Roger L. Jordan, O.D., pointed out that the enrollment and reenrollment forms for providers do not enable users to indicate they are exempt from the accreditation requirements. Jeffrey A. Ross, D.P.M., M.D., said CMS has the authority to make its exemptions for physician providers of DMEPOS permanent but has not yet done so.

Recommendations

68-K-1: PPAC recommends that CMS include on the DMEPOS supplier enrollment form an option to indicate the applicant is exempt from the accreditation requirement (in addition to the existing boxes of "accredited" and "not accredited").

68-K-2: PPAC recommends that CMS adopt language that would put in place a permanent exemption from DMEPOS accreditation requirements and surety bonds for physicians and licensed health care providers who provide DMEPOS to their patients as part of their professional services.

Agenda Item M — Testimony

The Council reviewed the written testimony of the American Medical Association on RACs, Medicare Advantage risk adjustment review, and physician RURs (Presentation 6).

Agenda Item O — Wrap Up and Recommendations

Dr. Bufalino asked for additional recommendations from the Council. The Council members reviewed the day's recommendations and revised them as needed. Recommendations of the Council are listed in Appendix B.

Recommendations

68-O-1: PPAC recommends that CMS provide to PPAC at the next meeting statistics on fraud and abuse involving physicians in the Medicare program.

68-O-2: PPAC recommends that CMS present information on the statistical accuracy of the data supplied in the physician RURs.

68-O-3: PPAC recommends that CMS and the RACs develop a special logo for correspondence to differentiate the RACs from other CMS-related requests for information.

68-O-4: PPAC recommends that CMS include risk-adjusted physicians' resource use data for attending physicians in academic medical centers to recognize the risks, benefits, and expenses of training residents and medical students.

68-O-5: PPAC recommends that CMS present an update on the RURs to physicians, especially with respect to:

- any planned public release of this information,
- any plans to correct the attribution methods to reflect more accurately the physicians' peer group for comparison, and
- any plans to correct the attribution methods to reflect the physician's actual contribution to the cost of care attributed to him or her.

68-O-6: PPAC recommends that CMS provide information on how the value-based purchasing program factors preventive services into its cost utilization studies.

68-O-7: PPAC recommends that CMS require hospitals to notify the treating physician and the patient when a patient's inpatient status is reclassified as outpatient.

68-O-8: PPAC recommends that CMS preclude the RACs from recouping overpayments to physicians based on coding errors that result from reclassification of a patient by the hospital from inpatient to outpatient.

68-O-9: PPAC recommends that CMS provide to PPAC the result of its research on the applicable statutes, regulations, policy statements, and precedents regarding PPAC's March 2009 recommendation on penalizing downstream providers (i.e., PPAC recommends that the RAC process be modified to exclude extending demands for repayment to subsequent consulting physicians for an index case for a particular surgery, procedure, or consultation).

68-O-10: PPAC recommends that, 2 years before releasing RURs, CMS notify physicians that the information will be publicly released and provide an opportunity for physicians to provide feedback that is included as part of the public record that is released.

68-O-11: PPAC recommends that potential reports on drug utilization be generated concisely and that an effort is made to avoid multiple communications.

68-O-12: PPAC recommends that CMS provide PPAC specific data regarding the periodic monitoring that CMS does to determine what percentage of Medicare beneficiaries have reliable access to medical services.

Dr. Bufalino noted that the next PPAC meeting will be held August 31, 2009, in Washington and not in Baltimore, as previously planned. He then adjourned the meeting.

Report prepared and submitted by
Dana Trevas, Rapporteur
Magnificent Publications, Inc.

PPAC Members at the June 1, 2009, Meeting

Vincent J. Bufalino, M.D., *Chair*
Cardiologist
Naperville, Illinois

John E. Arradondo, M.D.
Family Physician
Hermitage, Tennessee

Joseph A. Giaimo, D.O.
Osteopath/Pulmonologist
West Palm Beach, Florida

Pamela A. Howard, M.D.
Surgeon
Allentown, Pennsylvania

Roger L. Jordan, O.D.
Optometrist
Gillette, Wyoming

Janice A. Kirsch, M.D.
Internal Medicine
Mason City, Iowa

Tye J. Ouzounian, M.D.
Orthopedic Surgeon
Tarzana, California

Gregory J. Przybylski, M.D.
Neurosurgeon
Edison, New Jersey

Jeffrey A. Ross, D.P.M., M.D.
Podiatrist
Houston, Texas

Jonathan E. Siff, M.D.
Emergency Physician
Cleveland, Ohio

Fredrica E. Smith, M.D.
Internist/Rheumatologist
Los Alamos, New Mexico

Arthur D. Snow, M.D.
Family Physician
Shawnee Mission, Kansas

M. LeRoy Sprang, M.D.
Obstetrician-Gynecologist
Evanston, Illinois

Christopher J. Standaert, M.D.
Physical Medicine/Rehabilitation
Seattle, Washington

Karen S. Williams, M.D.
Anesthesiologist
Washington, DC

CMS Staff Present

Jonathan Blum, Director
Center for Medicare Management
Acting Director
Center for Drug and Health Plan Choice

Liz Richter, Deputy Director
Center for Medicare Management

Ken Simon, M.D., M.B.A., Executive Director
Practicing Physicians Advisory Council
Center for Medicare Management

Presenters

CDR Marie Casey, R.N., Nurse
Consultant
Division of Recovery Audit Operations
Financial Services Group

Lisa Grabert, M.P.H., Health Insurance
Specialist
Hospital & Ambulatory Policy Group
Center for Medicare Management

Marc Hartstein, Deputy Director
Hospital & Ambulatory Policy Group
Center for Medicare Management

Jeffrey Kelman, M.D., Chief Medical
Officer
Center for Drug and Health Plan Choice

LT Terrence Lew, Health Insurance
Specialist
Division of Recovery Audit Operations
Financial Services Group

Jesse Polansky, M.D., M.P.H., Medical
Director
Provider Compliance Group
Office of Financial Management

William Rogers, M.D., Director
Physicians Regulatory Issues Team
Office of External Affairs
Centers for Medicare & Medicaid
Services

Thomas Valuck, M.D., J.D., Medical
Officer, Senior Advisor
Center for Medicare Management

Frank Whelan, Health Insurance
Specialist
Division of Provider/Supplier
Enrollment
Office of Financial Management

Dana Trevas, Rapporteur
Magnificent Publications, Inc.

John O'Leary, Sound Engineer

APPENDICES

Appendix A: Meeting agenda
Appendix B: Recommendations from the June 1, 2009, meeting

The following documents were presented at the PPAC meeting on March 9, 2009:

Presentation 1: PRIT Update
Presentation 2: Value-Based Purchasing
Presentation 3: Inpatient Prospective Payment System Update
Presentation 4: RAC Update
Presentation 5: DMEPOS Surety Bond Policy and Implementation
Presentation 6: Statement of the American Medical Association

Appendix A

Practicing Physicians Advisory Council
Hubert H. Humphrey Building
Room 705A
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

June 1, 2009

08:30-08:40	**A. Opening Meeting**	**Vincent J. Bufalino, M.D., Chairman, Practicing Physicians Advisory Council**
08:40-08:50	**B. Welcome**	**Jonathan D. Blum, Director, Center for Medicare Management, and Acting Director, Center for Drug and Health Plan Choice** **Liz Richter, Deputy Director, Center for Medicare Management**
08:50-09:10	**C. PPAC Update**	**Kenneth Simon, M.D., M.B.A., Executive Director, Practicing Physicians Advisory Council**
09:10-09:30	**D. PRIT Update**	**William Rogers, M.D., Director, Physicians Regulatory Issues Team, Office of External Affairs**
09:30-10:15	**E. Value-based Purchasing**	**Thomas Valuck, M.D., J.D., Medical Officer and Senior Advisor, Center for Medicare Management** **Lisa Grabert, MPH, Health Insurance Specialist, Hospital & Ambulatory Policy Group, Center for Medicare Management**
10:15-10:30	**F. Break**	

10:30-11:15	**G. Inpatient Prospective Payment System (IPPS) Update**	**Marc Hartstein, Deputy Director, Hospital & Ambulatory Policy Group Center for Medicare Management**
11:15-12:00	**H. RAC Update**	**Lt. Terrence Lew, Health Insurance Specialist, Division of Recovery Audit Operations, Provider Compliance Group, Office of Financial Management** **Commander Marie Casey, R.N., Nurse Consultant, Division of Recovery Audit Operations, Provider Compliance Group, Office of Financial Management** **Jesse Polansky, M.D., MPH, Medical Director, Provider Compliance Group, Office of Financial Management**
12:00-1:00	**I. Lunch**	
1:00-1:45	**J. Medicare Part C & D Update**	**Jeffrey Kelman, M.D., Chief Medical Officer, Center for Drug and Health Plan Choice**
1:45-2:30	**K. DMEPOS Surety Bond Policy and Implementation** `	**Frank Whelan, Health Insurance Specialist, Division of Provider/Supplier Enrollment, Office of Financial Management**
2:30- 2:45	**L. Break**	

2:45- 3:00	**M. Testimony**
3:00-3:30	**N. Wrap Up/Recommendations**

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC)
RECOMMENDATIONS
June 1, 2009

Agenda Item H — Recovery Audit Contractor (RAC) Update

68-H-1: PPAC recommends that CMS assess the time required of physicians and other providers, the resources involved, and, hence, the cost per physician or provider to comply with the existing regulatory burdens posed by the Physicians Quality Reporting Initiative, electronic prescribing, and RAC medical records requests.

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