REPORT NUMBER SIXTY-NINE

to the

Secretary

U.S. Department of Health and Human Services

(Re: Physicians Regulatory Issues Team; Physician Quality Reporting Initiative; e-Prescribing; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding; Physician Fee Schedule Notice of Proposed Rulemaking; Outpatient Prospective Payment System and Ambulatory Surgical Center Notice of Proposed Rulemaking; Fraud and Abuse; Recovery Audit Contractors; and other matters)

From the

Practicing Physicians Advisory Council

(PPAC)

Hubert H. Humphrey Building

Centers for Medicare & Medicaid Services

Washington, DC

August 31, 2009

SUMMARY OF THE AUGUST 31, 2009, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the Hubert H. Humphrey Building in Washington, DC, on Monday, August 31, 2009 (see Appendix A). Vincent Bufalino, M.D., chair, welcomed the Council members and speakers.

Agenda Item B — Welcome

Jonathan D. Blum, Director of the Center for Medicare Management (CMM) in the Centers for Medicare & Medicaid Services (CMS), welcomed comments from the Council and the public on the proposed 2010 fee schedules for physicians, outpatient services, and ambulatory surgical centers (ASCs). Mr. Blum said one of the high-priority items on his agenda is the smooth, transparent implementation of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program. He noted that the Department of Health and Human Services (HHS) has partnered with the Department of Justice (DOJ) to address fraud and abuse (F&A) in the Medicare system more aggressively, and the recovery audit contractors (RACs) operate within that context. Mr. Blum emphasized that CMS has an obligation to the public to ensure that providers and their claims are legitimate, dollars are going to health care services, and funds are being well managed. Liz Richter, Deputy Director of CMM, said she believes two new Council members will be selected by the next PPAC meeting.

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 June 1, 2009, meeting (Report Number 68).

Agenda Item H — 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 Physician Quality Reporting Initiative (PQRI), electronic prescribing, and RAC medical records requests.

CMS Response: Our estimates of the cost to eligible professionals (EPs) associated with participation in the 2009 PQRI and e-Prescribing incentive programs was included in the Collection of Information Requirements section (73 FR 69915 through 69917) and the Regulatory Impact Analysis section (73 FR 69927 through 69928) of the calendar year 2009 Medicare Physician Fee Schedule (MPFS) Final Rule with comment period, which was published in the *Federal Register* on November 19, 2008. For both the PQRI and e-Prescribing incentive programs, we believe that the cost of participation is outweighed by the incentive payments that are received. For example, for the 2007 PQRI where EPs could earn an incentive payment equal to 1.5 percent of their total estimated allowed Medicare Part B Physician Fee Schedule charges for services furnished

July 1, 2007, through December 31, 2007, the average incentive payment was $634.69 per EP. With a 2.0 percent incentive payment in 2009 calculated based on services furnished during the entire calendar year, we would expect the average 2009 PQRI incentive payment and e-Prescribing incentive payment to be approximately $1,700 per EP per incentive program. Consequently, EPs who participate in both the e-Prescribing and PQRI incentive payment programs could earn approximately $3,400 in incentives, on average. By comparison, reporting a PQRI measures group with four measures for 30 instances (that is, using the consecutive patient sample method) would enable a practice to earn approximately $1,700 (as noted above) while only costing a medium-sized practice about $258 to submit the required quality data codes on their claims. This equates to an extra $1,442 for the year (after expenses) or $48 per patient for each of the 30 consecutive patients in a measures group. Additionally, CMS will consider this recommendation and seek input from the American Medical Association (AMA) and other stakeholders to determine the appropriate methodology to assess the provider burden associated with RAC additional documentation request letters.

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.

CMS Response: Under the Paperwork Reduction Act of 1995 (PRA), CMS is required to provide 60 days' notice in the *Federal Register* and solicit public comment before a collection-of-information requirement is submitted to the Office of Management and Budget for review and approval. Section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues: 1) the need for the information collection and its usefulness in carrying out the proper functions of our agency, 2) the accuracy of our estimate of the information collection burden, 3) the quality, utility, and clarity of the information to be collected, and 4) recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

In keeping with the PRA, we have included in the 2010 MPFS proposed rule the burden analysis for PQRI and requested comments. The 2010 MPFS proposed rule is available as a download on the PQRI website under Statute/Regulations/Program Instructions at http://www.cms.hhs.gov/pqri.

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.

CMS Response: CMS considers these costs as part of the indirect costs of the practice expense. At this time, CMS does not provide a separate payment for this service.

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.

CMS Response: CMS currently believes that we will be able to retrieve this type of data in the national RAC program. If reviews of this type have occurred prior to the first PPAC meeting in calendar year 2010, CMS will bring the data to the Council's attention.

Agenda Item K — DMEPOS Surety Bond Policy and Implementation
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").

CMS Response: CMS will revise the Medicare enrollment application to clarify that exempt suppliers should "check" the box designated "The enrolling supplier is not accredited" in Section 2.G. of the CMS-855S.

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.

CMS Response: With respect to surety bonds, physicians are already exempt from the bond requirement to the extent that they meet the requirements of Medicare regulations. We are somewhat uncertain as to the complete listing of provider/supplier types that PPAC includes within the term "licensed health care providers," though we suspect that it is limited to nonphysician practitioners. We note that most nonphysician practitioners, e.g., podiatrists, optometrists, etc., are exempt from the bond requirements as outlined in Medicare regulations. Those practitioners or other suppliers who do not fall within such exceptions are nonexempt because, as we stated in the preamble to the surety bond final rule, there is nothing in Section 1834(a)(16) of the Social Security Act that evidences a Congressional intent to exempt them from the bond requirement.

Agenda Item N — Wrap Up
68-N-1: PPAC recommends that CMS provide to PPAC at the next meeting statistics on F&A involving physicians in the Medicare program.

CMS Response: CMS will provide a presentation on F&A at today's meeting.

The Medicare Program contracts with Program Safeguard Contractors and Zone Program Integrity Contractors to detect and deter potential Medicare F&A. The contractors identify potential F&A using a variety of methods, including proactive

data analysis, individual provider claims analysis and medical record review, beneficiary complaints review, and review of potential F&A identified by law enforcement. It is important to note that contractors only identify potential F&A, as actual F&A is determined through the judicial process pursuant to a civil or criminal action brought by DOJ.

If potential F&A is identified, the contractors follow the process outlined in the Program Integrity Manual (PIM). For example, PIM Chapter 4, Sections 4.7 and 4.8, describes the activities contractors follow, as appropriate, for conducting investigations to substantiate allegations and determine if a case is appropriate for referral to law enforcement. The investigative methods described in Section 4.7 include reviewing a sample of the provider's recent claims and the corresponding medical records, conducting beneficiary interviews, and reviewing previous communications between Medicare contractors and the provider. Depending on the findings of a particular investigation of potential F&A, the contractor may refer the case to the Office of Inspector General or another law enforcement entity. Once a case referral is made, the length of time that passes until there is a resolution of the case varies, depending on what actions are taken by the Office of Inspector General and DOJ. In some cases a resolution may occur quickly, such as when the provider reaches a settlement with law enforcement or law enforcement determines that litigation is not appropriate and refers the case back to the contractor for speedy administrative action. If DOJ pursues litigation, the resolution may take several years.

If a referral to law enforcement is not appropriate, the contractor may initiate administrative action on a provider. Administrative actions include prepayment claims review, postpayment claims review, payment suspension, overpayment determination, and recommendation of a provider enrollment action, such as deactivation or revocation of billing privileges.

CMS monitors the potential F&A identified by its contractors at an aggregate level across all claim types (Part A, Part B, durable medical equipment, home health agency, etc.) to identify national trends and potential vulnerabilities that may affect multiple contractor jurisdictions. CMS does not monitor the identification of potential F&A at an individual provider level; however, CMS is actively involved in the operational execution of certain administrative actions on individual providers, such as payment suspensions and overpayment determinations.

68-N-2: PPAC recommends that CMS present information on the statistical accuracy of the data supplied in the physician resource use reports (RURs).

CMS Response: Ensuring statistical accuracy of the data supplied in the Physician Resource Use Measurement Program is one of CMS' top priorities. The RURs are based on actual paid claims data and therefore reflect payments made by Medicare. CMS understands that the peer comparison groups need to have a

minimum number of patients and episodes to be statistically reliable. One of our requirements is that each physician must meet CMS' minimum threshold requirements in order to receive an RUR. CMS appreciates PPAC's recommendation to present information on the statistical accuracy of the data. Further, CMS utilizes the expertise of senior level statisticians, both internal and external to the agency, to consult on the use of the Medicare fee-for-service claims data used in the RURs.

68-N-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.

CMS Response: CMS does not have sole discretion to begin utilizing a RAC-specific logo. CMS has chosen to use the CMS logo as well as the individual RAC's corporate logo. In addition, CMS has decided to indicate in bold type at the top that the letter is from a RAC. All RACs will also post a sample of their additional documentation request letters and demand letters to their websites to further assist the providers in identifying if the request is for a RAC audit.

CMS will send the link to the RAC page, located on the CMS website, to the AMA for distribution to all of the medical specialties.

68-N-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.

CMS Response: CMS has recognized benchmarking as one of several key factors ensuring that the peer comparisons in the reports capture physician resource use in a fair manner. CMS' research into the topic of benchmarking has illustrated that it is critical to have benchmarks based on large enough samples of patients and episodes to produce statistically reliable data. To date, the benchmarks CMS has used in RURs do not consider peer groups separately by type of setting (academic medical center) because those peer groups do not yield a large enough sample to derive statistically valid data. CMS will continue to examine this issue as we develop reporting approaches.

68-N-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.

CMS Response: CMS will continue to work collaboratively with the physician community on development, implementation, and maintenance of the Physician Resource Use Measurement and Reporting Program. Through our contractor, CMS has held face-to-face sessions with individual physicians and groups of physicians to gather feedback about the reports. Specifically, CMS has gathered physician input on various attribution methodologies. To date, physicians have indicated that the attribution of costs assigned by CMS is calculated accurately based on the attribution rules that are applied. Further, those physicians that participated in the pilot program support the policy considerations behind the attribution rules that CMS has chosen, including recognition of team-based care. Though CMS has selected two attribution rules for the program to date, CMS continues to test additional attribution methodologies to further refine the program.

Section 131(c) of the Medicare Improvements for Patients and Providers Act (MIPPA) gives the Secretary the authority to disseminate RURs on a confidential basis. CMS currently does not have plans in place to publicly release the data used in the RURs. We disseminated approximately 120 reports to selected physicians in April 2009 (Wave 1). A prototype copy of the report is publicly available at http://rurinfo.mathematica-mpr.com. We also disseminated an additional 120 reports to physicians in six geographic sites in August 2009 (Wave 2). The reports provide summary and drill-down information that identifies physicians as either high-cost outliers, low-cost outliers, or within the median range. Further, the reports educate physicians on which cost of service categories (i.e., ambulatory visits, inpatient hospitalizations, outpatient hospital services, imaging services, skilled nursing facility stays, home health care, etc.) may be contributing to their resource use classification (low, median, high). Further, CMS recently issued the calendar year 2010 MPFS Proposed Rule where we discuss a number of policy issues related to RURs (74 FR 33591) including: 1) use of quality measures in addition to cost of care measures and 2) reporting to groups of physicians in addition to reporting to individual physicians.

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

CMS Response: CMS has included a cost-of-service category analysis within the current RUR prototype. To date, the cost-of-service category analysis does not concentrate on preventive services. Including preventive services may rely on information at the individual procedure code level. Through our rigorous feedback process, physicians have indicated that receiving information on individual procedure codes is not feasible. However, CMS may test preventive services as one of the cost-of-service categories in future versions of the RURs.

68-N-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.

CMS Response: Condition Code 44 (CC44) is a billing code used on an outpatient claim to indicate that the hospital has changed the patient's status from inpatient to outpatient consistent with the criteria for the use of the code. One of the requirements for the use of CC44 is concurrence of the physician responsible for the care of the patient with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as an outpatient. Another is that the decision must be made before discharge, while the beneficiary is still a patient of the hospital. These prerequisites for use of CC44 are consistent with the requirements in the hospital conditions of participation in 42 C.F.R.§482.30(d) of the regulations. This paragraph provides that the physician or other practitioner(s) responsible for the care of the patient must be consulted and allowed to present their views before the utilization review committee or quality improvement organization makes its determination that an admission is not medically necessary. It also requires that the hospital provide written notification of the decision about the admission or continued stay to the patient, the hospital, and the physician or other practitioner(s) responsible for the care of the patient no later than two days after the decision is made. In addition, we have advised in manual guidance that it may also be appropriate to include the practitioner who admitted the patient if this is a different person than the physician or other practitioner responsible for the care of the patient. The policy and guidance for the use of CC44 are located in the Medicare Claims Processing Manual, Chapter 1, Section 50.3

68-N-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.

CMS Response: CMS is responsible for reducing payment errors and protecting and strengthening the Medicare trust funds. If a RAC submits the Part B coding error as a new issue that was associated with a Part A inpatient claim to CMS and CMS approves the new issue for widespread review, it would not be in the best interest of the trust fund if CMS precluded the RAC from collecting an improper payment.

68-N-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).

CMS Response: CMS has researched this issue and determined that, currently, we do not have a policy that would allow a RAC to automatically demand repayment from consulting physicians for which the primary surgery/procedure is denied by the RAC. However, a RAC may make an individual claim determination that the services were not rendered, were not correctly coded, or were not reasonable and necessary based on the medical record documentation submitted.

68-N-10: PPAC recommends that, two 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.

CMS Response: CMS currently does not have plans in place to publicly release the data used in the RURs. Further, Section 131(c) of MIPPA gives the Secretary the authority to disseminate RURs on a confidential basis.

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

CMS Response: CMS has included a cost-of-service category analysis within the current RUR prototype. To date, the cost-of-service category analysis does not concentrate on drug utilization. Similar to including specific preventive services, including drug utilization may rely on information at the individual procedure code level. Through our rigorous feedback process, physicians have indicated that receiving information on individual procedure codes is not feasible. However, CMS may test drug utilization as one of the cost-of-service categories in future versions of the RURs.

68-N-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.

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 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 reported 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 comparable results. CMS has hired additional personnel to help assess our current methodological review process and

explore ways to design an updated analysis for monitoring beneficiary access to care.

Roger Jordan, O.D., commended CMS for responding swiftly to fix the form required for DMEPOS suppliers regarding accreditation, which he hoped would streamline the process and prevent some claim denials.

NEW BUSINESS

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

William Rogers, M.D., Director of PRIT, outlined the active PRIT issues, of which there were very few (Presentation 1). After surveying the country to identify which States do not allow or have difficulty submitting Medicare claims to Medicaid programs (i.e., crossover claims), Dr. Rogers said only three States (New Jersey, New York, and South Carolina) have such problems, and PRIT is working with all of them to address it. Also, PRIT is investigating the policy of requiring providers who have not submitted a bill for 12 months to reenroll in Medicare before they can be paid. Tye J. Ouzounian, M.D., said the policy creates a significant disincentive for providers to care for Medicare patients because the enrollment process is so burdensome.

Agenda Item E —PQRI and e-Prescribing Update

Daniel Green, M.D., Acting Director of the Division of Ambulatory Care and Measures Management in the Office of Clinical Standards and Quality, said that for 2010, physicians can report quality measures using claims, registries, or, for individual measures only, electronic health records (EHRs) (Presentation 2). He said the experience with registries has been very good, and CMS provides a list of all the participating registries on its website. Latousha Leslie, R.N., M.S., Senior Policy Advisor, summarized the proposed changes to criteria and measures for PQRI. For example, CMS is proposing a group practice reporting option for practices with 200 or more EPs.

Dr. Green outlined changes to the e-Prescribing incentive program intended to simplify reporting and open the program to more types of providers. Andrew Morgan, M.B.A., Lead Analyst for e-Prescribing in the Office of E-Health Standards and Services, Office of the Administrator, described the e-Prescribing program in more detail (Presentation 3). He noted that CMS and the Drug Enforcement Agency formed a workgroup to find a mutually acceptable mechanism for e-Prescribing controlled substances.

In response to a question, Dr. Green explained that claims-based reporting limits CMS to evaluating process measures, while use of registries and EHRs facilitates evaluation of both process and outcomes and provides more complete information. Dr. Green later said the program seeks to avoid penalizing early adopters of EHRs whose systems may not wholly comply with current certification criteria.

Ms. Leslie said the results of the 2007 and 2008 PQRI would be available beginning in October. In the future, she hoped PQRI results would be available in the summer, but PQRI accepts claims for the previous year through February, so staff does not get all the claims data until April. Dr. Bufalino suggested that, for the e-Prescribing incentive program, some practices may be able to provide sufficient data in a six-month reporting period.

Agenda Item G — DMEPOS Competitive Bidding Update

Lorrie Ballantine, Acting Deputy Director of the Division of DMEPOS Policy in the Chronic Care Policy Group, explained the rationale for instituting the competitive bidding program and its goals (Presentation 4). Projected savings from the first round of the program are 26 percent, or about $900 million, Ms. Ballantine estimated. She clarified that beneficiaries in rural areas should not be adversely affected, because the program excludes areas with low population or areas otherwise considered noncompetitive. The program requires contractors to provide specific brands or products if a provider requests them. Ms. Ballantine hoped the program would give CMS stronger authority to address problems and complaints related to DMEPOS.

Agenda Item H — MPFS Notice of Proposed Rulemaking (NPRM)

Marc Hartstein, Deputy Director of the Hospital & Ambulatory Policy Group, said that CMS proposes to use the AMA's Physician Practice Information Survey (PPIS) to calculate practice expenses, which will improve assessment of indirect costs and may have significant redistributive effects (Presentation 5).

Cassandra Black, Director of the Division of Practitioner Services, said CMS proposes to eliminate use of all consultation codes because it believes the services provided and documentation requirements for consultation are similar across evaluation and management services. In addition, CMS proposes implementing Section 139 of MIPPA, which establishes a special payment rule for anesthesiologists who teach and payment guidance for certified registered nurse anesthetists (CRNAs) who teach. Comments are requested on how case handoffs among anesthesiologists affect the continuity and quality of care. CMS also seeks comments on the creation of a standing panel of experts separate from the AMA's Relative (Value) Update Committee (RUC) to review relative value units (RVUs).

Janice Ann Kirsch, M.D., said there are geographic differences in the cost of the technical components of services that CMS does not account for in calculating practice expenses. Several Council members said CMS' proposal substantially undervalues the amount of time and work involved in providing consultations, which could have the effect of decreasing access to specialist consultations. Dr. Bufalino noted that the PPIS suggests that practice expenses for some specialties decreased from 2002 to 2005, which he does not believe to be the case. Therefore, he hoped CMS would fully evaluate the impact on specialists of using PPIS data to calculate payment rates. Christopher Standaert, M.D., observed that CMS' efforts to reign in spending, curb overpayments, and eliminate F&A are creating disincentives to care for patients with complex conditions.

Recommendations

69-H-1: PPAC recommends that CMS fully implement the data from the AMA's PPIS to more accurately calculate practice expense RVUs and more fairly calculate reimbursement for all medical specialties. The data should be fully implemented in 2010.

69-H-2: PPAC recommends that CMS review the AMA PPIS' extrapolation of geographic data when it becomes available.

69-H-3: PPAC recommends that, if CMS decides to form a supervisory body to oversee the AMA's RUC, PPAC be considered as the appropriate group to perform that role.

69-H-4: Any move to decrease compensation for consultative services will adversely affect access to these services and severely affect the quality of care for beneficiaries. Therefore, PPAC recommends that CMS reevaluate studies that determine the actual cost of providing consultative care and provide the findings to PPAC.

69-H-5: PPAC believes that 1) recent CMS statements questioning the quality of current academic anesthesiology practice are unfounded and 2) that the intent of Section 139 of MIPPA was simply to restore full payment to academic anesthesiology training programs based on current practice. Therefore, PPAC recommends that CMS implement Section 139 of MIPPA without the additional criteria requiring that only one individual teaching anesthesiologist (the one who initially started the case) be present during all of the key and critical portions of the anesthesia procedure.

Agenda Item J — Outpatient Prospective Payment System (OPPS)/ASC NPRM

Christina Ritter, Ph.D., Deputy Director of the Division of Outpatient Care in the Hospital & Ambulatory Policy Group, gave an overview of proposed changes to OPPS/ASC payment (Presentation 6). She described CMS' proposal to pay for drugs, biologicals, and radiopharmaceuticals at a rate of average sales price plus four percent for all those that cost more than $65 per day, which includes a redistribution of $150 million in pharmacy overhead costs currently attributed to packaged drugs (those that cost less than $65 per day that are packaged with the costs of the procedure).

Dr. Ritter asked the Council for suggestions on disseminating information about new benefits and input on the affect of proposed ASC payment updates on ASC services. Dr. Bufalino recommended CMS contact specialty societies to communicate new benefits and that CMS use multiple channels to reach the target audience. Dr. Kirsch said she would seek comments on the effects of ASC payment rates.

Agenda Item K — F&A and RAC Update

Kim Brandt, Director of the Program Integrity Group in the Office of Financial Management, said HHS Secretary Sebelius and Attorney General Holder announced a

joint initiative to combat F&A. CMS is seeks to prevent improper payments through verification of enrolled providers and use of claims data to identify problems earlier. Ms. Brandt emphasized that HHS is working to communicate that only a small percentage of providers are involved in F&A schemes, but media coverage of those few providers tends to skew the perception.

Patricia Fenton, R.N., Nurse Consultant in the Division of Recovery Audit Operations; Jesse Polansky, M.D., M.P.H., Medical Director of the Provider Compliance Group; and CDR Marie Casey, R.N., also a Nurse Consultant, gave a brief update on the efforts to phase in the RAC program (Presentation 7). The Contractor Medical Director (CMD) for each of the four RACs and one subcontractor CMD introduced themselves and described the roles they play in their organizations:

- Earl Berman, M.D., CMD
  PRG-Schultz: RAC Subcontractor
- Ellen Evans, M.D., CMD
  HealthDataInsights: RAC Region D
- James Lee, D.O., CMD
  Connolly HealthCare: RAC Region C
- Percival Seaward, M.B., B.Ch., CMD
  CGI: RAC Region B
- Eugene Winter, M.D., CMD
  DCS: RAC Region A

Dr. Polansky emphasized that all of the RACs and their subcontractors are contractually bound to follow the policies and procedures established by CMS. Before deciding to investigate any issue, RACs must submit a proposal to CMS' New Issue Review Board for approval of the topic. Dr. Polansky noted that RACs will focus initially on areas such as coding errors that do not involve substantial medical judgment. When the RACs do address situations involving questions of clinical judgment, they must use CMS' local and national coverage decisions and other policies for guidance. Some Council members described concerns about unreasonable procedures and investigations during the RAC demonstration project.

Recommendations

69-K-1: PPAC recommends that CMS provide to PPAC at the next meeting statistics on F&A involving physicians in the Medicare program.

69-K-2: PPAC recommends that CMS provide PPAC information on its mechanism for oversight of investigations by RACs and the guidelines for when investigations should be terminated when no problems are found.

69-K-3: PPAC recommends that CMS establish a neutral arbitrator at CMS, outside the RACs, to whom physicians or other providers can appeal for assistance when a RAC investigation seems unreasonable.

Agenda Item M — Wrap Up and Recommendations

Dr. Bufalino asked for additional recommendations from the Council. The Council members reviewed the day's recommendations. The full list of recommendations offered by the Council are listed in Appendix B.

Recommendations

69-M-1: PPAC recommends that CMS explain its use of a 10-percent threshold for attribution of care in its Resorce Use Reports (RURs), instead of the 25–30 percent recommended by the Leapfrog Group and the National Committee for Quality Assurance and the 35-percent threshold that the MedPAC employed in its analysis.

69-M-2: PPAC recommends that CMS provide data on the number of appeals and percentage of overturned cases of RAC determinations, by RAC and, if possible, by the site of the appellant's practice, at least annually.

69-M-3: PPAC recommends that CMS provide data from the validation contractor reports for each of the RACs at least annually.

Council members requested that future PPAC meetings be held in Room 800 of the Humphrey Building. Dr. Bufalino adjourned the meeting.

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

PPAC Members at the August 31, 2009, Meeting

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

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

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

Pamela Howard, M.D.
Surgeon
Little Rock, Arkansas

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

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

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

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

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

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

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

Christopher 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

Lorrie Ballantine, Acting Deputy Director
Division of DMEPOS Policy
Chronic Care Policy Group
Center for Medicare Management

Cassandra Black, Director,
Division of Practitioner Services
Hospital & Ambulatory Policy Group
Center for Medicare Management

Kim Brandt, Director
Program Integrity Group
Office of Financial Management

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

Patricia Fenton, R.N., Nurse Consultant
Division of Recovery Audit Operations
Provider Compliance Group
Office of Financial Management

Daniel Green M.D., Acting Director
Division of Ambulatory Care and Measures Management
Office of Clinical Standards and Quality

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

Latousha D. Leslie, RN, BSN, MS, Senior Policy Advisor
Division of Ambulatory Care and Measures Management
Office of Clinical Standards and Quality

Andrew M. Morgan, MBA, E-Prescribing Lead Analyst
Office of E-Health Standards and Services
Office of the Administrator

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

Christina Ritter, Ph.D., Deputy Director
Division of Outpatient Care
Hospital & Ambulatory Policy Group
Center for Medicare Management

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

_____

Dana Trevas, Rapporteur
Magnificent Publications, Inc.

John O'Leary, Sound Engineer
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting agenda
Appendix B: Recommendations from the August 31, 2009, meeting

The following documents were presented at the PPAC meeting on August 31, 2009:

Presentation 1: PRIT Update
Presentation 2: PQRI Update
Presentation 3: e-Prescribing Update
Presentation 4: DMEPOS Competitive Bidding Update
Presentation 5: Physician Fee Schedule NPRM
Presentation 6: OPPS/ASC Fee Schedule Update
Presentation 7: RAC Update

Appendix A

Practicing Physicians Advisory Council
Hubert H. Humphrey Building
Room 800
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201
8-31-2009

08:30-08:40	**A. Opening Remarks**	**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**
09:30-10:30	**E. PQRI Update**	**Daniel Green M.D., Acting Director, Division of Ambulatory Care and Measures Management, Office of Clinical Standards and Quality** **Latousha D. Leslie, RN, BSN, MS, Senior Policy Advisor, Division of Ambulatory Care and Measures Management, Office of Clinical Standards**

		and Quality
	e-Prescribing Update	**Andrew M. Morgan, MBA, e-Prescribing Lead Analyst, Office of E-Health Standards and Services, Office of the Administrator**
10:30-10:45	**F. Break** (*Chair Discretion)*	
10:45-11:30	**G. DMEPOS Competitive Bidding Update**	**Lorrie Ballantine, Acting Deputy Director, Division of DMEPOS Policy, Chronic Care Policy Group, Center for Medicare Management**
11:30-12:15	**H. Physician Fee Schedule NPRM**	**Cassandra Black, Director, Division of Practitioner Services, Hospital & Ambulatory Policy Group, Center for Medicare Management**
		Marc Hartstein, Deputy Director, Hospital & Ambulatory Policy Group, Center for Medicare Management
12:15-01:15	**I. Lunch**	
01:15-2:00	**J. OPPS/ASC Fee Schedule NPRM**	**Christina Ritter, Ph.D., Deputy Director, Division of Outpatient Care, Hospital & Ambulatory Policy Group, Center for Medicare Management**
02:00-02:45	**K. Fraud and Abuse Update**	**Kim Brandt, Director, Program Integrity Group, Office of**

		Financial Management
	*** Recovery Audit Contractors (RAC) Update**	**Patricia Fenton, 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** **Commander Marie Casey, R.N., Nurse Consultant, Division of Recovery Audit Operations, Provider Compliance Group, Office of Financial Management**
02:45-03:00	**L. Break**	*(Chair Discretion)*
03:00-03:15	**M. Wrap Up and Recommendations**	

****Recovery Audit Contractors (RACs)***
Contractor Medical Directors (CMDs)

Earl Berman, M.D.
PRG Medical Director (CMD)
PRG-Schultz - RAC Subcontractor

Ellen Evans, M.D.
Contractor Medical Director (CMD)
HealthDataInsights - RAC Region D

James Lee, D.O.
Contractor Medical Director (CMD)
Connolly HealthCare - RAC Region C

Percival Seaward, MB. BCh. (Rand) CMSA (FCS). FACS
Contractor Medical Director (CMD)
CGI – RAC Region B

Eugene Winter, M.D.
Contractor Medical Director (CMD)
DCS – RAC Region A

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC)
RECOMMENDATIONS
August 31, 2009

Agenda Item H — Physician Fee Schedule Notice of Proposed Rulemaking

69-H-1: PPAC recommends that CMS fully implement the data from the American Medical Association's (AMA's) Physician Practice Information Survey (PPIS) to more accurately calculate practice expense relative value units and more fairly calculate reimbursement for all medical specialties. The data should be fully implemented in 2010.

69-H-2: PPAC recommends that CMS review the AMA PPIS' extrapolation of geographic data when it becomes available.

69-H-3: PPAC recommends that, if CMS decides to form a supervisory body to oversee the AMA's Relative Value Scale Update Committee, PPAC be considered as the appropriate group to perform that role.

69-H-4: Any move to decrease compensation for consultative services will adversely affect access to these services and severely affect the quality of care for beneficiaries. Therefore, PPAC recommends that CMS reevaluate studies that determine the actual cost of providing consultative care and provide the findings to PPAC.

69-H-5: PPAC believes that 1) recent CMS statements questioning the quality of current academic anesthesiology practice are unfounded and 2) that the intent of Section 139 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was simply to restore full payment to academic anesthesiology training programs based on current practice. Therefore, PPAC recommends that CMS implement Section 139 of MIPPA without the additional criteria requiring that only one individual teaching anesthesiologist (the one who initially started the case) be present during all of the key and critical portions of the anesthesia procedure.

Agenda Item K — Fraud and Abuse Update and Recovery Audit Contractor (RAC) Update

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

69-K-2: PPAC recommends that CMS provide PPAC information on its mechanism for oversight of investigations by RACs and the guidelines for when investigations should be terminated when no problems are found.

69-K-3: PPAC recommends that CMS establish a neutral arbitrator at CMS, outside the RACs, to whom physicians or other providers can appeal for assistance when a RAC investigation seems unreasonable.

Agenda Item M — Wrap Up

69-M-1: PPAC recommends that CMS explain its use of a 10-percent threshold for attribution of care in its resource utility reports, instead of the 25–30 percent recommended by the Leapfrog Group and the National Committee for Quality Assurance and the 35-percent threshold that the Medicare Payment Advisory Commission employed in its analysis.

69-M-2: PPAC recommends that CMS provide data on the number of appeals and percentage of overturned cases of RAC determinations, by RAC and, if possible, by the site of the appellant's practice, at least annually.

69-M-3: PPAC recommends that CMS provide data from the validation contractor reports for each of the RACs at least annually.