

**PRACTICING PHYSICIANS ADVISORY COUNCIL  
RECOMMENDATIONS – 3-3-07 MEETING  
To Be Reported During 5-19-08 Meeting**

**CMS Requests**

<b><u>Recommendations</u></b>	<b><u>Respondent</u></b>	<b><u>CMS Response</u></b>
<b><u>Agenda Item C – PPAC Update</u></b>		
<b>63-C-1:</b> PPAC recommends that CMS present to the Council at its May 2008 meeting the preliminary data on PQRI participation and other statistics through November 2007 that were reported by the Physician Performance Information Center.	<b>Kenneth Simon, M.D., M.B.A., Executive Director, Practicing Physicians Advisory Council, Center for Medicare Management</b>	
<b><u>Agenda Item E —NPI Update</u></b>		

<u>Recommendations</u>	<u>Respondent</u>	<u>CMS Response</u>
<p><b>63-E-1:</b> PPAC recommends that CMS 1) closely monitor the rate of claims rejected following the March 1, 2008, deadline; 2) share information on the rejection rates with the physician community in a timely fashion; 3) allow the use of legacy provider numbers only (i.e., in lieu of NPI) if the rejection rate immediately following the March 1, 2008, deadline exceeds a reasonable amount; and 4) not reject claims in situations in which practices have experienced enrollment backlogs.</p>	<p><b>Cathy Carter, Director Business Applications Management Group, Office of Information Services</b></p>	

<u>Recommendations</u>	<u>Respondent</u>	<u>CMS Response</u>
<b>Agenda Item G – RAC Update</b>		
<p><b>63-G-1:</b> PPAC recommends that CMS make available the specific rules for evaluating E&amp;M codes for subsequent RAC audits, with particular attention to the definitions of the components of history, physical examination, and medical decision-making, and whether the 1995 or 1997 E&amp;M rules will be applied.</p>	<p><b>Connie Leonard, Project Officer, Rac Division of Medicare Overpayments,</b></p>	
<p><b>63-G-2:</b> PPAC recommends that CMS report back to the Council a detailed analysis of data from the RAC audits and the RAC performance evaluation contractors to refine claims identification on the basis of unique, specific practice patterns and to provide education to improve the accuracy of claims submission.</p>	<p><b>Melanie Combs, RN, Senior Technical Advisor, Division Demonstrations Management, Financial Services Group</b></p>	

<u>Recommendations</u>	<u>Respondent</u>	<u>CMS Response</u>
<p><b>63-G-3:</b> PPAC recommends that CMS streamline the process for physician appeals of RAC audit determinations.</p> <p><b>63-P-3:</b> PPAC recommends that CMS RACs to reimburse physicians for the costs of all medical record requests</p> <p><b>63-P-4:</b> PPAC urges CMS to revise subsection E-9 on staff performing complex coverage review to ensure denials of Medicare claims based on medical necessity should be reviewed by a physician in the same specialty and licensed in the same state as the physician whose claim was denied.</p> <p><b>63-P-5:</b> PPAC recommends that CMS change the minimum amount that RACs can attempt to recoup in overpayments to \$25, consistent with the minimum amount of debt eligible for referral to the Department of Treasury.</p>		

<u>Recommendations</u>	<u>Respondent</u>	<u>CMS Response</u>

Recommendations	Respondent	CMS Response
<b><u>Agenda Item H – Hospital Measures Physician &amp; Quality</u></b>		
<p><b>63-H-1:</b> The Council requests that CMS provide at the May 2008 meeting more detailed data on participation and reporting from the 2007 PQRI.</p>	<p><b>Michael Rapp, M.D., J.D.,  Physician &amp; Quality Director, Quality Measurement and Health Assessment Group, Office of Clinical Standards and Quality</b></p>	

Recommendations	Respondent	CMS Response
<b>Agenda Item P – Wrap Up and Recommendations</b>		
<p><b>63-P-1:</b> PPAC recommends that CMS clarify and define whether physicians who supply durable medical equipment, prosthetics, and orthopedics supplies (DMEPOS) as part of their professional service (as opposed to physicians acting as commercial suppliers) are subject to all the requirements of the DMEPOS competitive bidding Final Rule, including the requirement for accreditation.</p> <p><b>63-P-2:</b> PPAC recommends that CMS take immediate steps to ensure that practices do not experience cash flow interruptions as a result of the transition to NPIs.</p> <p><b>63-P-4:</b> PPAC urges CMS to revise subsection E-9 on staff performing complex coverage review to ensure that denials of Medicare claims based on medical necessity should be reviewed by a physician in the same specialty and licensed in the same state as the physician whose claim was denied.</p>	<p><b>William Rogers, M.D., Director Physicians Regulatory Issues Team, Office of Public Affairs, Centers for Medicare &amp; Medicaid Services</b></p>	