

REPORT NUMBER SIXTY-FIVE

to the

Secretary

U.S. Department of Health and Human Services

**(Re: Physician Fee Schedule Proposed Rule, Physicians Regulatory Issues Team,
Stark Phase III, Outpatient Prospective Payment System and Ambulatory Surgical
Centers Fee Schedule Proposed Rule, Recovery Audit Contractors, Durable Medical
Equipment Suppliers, Demonstration Projects, Medicare Contractor Provider
Satisfaction Survey, and other matters)**

From the

Practicing Physicians Advisory Council

(PPAC)

Centers for Medicare & Medicaid Services Single Site Campus

Baltimore, MD

August 18, 2008

SUMMARY OF THE AUGUST 18, 2008, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the Centers for Medicare and Medicaid Services (CMS) Single Site Campus in Baltimore, MD, on Monday, August 18, 2008 (see Appendix A). Vincent Bufalino, M.D., chair, welcomed the Council members and encouraged their practical contributions on issues that affect the medical community.

Agenda Item B — Welcome

Herb Kuhn, Deputy Administrator of CMS, welcomed the members and said the agency did everything it could to manage the mid-year transition that resulted from passage of the Medicare Improvements for Patients and Providers Act (MIPPA) on July 15, 2008. He noted that CMS made an effort to ensure physician offices were able to maintain cash flow during the transition period and that agency staff dealt with reprocessing claims instead of asking physician offices to resubmit claims. Mr. Kuhn reminded the Council that a 20-percent cut to the physician fee schedule is planned for January 2010, so the input of the Council is especially important over the next 6–12 months. Finally, CMS is working on a proposal on value-based purchasing practices in the physician fee schedule, as required by Congress.

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 May 19, 2008, meeting (Report Number 64).

Agenda Item D — PPAC Update

64-D-1: PPAC recommends that all agenda items, including testimony, be provided to Council members two Fridays before a Monday meeting (approximately 10 days in advance).

CMS Response: CMS will continue to make every effort to provide all meeting materials to the council once they have been reviewed and cleared internally by the agency as early as possible prior to each meeting.

Agenda Item G — National Provider Identifier (NPI) Update

64-G-1: PPAC recommends that CMS allow physician practices and others to continue to submit transactions that contain both legacy numbers and NPI numbers for a minimum of 6 months after the May 23, 2008, deadline.

CMS Response: CMS did not have the authority to allow the use of legacy numbers after May 23, 2008. Fortunately, most providers were able to comply with the NPI-only mandate. We are pleased to report that most contractors report over 95-percent compliance, and, in fact, the national aggregate is estimated to be above 95-percent compliance.

64-G-2: PPAC recommends that CMS closely monitor the readiness of covered entities to submit claims with only the NPI number and take appropriate steps necessary to ensure the industry does not experience wide scale disruptions in claims processing and payment during the transition.

CMS Response: CMS agrees. CMS has been closely monitoring NPI implementation before and after May 23, 2008. With regard to Medicare, there were some concerns with secondary identifiers. These were quickly resolved by providers and clearinghouses with excellent results.

CMS does not receive data (on NPI issues or implementation) from individual payers. However, we monitor NPI implementation based on the number of complaints and inquiries we've received and on listserv activity. To date, we have received fewer than 30 complaints and problem inquiries since the end of the contingency period on May 23, 2008, and all of those were handled within 24 to 48 hours of receipt. We have not had any new inquiries or complaints since July 20. We have not heard of wide scale disruptions in claims processing and payment during the transition.

64-G-3: PPAC recommends that CMS determine whether compliance with regulations prohibits CMS from ignoring the legacy number on a claims submission as an alternative to rejecting all claims that contain both NPI and legacy numbers as of May 23, 2008.

CMS Response: The NPI is required to identify covered health care providers in Health Insurance Portability and Accountability Act (HIPAA) transactions. For Medicare fee-for-service, all Medicare claims (electronic and paper) must use the NPI as the sole provider identifier.

64-G-4: PPAC recommends that CMS continue to accept claims and other transactions that contain both legacy and NPI numbers until it is apparent that at least 95 percent of claims are processed successfully with only the NPI number.

CMS Response: CMS implemented the NPI on May 23, 2008, in accordance with the regulations. CMS closely monitored implementation and had daily meetings with all Medicare contractors. We are pleased to report that most contractors report over 95-percent compliance, and, in fact, the national aggregate is estimated to be above 95-percent compliance.

64-G-5: PPAC recommends that, if the contingency timeframe terminates on May 23, 2008, as currently planned, CMS closely monitor the rejection rates and claims processing interruptions immediately following the deadline and be prepared to allow claims to be submitted or resubmitted with the NPI and legacy numbers together if there are significant interruptions—that is, if the claims rejection or suspension rates increase more than 5 percent over baseline. PPAC

requests that CMS report the results of monitoring to the Council at its August 18, 2008, meeting.

CMS Response: CMS continues to closely monitor NPI progress, and results have been favorable and manageable. Most rejection and suspension rates have been well below 5 percent.

Agenda Item H — Overview of CMS Quality/Value Agenda

64-H-1: PPAC recommends that CMS provide significant, specific incentives, including process and outcome incentives, to physicians and patients to improve health.

CMS Response: CMS currently has no statutory authority to provide significant, specific incentives, including process and outcome incentives, to physicians and patients to improve health. CMS is seeking to establish the framework for financial incentives to physicians and other professionals for better quality care. The Physician Quality Reporting Initiative (PQRI) is an important part of the framework. Under PQRI, there are 119 measures for 2008. These include not only process measures but also structural and intermediate outcome measures, all of which relate to better quality care.

64-H-2: PPAC recommends that as part of the Health Care Transparency Initiative, the Secretary's Four Cornerstones include as part of "information on quality" both process and outcome information, e.g., recorded patient compliance information.

CMS Response: PQRI contains both structural and intermediate outcome measures. CMS expects to include more outcome measures as such measures become available.

Agenda Item K — PQRI Update

64-K-1: PPAC recommends that in the event that CMS plans to make any physician-specific PQRI data public that it notify physicians and other eligible professionals prospectively that the data collected will be made public and that notification be given at least 2 years in advance of the information becoming public.

CMS Response: We appreciate the recommendation by PPAC. CMS is exploring the initiation of a Physician Compare website later in 2008. This would complement the CMS Hospital, Nursing Home, Home Health, and Dialysis Facility Compare websites. We are actively soliciting input on how best to design and implement a Physician Compare website. CMS does not intend to post performance rates for PQRI measures at the individual or group level as part of a Physician Compare website for 2008. CMS intends to provide notice, prior to the applicable date for submission of PQRI data, if such data may potentially be used

to publicly report measure performance rates for individual professionals who participate in PQRI.

Agenda Item O — Wrap Up and Recommendations

64-O-1: PPAC recommends that CMS support immediate Congressional action to avert the pending Medicare physician payment rate cut scheduled for July 1 and replace it with a positive update of 0.5 percent for the remainder of 2008, followed by a 2009 update that adequately reflects increases in medical practice costs. CMS should again support measures to ensure that these updates not increase the size or duration of Medicare physician payment cuts in future years. CMS should recommend to Congress that time is needed to pave the way for longer-term reform of the Medicare physician update formula.

CMS Response: MIPPA was enacted on July 15, 2008. As a result of the new law, the mid-year 2008 Medicare Physician Fee Schedule (MPFS) rate reduction of -10.6 percent is retroactively replaced with the fee schedule rates in effect from January through June, 2008, which reflected a 0.5-percent update from 2007 rates. In addition, MPFS rates will increase by an additional 1.1 percent in 2009.

64-O-2: PPAC recommends that, in view of the fact that medical necessity determination is subjective and requires extensive clinical review, CMS remove medical necessity determination from the purview of recovery audit contractors (RACs).

CMS Response: CMS understands PPAC's concerns. However, the Comprehensive Error Rate Testing (CERT) program continues to find that a significant portion of the Medicare fee-for-service error rate is caused by providers submitting claims that do not comply with Medicare's medical necessity criteria for a given service or a given setting. Therefore, CMS believes it is important to utilize the RAC program as a tool to help detect and correct these kinds of improper payments. CMS has taken steps to expand the use of an independent verification and validation contractor, which began during the demonstration phase, to ensure that RAC claim determinations are consistent with Medicare rules and regulations. In addition, CMS has implemented a new issue review process that will allow a RAC to proceed with a review only after CMS agrees with the potential findings.

64-O-3: PPAC recommends that CMS establish a comment and appeals process for physicians and other providers before making PQRI data publicly available and that the process be reviewed by PPAC before it is adopted.

CMS Response: CMS, as part of PQRI, has established a confidential feedback mechanism for physicians and other eligible professionals who submit data. This gives physicians and other eligible professionals the ability to review the reporting and performance results under PQRI. Under the statute authorizing

PQRI, there is no provision for an appeals process with respect to the calculation of reporting or performance rates.

64-O-4: PPAC recommends that as CMS goes forward with discussion of its quality road map and strategies for quality improvement, it include evidence that issues under discussion actually improve the quality of patient care.

CMS Response: As CMS and its partners develop health care quality measures, the measures are deployed and tested in several venues. One venue is within various demonstration projects conducted from our Office of Research, Demonstration, and Information (ORDI). The results of all such studies are widely disseminated outside of CMS and also shared with Congress. A second venue for establishing evidence is within the Medicare Quality Improvement Program, a nationwide program authorized by statute. The current contract for the quality improvement organization program includes an enhanced measurement and evaluation strategy designed specifically in response to the Institute of Medicine's recommendations for a more robust evaluation of specific attempts to improve the quality of patient care. These projects will be evaluated by an independent, non-CMS evaluation contractor. The results of these evaluations will be shared widely outside of CMS. Finally, administrative data from the Medicare claims files allow quantitative monitoring of changes in quality measures over time, particularly as related to the implementation of value-based purchasing programs.

64-O-5: PPAC recommends that CMS not allow the RACs to review evaluation and management services.

CMS Response: CMS will consult with the American Medical Association (AMA) and PPAC prior to beginning any reviews of evaluation and management services based on the level of service. After such consultation, CMS will allow the RACs to proceed with reviews of evaluation and management services. CMS will direct the RACs to use the same review methodology utilized by the CERT contractor, carriers, and Medicare administrative contractors (MACs)—that is, to use either the 1995 or 1997 evaluation and management guidelines, whichever is more advantageous to the provider.

64-O-6: PPAC recommends that any items selected for reduction or inclusion in value-based purchasing initiatives be open to public comment and that recommendations be published in the notice of proposed rulemaking so that specialty societies can comment.

CMS Response: CMS anticipates implementing Medicare value-based purchasing initiatives through notice and comment rulemaking, which provides an opportunity for formal public comment. CMS also hosts periodic forums during which informal public comments are encouraged.

64-O-7: PPAC recommends that CMS preclude RACs from reviewing any claims within the past 12 months and only authorize reviews for claims processed in the past 12–24 months to allow time for fiscal intermediaries to complete their ongoing reviews of claims.

CMS Response: CMS has a RAC data warehouse that will exclude those claims undergoing carrier or fiscal intermediary review from RAC review. This process worked very well during the demonstration phase.

NEW BUSINESS

Agenda Item D — NPI Update

Stewart Streimer, Director, Provider Billing Group, said CMS is encouraged that the compliance rate for the NPI implementation is over 99 percent. Very few claims were rejected or suspended on the basis of an NPI issue; some problems occurred because provider enrollment records were not up-to-date. Some Council members described problems they had encountered with claims payment, suggesting that the transition is not going as smoothly as CMS believes.

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

William Rogers, M.D., Director of PRIT, echoed Mr. Streimer, saying that most physicians appear to have resolved problems that arose with the NPI transition and that remaining barriers are related to provider enrollment issues (Presentation 1). He added that PRIT is working with a number of professional societies to address the lack of identifying information about claims in recoupment notices sent to providers and that PRIT seeks to make PQRI reports more accessible to physicians. Council members indicated they would like feedback from CMS on physician participation in PQRI, especially successful participation (i.e., receipt of bonus payments).

Recommendations

65-E-1: PPAC recommends that CMS provide the 2007 PQRI data set files to the AMA so that the AMA can better understand possible barriers and stimuli to physician reporting and assist in increasing the number of physicians who successfully participate in PQRI.

65-E-2: PPAC recommends that CMS work with the physician community to evaluate and address continued barriers to participation in the PQRI program.

65-E-3: PPAC recommends that CMS provide in the Final Rule a thorough explanation of why some measures proposed by the AMA's Physician Consortium for Performance Improvement were not included in the 2009 PQRI measures set.

65-E-4: PPAC recommends that CMS provide more comprehensive guidelines and instructions to providers regarding NPIs and other identification numbers to

prevent rejection and delay of claims and require that carriers provide liaisons to assist providers in submitting claims.

Action Item

PPAC staff will disseminate information to the Council members on enrolling in CMS' Individuals Authorized Access to the CMS Computer Services (IACS) program, which enables access to PQRI statistical reports.

Agenda Item F — Physician Fee Schedule Proposed Rule

Cassandra Black, Acting Director, Division of Practitioner Services, Center for Medicare Management (CMM), provided details about issues related to the physician fee schedule that are addressed in the proposed rule (Presentation 2). She noted that CMS is working with the AMA's Resource-Based Relative Value Scale Update Committee (RUC) to identify misvalued practice expense codes and that CMS is in the third year of implementing a new practice expense methodology. CMS is also seeking public comments on proposed options for revising how it assesses geographic variations in costs, which are currently addressed using geographic practice cost indices (GPCIs).

Action Item

At a future meeting, PPAC staff will provide an update on the GPCI review process.

James Bossenmeyer, Director, Division of Provider/Supplier Enrollment, Office of Financial Management, described proposed changes related to independent diagnostic testing facilities, emphasizing that the changes are intended to ensure that offices providing imaging services meet basic performance standards, such as maintaining their equipment and ensuring staff are qualified to provide services. Council members suggested that States already have processes in place to ensure that imaging facilities meet minimum standards. Dr. Simon noted that MIPPA includes guidelines and requirements for advanced diagnostic imaging services that go into effect in 2012. Mr. Bossenmeyer also briefly explained proposed changes to the retroactive billing policy.

Recommendations

65-F-1: PPAC recommends that rather than extend the inpatient hospital-acquired conditions (HACs) policy to other settings, such as physician offices, CMS focus its efforts on encouraging compliance with evidence-based guidelines developed by health care professionals.

65-F-2: PPAC recommends that CMS reexamine the HACs policy in the hospital setting to focus on evidence-based data that does or does not support recommendations for nonpayment of certain conditions.

65-F-3: PPAC recommends that CMS *not* adopt the proposed changes to billing retroactively and instead consider other methods of verification.

65-F-4: PPAC recommends that CMS abandon its proposal to treat physician offices as independent diagnostic testing facilities and instead focus on ensuring smooth implementation of new accreditation procedures mandated by Congress.

Action Item

At a future meeting, PPAC staff will provide an update on how MIPPA requirements will be incorporated into a notice of proposed rulemaking.

Agenda Item G — Stark Update

Donald Romano, Director, Division of Technical Payment Policy, CMM, described a number of efforts related to physician self-referral and anti-markup provisions. For example, he noted that the Inpatient Prospective Payment System Final Rule finalized some issues raised in previous physician fee schedules, such as 1) clarifying the circumstances in which physicians “stand in the shoes” of their physician organizations in terms of relationships with other entities and 2) determining when a physician can refer patients to an organization with which the physician previously had a financial relationship. Council members complained that no background or written information was provided to help them understand the extremely complicated proposals described by Mr. Romano.

Action Item

PPAC staff will provide a written version of Mr. Romano’s update on Stark physician self-referral and related issues proposed for 2009.

Agenda Item I — Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) Fee Schedule Proposed Rule

Carol Bazell, M.D., M.P.H., Director, Division of Outpatient Care, CMM, gave an overview of proposed changes to the OPPS and ASC fee schedule (Presentation 3). She pointed out that hospitals will be required to report on 11 quality measures in 2009, and CMS is proposing to validate the accuracy of the quality reporting measures through a study of 800 randomly selected hospitals. Dr. Bazell said CMS proposed to pay for drugs at a rate of average sales price plus 4 percent in 2009. One Council member noted that drug acquisition costs vary dramatically among physician practices because of differences in practice size and volume of drug acquisitions.

Agenda Item J — RAC Update

Amy Reese, Health Insurance Specialist, Division of Recovery Audit Operations, Financial Services Group, explained that CMS collected a net \$693 million in overpayments as a result of the RAC demonstration, following appeals and reviews (Presentation 4). Ms. Reese said that 14 percent of all RAC overpayment determinations were appealed and, of those, 4.6 percent, or about one third, were overturned on appeal. She added that 85 percent of overpayments were collected from inpatient hospitals; 2 percent (\$19.9 million) were collected from physicians, and 1 percent (\$6.3 million) from durable medical equipment (DME) suppliers.

Melanie Combs-Dyer, RN, Senior Technical Advisor in the Division of Recovery Audit Operations, described lessons learned from the demonstration that would inform the permanent recovery audit program that CMS is establishing. For example, CMS is hiring an independent evaluator to determine the accuracy rate of RAC determinations, and RACs will be required to post information on a website so providers can track medical record requests and the status of their claims under review. A Council member requested that CMS evaluate its data to determine whether a dollar threshold exists below which individuals do not bother to appeal overpayment determinations.

Recommendation

65-J-1: PPAC recommends that CMS require RACs to provide data on overpayments collected for DME claims and differentiate between physicians and commercial DME suppliers.

Agenda Item L — DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Update

Joel Kaiser, Deputy Director, Division of DMEPOS Policy, CMM, explained that MIPPA delayed the start of the DMEPOS Competitive Bidding Program and terminated all the contracts that were in place in anticipation of the program (Presentation 5). He noted that MIPPA gave the Secretary of the Department of Health and Human Services (HHS) the authority to exempt physicians who furnish DMEPOS to patients in their offices from the quality standards and accreditation requirements for DMEPOS suppliers if the physicians' licensing and certification requirements would satisfy the quality standards and accreditation requirements.

Recommendation

65-L-1: PPAC recommends that 1) the Secretary of HHS and CMS immediately halt the DMEPOS accreditation requirement for physicians and licensed health care professionals and that 2) the Secretary and CMS exercise its newly expanded authority to exempt physicians and licensed health care professionals from quality standards and accreditation requirements considering the licensing, accreditation, and other quality requirements that physicians and licensed health care professionals must meet.

Agenda Item M — ORDI Demonstration Projects

Rachel Duguay, Project Manager, Acute Care Episode Demonstration, ORDI, said the demonstration seeks to evaluate whether reimbursing for an entire episode of inpatient care with a flat fee 1) provides an incentive to physicians and hospitals to collaborate to reduce the cost of care and 2) encourages beneficiaries to select providers on the basis of cost and quality information (Presentation 6a). She emphasized that in the demonstration the providers propose to CMS the amount of the flat fee on the basis of historic data. Council members pointed out that the demonstration relies on physician–hospital organizations to ensure fair distribution of the reimbursement.

Jim Coan, Project Officer, Medical Home Demonstration, ORDI, explained that CMS is still in the design phase of a demonstration that would offer incentives to primary care providers to improve coordination of care for beneficiaries, particularly those with chronic diseases (Presentations 6b, 6c). Council members suggested that beneficiaries be asked to sign an agreement committing to the demonstration program with their provider for a specified period (at least 1 year) so that CMS can collect adequate data on the effectiveness of coordination of care.

Agenda Item O — Medicare Contractor Provider Satisfaction Survey (MCPSS)

Results

Gladys Valentin, Project Officer, MCPSS, Division of Provider Relations and Evaluations, CMM, described the 2008 MCPSS methods and results, noting that the response rate increased to 70 percent, up from 65 percent in 2007 (Presentation 7). Colette Shatto, Health Insurance Specialist in the Division of Provider Relations and Evaluations, pointed out that each contractor receives a customized report of the findings that, for example, maps the contractor's performance scores against the areas of most importance to providers. Council members asked that in the future, CMS evaluate what contractors are doing to address the shortfalls identified by the survey. None of the members were aware that the survey was being conducted.

Action Item

To encourage Council members to stay informed about the MCPSS and other CMS activities, the office of the Provider Communications Group will send via PPAC staff a description of CMS listservs.

Agenda Item P — Testimony

The Council members reviewed the written testimony of the AMA on several issues (Presentation 8) and a joint statement from a group of professional associations regarding DMEPOS provisions (Presentation 9).

Agenda Item Q — Wrap Up and Recommendations

Dr. Bufalino asked for additional recommendations from the Council. He then adjourned the meeting. Recommendations of the Council are listed in Appendix B.

Recommendations

65-Q-1: PPAC recommends that CMS 1) prohibit any contractor from auditing physicians on consultations until a clear policy is in effect and 2) continue an open dialogue on concerns raised by the AMA on medical consultation reimbursement.

65-Q-2: PPAC recommends that, if possible, CMS provide data on trends of providers who are showing decreasing trends in beneficiary care.

65-Q-3: PPAC recommends that CMS not expand the HACs nonpayment policy from inpatient hospital settings until the hospital policy has been evaluated and

analyzed, in particular determining the impact of the policy regarding the following issues:

1. Quality of care delivered to patients, especially in proportion to the additional costs to the Medicare program to comply with the HACs requirements
2. Need for appropriate risk-adjustment techniques
3. How attribution issues will be determined with respect to when, where, and why a condition occurred
4. Reasonable number of expected incidences in which these conditions will occur in individual hospitals, especially with regard to high-risk patients, when evidence-based guidelines are followed.

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

PPAC Members at the August 18, 2008, Meeting

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

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

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

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

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

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

Pamela Howard, M.D.
Surgeon
Allentown, Pennsylvania

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

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

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

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

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

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

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

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

CMS Staff Present

Herb Kuhn, Acting Deputy Administrator
Centers for Medicare and Medicaid Services

Elizabeth Richter, Deputy Director
Center for Medicare Management

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

James Bossenmeyer, Director
Division of Provider/Supplier Enrollment
Office of Financial Management
Centers for Medicare and Medicaid Services

Jim Coan, Project Officer
Medical Home Demonstration
Office of Research, Demonstration, and
Information
Centers for Medicare and Medicaid Services

Presenters

Carol Bazell, M.D., M.P.H., Director
Division of Outpatient Care
Center for Medicare Management

Cassandra Black, Acting Director
Division of Practitioner Services
Center for Medicare Management

Melanie Combs-Dyer, RN, Senior Technical
Advisor
Division of Recovery Audit Operations
Financial Services Group
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Rachel Duguay, Project Manager
Acute Care Episode Demonstration
Office of Research, Demonstration, and
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Centers for Medicare and Medicaid Services

Joel Kaiser, Deputy Director
Division of Durable Medical Equipment,
Prosthetics, Orthotics, and Supplies Policy
Center for Medicare Management

Amy Reese, Health Insurance Specialist
Division of Recovery Audit Operations
Financial Services Group
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Centers for Medicare and Medicaid Services

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

Donald Romano, Director
Division of Technical Payment Policy
Center for Medicare Management

Colette Shatto, Health Insurance Specialist
Division of Provider Relations and Evaluations
Center for Medicare Management

Stewart Streimer, Director
Provider Billing Group
Center for Medicare Management

Gladys Valentin, Project Officer
Medicare Contractor Provider Satisfaction
Survey
Division of Provider Relations and Evaluations
Center for Medicare Management

Dana Trevas, Rapporteur
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting agenda

Appendix B: Recommendations from the August 18, 2008, meeting

The following documents were presented at the PPAC meeting on August 18, 2008, and are appended here for the record:

Presentation 1: PRIT Update

Presentation 2: Physician Fee Schedule Proposed Rule

Presentation 3: OPPS/ASC Fee Schedule Proposed Rule

Presentation 4: RAC Update

Presentation 5: DME Update

Presentation 6a: ORDI Demonstration Projects: Acute Care Episode Demonstration

Presentation 6b: ORDI Demonstration Projects: Designing a Medical Home for Medicare Beneficiaries

Presentation 6c: Expanding Access to Primary Care Services

Presentation 7: Medicare Contractor Provider Satisfaction Survey Results

Presentation 8: Statement of the American Medical Association

Presentation 9: DMEPOS Provisions in the Medicare Improvements for Patients and Providers Act of 2008

Appendix A

**Practicing Physicians Advisory Council
CMS Single Site Campus
Multipurpose Room
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244
*August 18, 2008***

08:30-08:40	A. Opening Meeting	Vincent Bufalino, M.D. Chairman, Practicing Physicians Advisory Council
08:40-08:45	B. Welcome	Herb Kuhn, Deputy Administrator, Centers for Medicare & Medicaid Services Elizabeth Richter, Deputy Director, Center for Medicare Management, Centers for Medicare & Medicaid Services
08:45-09:05	C. PPAC Update	Kenneth Simon, M.D., M.B.A., Executive Director, Practicing Physicians Advisory Council
09:05-9:20	D. NPI Update	Cathy Carter, Director, Business Applications Management Group, Office of Information Services
09:20-09:35	E. PRIT Update	William Rogers, M.D., Director Physicians Regulatory Issues Team, Office of External Affairs
09:35-10:10	F. Physician Fee Schedule Proposed Rule	Cassandra Black, Acting Director, Division of Practitioner Services, Center for Medicare Management James Bossenmeyer, Director Division of Provider/Supplier

		Enrollment, Office of Financial Management
10:10-10:30	G. Stark Update	Donald Romano, Director, Division of Technical Payment Policy, Center for Medicare Management
10:30-10:45	H. Break	
10:45-11:20	I. OPPS/ASC Fee Schedule Proposed Rule	Carol Bazell, M.D., M.P.H. Director, Division of Outpatient Care, Center for Medicare Management
11:20-12:00	J. RAC Update	Amy Reese, Health Insurance Specialist, Division of Recovery Audit Operations, Financial Services Group
		Melanie Combs-Dyer, RN, Senior Technical Advisor, Division of Recovery Audit Operations, Financial Services Group
12:00-01:00	K. Lunch	
01:00-01:45	L. DME Update	Joel Kaiser, Deputy Director, Division of DMEPOS Policy, Center for Medicare Management
01:45-02:30	M. ORDI Demonstration Projects	Rachel Duguay, Project Manager, Acute Care Episode Demonstration, Office of Research, Development and Information
		Jim Coan, Project Officer, Medical Home Demonstration Office of Research Develop- ment and Information
02:30-02:45	N. Break	

02:45-03:30

**O. Medicare Contractor
Provider Satisfaction
Survey (MCPSS) Results**

**Gladys Valentin, Project
Officer/MCPSS, Division
of Provider Relations and
Evaluations, Center for
Medicare Management**

**Colette Shatto, Health
Insurance Specialist, Division
of Provider Relations and
Evaluations, Center for
Medicare Management**

**Pamela Giambo, Deputy
Project Director for MCPSS
Westat**

03:30-03:45

P. Testimony

03:45-04:15

Q. Wrap Up/Recommendations

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC) RECOMMENDATIONS AND ACTION ITEMS August 18, 2008

Agenda Item E — Physicians Regulatory Issues Team Update

65-E-1: PPAC recommends that CMS provide the 2007 Physician Quality Reporting Initiative (PQRI) data set files to the American Medical Association (AMA) so that the AMA can better understand possible barriers and stimuli to physician reporting and assist in increasing the number of physicians who successfully participate in PQRI.

65-E-2: PPAC recommends that CMS work with the physician community to evaluate and address continued barriers to participation in the PQRI program.

65-E-3: PPAC recommends that CMS provide in the Final Rule a thorough explanation of why some measures proposed by the AMA Physician Consortium for Performance Improvement were not included in the 2009 PQRI measures set.

65-E-4: PPAC recommends that CMS provide more comprehensive guidelines and instructions to providers regarding National Provider Identifiers and other identification numbers to prevent rejection and delay of claims and require that carriers provide liaisons to assist providers in submitting claims.

Agenda Item F — Physician Fee Schedule Proposed Rule

65-F-1: PPAC recommends that rather than extend the inpatient hospital-acquired conditions (HACs) policy to other settings, such as physician offices, CMS focus its efforts on encouraging compliance with evidence-based guidelines developed by health care professionals.

65-F-2: PPAC recommends that CMS reexamine the HACs policy in the hospital setting to focus on evidence-based data that does or does not support recommendations for nonpayment of certain conditions.

65-F-3: PPAC recommends that CMS not adopt the proposed changes to billing retroactively and instead consider other methods of verification.

65-F-4: PPAC recommends that CMS abandon its proposal to treat physician offices as independent diagnostic testing facilities and instead focus on ensuring smooth implementation of new accreditation procedures mandated by Congress.

Agenda Item J — Recovery Audit Contractor (RAC) Update

65-J-1: PPAC recommends that CMS require RACs to provide data on overpayments collected for durable medical equipment (DME) claims and differentiate between physicians and commercial suppliers of DME.

Agenda Item L — DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Update

65-L-1: PPAC recommends that 1) the Secretary of the Department of Health and Human Services and CMS immediately halt the DMEPOS accreditation requirement for physicians and licensed health care professionals and that 2) the Secretary and CMS exercise its newly expanded authority to exempt physicians and licensed health care professionals from quality standards and accreditation requirements considering the licensing, accreditation, and other quality requirements that physicians and licensed health care professionals must meet.

Agenda Item Q— Wrap Up and Recommendations

65-Q-1: PPAC recommends that CMS 1) prohibit any contractor from auditing physicians on consultations until a clear policy is in effect and 2) continue an open dialogue on concerns raised by the AMA on medical consultation reimbursement.

65-Q-2: PPAC recommends that, if possible, CMS provide data on trends of providers who are showing decreasing trends in beneficiary care.

65-Q-3: PPAC recommends that CMS not expand the HACs nonpayment policy from inpatient hospital settings until the hospital policy has been evaluated and analyzed, in particular determining the impact of the policy regarding the following issues:

1. Quality of care delivered to patients, especially in proportion to the additional costs to the Medicare program to comply with the HACs requirements
2. Need for appropriate risk-adjustment techniques
3. How attribution issues will be determined with respect to when, where, and why a condition occurred
4. Reasonable number of expected incidences in which these conditions will occur in individual hospitals, especially with regard to high-risk patients, when evidence-based guidelines are followed.

ACTION ITEMS

Agenda Item E — Physicians Regulatory Issues Team Update

PPAC staff will disseminate information to the Council members on enrolling in CMS' Individuals Authorized Access to the CMS Computer Services (IACS) program, which enables access to PQRI statistical reports.

Agenda Item F —Physician Fee Schedule Proposed Rule

At a future meeting, PPAC staff will provide an update on the geographic practice cost index (GPCI) review process.

At a future meeting, PPAC staff will provide an update on how Medicare Improvements for Patients and Providers Act requirements will be incorporated into a notice of proposed rulemaking.

Agenda Item G — Stark Update

PPAC staff will provide a written version of Donald Romano's update on Stark issues proposed for 2009.

Agenda Item O — Medicare Contractor Provider Satisfaction Survey Results

To encourage Council members to stay informed about the Medicare Contractor Provider Satisfaction Survey and other CMS activities, the office of the Provider Communications Group will send via PPAC staff a description of CMS listservs.