

REPORT NUMBER SIXTY-ONE

to the

Secretary

U.S. Department of Health and Human Services

(Re: Coverage with Evidence Development, Recovery Audit Contracts, Medically Unlikely Edits, Physician Proposed Rule, Outpatient Prospective Payment System and Ambulatory Surgical Centers Proposed Rules, National Provider Identifiers Data Dissemination Notice, Physicians Regulatory Issues Team Update, and other matters)

From the

Practicing Physicians Advisory Council

(PPAC)

CMS Single Site Location

Centers for Medicare and Medicaid Services

Baltimore, MD

August 27, 2007

SUMMARY OF THE AUGUST 27, 2007, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the CMS Single Site Location in Baltimore, MD, on Monday, August 27, 2007 (see Appendix A). The chair, Anthony Senagore, M.D., welcomed the Council members and the audience.

Agenda Item B — Welcome

Herb Kuhn, Acting Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS), said the work of the Council members is greatly appreciated and worth acknowledging again because it is so valuable to CMS. He announced that Kerry Weems was nominated to be the next Administrator of CMS. Confirmation hearings were held in late July, and Mr. Kuhn said the confirmation is working its way through the process.

OLD BUSINESS

Ken Simon, M.D., M.B.A., Executive Director of PPAC, presented the responses from CMS to PPAC recommendations made at the May 21, 2007, meeting (Report Number 60).

60-C-1: PPAC requests that CMS present timely reports that include assessments of the quality and outcomes of its various demonstration projects (e.g., the Gainsharing Demonstration, the Medicare Healthcare Quality Demonstration, the Physician Hospital Collaborative Demonstration, and the Physician Group Practice Demonstration), specifically as they relate to gainsharing across Medicare Parts A and B.

CMS Response: CMS agrees with the Council regarding the importance of reviewing the analysis and outcomes of the various demonstration projects underway by the agency. We recognize this information has the potential to 1) provide greater insight into ways of improving the delivery and quality of health care received by Medicare beneficiaries and 2) create the opportunity to establish new incentives for health care providers and institutions that can be rewarding financially.

Once a report of a CMS demonstration project is publicly available, individuals are informed of the release on a quarterly basis through the CMS RESEARCH email list. The public may access the reports as soon as they are released on the CMS website. Timely release of reports is affected by the fact that most of the CMS demonstration projects are Congressionally mandated. Evaluation reports on these mandated demonstrations can only be released to the public after the report is formally presented to Congress.

Individuals may subscribe to the CMS RESEARCH email list at https://list.nih.gov/cgi-bin/wa?SUBED1=cms_research&A=1.

60-C-2: PPAC recommends that the Secretary of the Department of Health and Human Services (HHS) and CMS leadership make it a priority this year to work with Congress to enact legislation that would repeal the Sustainable Growth Rate (SGR), replace it with a system that adequately keeps pace with the increase in medical practice costs, and establish a 1.7-percent update for physicians in 2008, as recommended by the Medicare Payment Advisory Commission.

CMS Response: CMS is aware of the concerns expressed by the medical community regarding the use of the SGR methodology in determining the update for Medicare physician payment. Legislative action would be required to make the types of changes recommended by PPAC.

60-C-3: PPAC recommends that drugs be removed from the SGR calculation prospectively.

CMS Response: Prospective removal of drugs from the SGR calculation is estimated to have no impact for the first 8 years of the 10-year period 2008–2017. In other words, removing drugs from the SGR calculation on a prospective basis would not have any impact on the physician update until 2016. The cost of removing drugs from the SGR calculation is currently estimated to represent about 5 percent of the cost of eliminating the SGR and replacing it with the Medicare Economic Index. Removing drugs from the SGR calculation on a prospective basis would, however, have the effect of increasing the Part B premium paid by beneficiaries in 2016 and 2017.

60-D-1: PPAC recommends that all carrier advisory committees allow alternate delegates as well as delegates to attend meetings to facilitate mentoring of alternate delegates so they can effectively substitute for delegates who are unable to attend meetings.

CMS Response: CMS concurs with the recommendation. The contractor medical directors (CMDs) allow delegates as well as alternate delegates to attend the carrier advisory committee meetings.

60-E-1: PPAC recommends that CMS expand to physicians the exemption from the competitive bidding process for dispensing orthotics that has been proposed for physical and occupational therapists.

CMS Response: CMS does not anticipate that many items will meet the definition of off-the-shelf orthotics. In addition, we believe off-the-shelf orthotics are routinely used by occupational therapists or physical therapists as an integral part of their therapeutic services. CMS did not receive any written comments from the physician community on this issue during the comment period prior to the durable medical equipment Final Rule. We extended this exemption to occupational therapists or physical therapists; however, we welcome any written comments from the physician community on this issue.

60-E-2: PPAC recommends that where the Final Rule exempts health care providers from competitive bidding requirements for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that CMS also consider including physicians among those providers who are exempt.

CMS Response: Exemptions have been provided in the Final Rule to allow physicians and treating practitioners to furnish crutches, canes, walkers, folding manual wheelchairs, blood glucose monitors, and infusion pumps as part of their professional service. Physicians who act as commercial suppliers of DMEPOS as opposed to furnishing items as part of their professional service are subject to all of the requirements of the Final Rule.

60-E-3: PPAC recommends that CMS acknowledge that physicians are qualified to supply DMEPOS by virtue of their education, training, and experience and therefore should be deemed accredited for this process.

CMS Response: The law did not give CMS authority to acknowledge physicians as having already met the quality standards and thus be exempt from accreditation. In general such suppliers shall be required to comply in order to furnish any such item or service for which payment is made and receive or retain a provider or supplier number used to submit claims for reimbursement for any item or service for which payment may be made under Medicare.

60-F-1: PPAC strongly recommends that CMS allow national physician participation in the critical phase of the Medicare administrative contractor (MAC) communication and development meetings.

CMS Response: CMS welcomes the participation of physicians and national physician groups within the limits of the procurement process as defined by Federal Acquisition Regulation. Since the start of the MAC procurement efforts, CMS has held public forums to engage stakeholders including physicians in the development of areas such as contract performance standards. Requests for information have been employed to further gather stakeholder feedback and inform the procurement process. CMS will continue to engage physicians and physician groups as additional MAC contracts are awarded and lessons are learned.

60-F-2: PPAC recommends that CMS require a performance rating of 90 percent or better on the Provider Satisfaction Survey as the standard of performance for MAC contractors.

CMS Response: Medicare Contractor Provider Satisfaction Survey (MCPSS) scores are not percentage-based; rather, the scores are based on an anchored scale ranging from 1 to 6 and correspond to how satisfied a provider is with their Medicare contractor (1 being “not at all satisfied” and 6 being “completely

satisfied”). Again in 2007, CMS is pleased that the scores have shown that providers are satisfied with their contractor; the national average satisfaction score was a 4.56, with no contractor scoring below a 4.0 on average.

However, CMS agrees that provider satisfaction is a key responsibility of its claims processing contractors. All of the satisfaction scores are provided to each contractor in detail so that the contractor may continuously work to improve satisfaction levels. In the future, MACs will—at a minimum—be held to a performance standard to ensure that their scores do not fall below 1.5 standard deviations from the previous year’s national mean score. Further, CMS will be exploring ways to provide incentives to MACs to achieve higher rates of satisfaction.

60-J-1: PPAC recommends that CMS annually review the appropriateness of continued use of individual quality measures through a Notice of Proposed Rulemaking and comment period in which specialty societies and others can provide additional analyses of peer-reviewed published data (or the absence of such data) that may refute the applicability of individual measures in specific circumstances.

CMS Response: CMS is constantly monitoring the evidence base to ensure that our measures are consistent with the current clinical evidence. CMS anticipates that it will annually review the appropriateness of the quality measures and other measures used in its value-based purchasing initiatives, with ample opportunity for public comment. Congress required that the measures for 2008 physician quality reporting be proposed and finalized on an explicit timetable through the notice and comment rulemaking process. In future years, CMS may use the notice and comment rulemaking process or a more flexible process. For example, the need for timely review may not correspond precisely with the physician fee schedule rulemaking timetable.

60-M-1: PPAC recommends that CMS allow physicians (e.g., residents) who are relocating to a new area to apply for a National Provider Identifier (NPI) and be enrolled as a Medicare provider at least 6 months in advance of anticipated service to Medicare beneficiaries and other patient groups that require an NPI for physician registration for payment.

CMS Response: While we have considered allowing physicians additional lead time to apply, we believe that allowing physicians more than 30 days to apply in advance of the enrollment effective date would limit CMS’ ability to verify critical information during the enrollment process. Specifically, Medicare contractors are required to verify state licensure, tax information, practice location, and banking information if the physician will receive direct payments. By establishing an application date that is close to the effective date, we believe that we can help reduce delays in the enrollment process as well as hold our

contractors to the processing standards established in the Program Integrity Manual.

Moreover, if a physician submits a complete enrollment application, including state licensure, NPI, tax information, and, if applicable, the CMS-588 form (Electronic Funds Transfer Authorization Agreement) at the time of filing, CMS' Medicare contractors will be able to process the enrollment application in a timely manner.

Finally, CMS expects to implement the Provider Enrollment, Chain and Ownership System (PECOS) Web, an Internet version of the Medicare enrollment process, in fiscal year 2008. With the implementation of PECOS Web, we expect that the processing time to review and process an enrollment application will be significantly reduced.

60-O-1: PPAC recommends that CMS partner with the National Medical Association (and similar groups serving underserved populations) to conduct pilots/demonstrations among underserved patients (involving providers who traditionally serve the underserved) to collect information that would enable CMS to adjust value-based purchasing and Physician Quality Reporting Initiative (PQRI) rules/practices that affect underserved populations.

CMS Response: CMS is working with the National Medical Association and similar groups serving underserved populations to plan the evaluation of our physician and hospital value-based purchasing initiatives. We will evaluate the impact of our initiatives on underserved populations and their providers so that we can adjust our programs to minimize any unintended consequences related to health care disparities.

Dr. Simon presented further responses from CMS to PPAC recommendations made at the March 5, 2007, meeting (Report Number 59).

59-D-5: PPAC requests that CMS define the methodology used for data analysis related to performance measure submission under the new PQRI.

CMS Response: CMS has defined the methodology that will be used to determine satisfactory reporting under the 2007 PQRI:

- An eligible professional selects a measure as being applicable to his or her practice by submitting, at least once during the reporting period, a quality code that represents the numerator for that measure.
- That professional's claims from the entire reporting period will then be analyzed to determine whether the 80-percent threshold was met for that measure.
- In the analysis, the number of opportunities for reporting, as defined by the

presence of the measure denominator's International Statistical Classification of Diseases, 9th edition (ICD9) and Current Procedural Terminology (CPT) category-I codes on the claims, is compared with the number of times that the numerator quality codes for that measure were actually reported on the corresponding claims.

- The analysis is repeated for every measure on which an eligible professional reports.
- The professional must meet the 80-percent threshold for reporting on one, two, or three measures, depending on the number of measures that are applicable to the patients who were treated during the reporting period.
- If the professional has reported satisfactorily on three measures, then the bonus payment will be calculated accordingly.

If the professional has selected and reported satisfactorily on only one or two measures, then a validation will be performed on the claims from the reporting period to determine whether another measure was applicable to the professional's practice and could have been reported. If there are no other measures applicable to the professional's practice during the reporting period, then the bonus payment will be calculated. If one or more additional measures were applicable to the professional's practice, then no bonus will be paid.

59-E-1: PPAC recommends that CMS provide assurance to providers that private information will be secure and that access to NPIs be restricted (including sale of NPIs) to only those physicians and other entities with legitimate health care administration needs.

CMS Response: A Privacy Act statement is part of the NPI application. The statement indicates that health care provider data collected by the HHS from the NPI application are protected under various laws and that data may be disclosed under specific circumstances to certain entities. HHS will be publishing a notice that will describe the policy by which HHS will disclose health care provider data from the National Provider and Plan Enumeration System (NPES). The notice is expected to be published soon.

59-E-2: PPAC recommends that CMS publish the NPI data disclosure notice as soon as possible and allow time for public comment following publication.

CMS Response: We appreciate PPAC's interest in this important matter and for sharing your comments and concerns with us. HHS expects to publish a notice in the *Federal Register* that will describe our policy with respect to the availability of information from the NPES. We expect this notice will be published soon.

NEW BUSINESS

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

William Rogers, M.D., Director of PRIT, gave an update on issues recently addressed by PRIT (Presentation 1). Dr. Rogers noted that improving communication between recovery audit contractors (RACs) and providers seems to facilitate resolution of concerns surrounding RAC audits. Following PRIT suggestions, CMS reduced the paperwork burden for physicians involved in volunteer graduate medical education and made the online enrollment process easier. After investigating why the requirements for retaining records vary across Medicare programs, PRIT determined that any action on its part might result in requiring all records to be held for the longest period required (10 years) and so declined to address the issue.

Agenda Item E — Coverage with Evidence Development (CED)

Rosemarie Hakim, Ph.D., an epidemiologist in the Division of Operations and Information Management of the Office of Clinical Standards and Quality described situations in which CMS might stipulate that a national coverage decision include a requirement that affected patients be enrolled in a clinical trial, a process known as CED (Presentation 2). That is, if a treatment appears safe and promising for Medicare beneficiaries but lacks persuasive evidence, CMS may require CED, agreeing to pay for the treatment if the Medicare beneficiary is enrolled in a correlating study. If no clinical trials address the treatment, CMS may provide financial and technical assistance to help establish a clinical trial for the purpose of CED.

Recommendation

61-E-1: PPAC recommends that CMS increase awareness and education among medical specialty communities regarding the availability of CED and funding of clinical trials.

Agenda Item G —RAC Update

Melanie Combs, RN, Senior Technical Advisor in the Division of Demonstrations Management of the Financial Services Group, summarized improper payments identified by RACs in 2006 and described CMS' efforts to reduce erroneous claims for specific services identified by the RACs (Presentation 3). Connie Leonard, Project Officer for the RAC Division of Medicare Overpayments in the Office of Financial Management, said the RAC program would take a stepwise approach to becoming permanent and nationwide by 2010. In 2008, the three current RACs will begin evaluating hospitals in Arizona, Massachusetts, and South Carolina. Earl Berman, M.D., Contractor Medical Director of PRG Shultz, described his organization's approach to the process, adding that returning the money recovered through the RAC process to the Medicare Trust Fund will help the program's long-term solvency.

The Council discussed whether it is fair to deny payment to an anesthesiologist when a RAC retroactively determines that a surgery was unnecessary, then extrapolated the scenario to all "downstream" service providers acting in good faith. The Council questioned whether individual physicians represented a significant source of Medicare overpayments.

Recommendations

61-G-1: PPAC recommends that CMS continue to work collaboratively with the American Medical Association to disconnect payment denials for anesthesia when a RAC retroactively determines that surgery was unnecessary.

61-G-2: PPAC recommends that CMS direct the RAC program to create clear, uniform notification and demand letters. The objective of the letters should be to decrease confusion and inefficiency and increase clarity and compliance.

61-G-3: PPAC recommends that CMS and its contractors consider the medical necessity of each service provided downstream of a denied service on the original merits based on the information that was available to the downstream provider at the time the downstream service was provided.

61-G-4: PPAC recommends that CMS direct the RACs to provide to PPAC data reflecting the percentage of physician chart audits that result in payment modification.

61-G-5: PPAC recommends that CMS provide PPAC with RAC audit data specific to physicians only, not combined with any other provider group.

Agenda Item H — Medically Unlikely Edits (MUEs)

Brenda Thew, Director of the Division of Benefit Integrity Management Operations in the Office of Financial Management, and Kim Brandt, Director of the Program Integrity Group in the Office of Financial Management, described the development process for MUEs and CMS' criteria for defining and applying MUEs to claims (Presentation 4). Ms. Thew noted that modifier codes are available to distinguish an “unlikely” service from one that is unusual but appropriate in the given situation. The Council voiced concern that, in procedures involving the spine, the contractor applies edits not to situations that are anatomically unlikely but rather to those that are outside the range of typical. Ms. Brandt agreed to look into the issue.

Recommendations

61-H-1: PPAC recommends that CMS make the MUEs available to the public.

61-H-2: PPAC recommends that CMS allow the use of modifiers—including modifiers 59 (distinct procedural service), 76 (repeat procedure by the same physician), 77 (repeat procedure by another physician), and 91 (repeat clinical diagnostic laboratory test)—when medically necessary and appropriate, that exceed MUE limits.

Agenda Item I — Physician Proposed Rule

Amy Bassano, Director of the Division of Practitioner Services for the Center for Medicare Management, outlined the highlights of the proposed rule that includes the

physician fee schedule (Presentation 5). Ms. Bassano said CMS is transitioning to a new methodology for calculating practice expenses. She noted that the geographic practice cost index is being updated, which will affect liability and practice expense calculations. She described three possible options for reconfiguring California localities. Ms. Bassano said that CMS had looked at data from the Physician Insurers Association of America, as requested, but did not find it substantially different from the data CMS currently uses.

Recommendations

61-I-1: PPAC recommends that CMS consider using data from the Physician Insurers Association of America because it is more timely than data CMS currently uses.

61-I-2: PPAC recommends that CMS provide the geographic practice expense data that will be used to calculate the proposed geographic adjustment factor changes so that PPAC can verify the agency's calculations. PPAC recommends that CMS update the payment localities every 3 years using the 5-percent threshold. PPAC recommends that CMS maintain reimbursement in counties remaining in the original payment localities by establishing a geographic payment floor.

Agenda Item K — Outpatient Prospective Payment System and Ambulatory Surgical Centers (ASCs) Proposed Rule

Don Thompson, Acting Deputy Director of the Hospital and Ambulatory Policy Group, gave an overview of the proposed rule (Presentation 6). Mr. Thompson noted that to prevent migration of procedures from the physician's office to an ASC, reimbursement rates for procedures performed in ASCs would be the same as the rate for performing the same procedure in a physician's office. Under the proposed rule, the payment methodology for ASCs more closely resembles the outpatient prospective payment system. The number of reimbursed ASC procedures would expand from 2,500 to 3,300.

Agenda Item L — MCPSS

Dave Clark, Director of the Office of Provider Relations and Evaluations in the Center for Medicare Management, presented results from the second national MCPSS (Presentation 7). The overall average score was 4.56 (on 6-point scale). Fiscal intermediaries and regional home health intermediaries scored above the national average; carriers and durable medical equipment contractors scored below the national average. Karen Jackson, Director of the Medicare Contractor Management Group for the Center for Medicare Management, said performance in the areas of provider inquiries and claims processing were strongly tied to overall levels of satisfaction.

Recommendations

61-L-1: PPAC recommends that CMS incorporate into the MCPSS a measure to assess satisfaction of physicians who have participated in the RAC program.

Agenda Item N —NPI Data Dissemination Update

Patricia Peyton, Health Insurance Analyst in the Division of Provider/Supplier Enrollment of the Office of Financial Management, explained that the NPI registry would be available online and also in a downloadable format in September (Presentation 8). Providers can update or edit their profile data online anytime, and CMS will ensure that certain sensitive information is not disclosed. Ms. Peyton advised individuals not to include their home addresses in their profiles. James Bossenmeyer, Director of the Division of Provider/Supplier Enrollment in the Office of Financial Management, said the online version allows a simple search of the information; more detailed searches require the user to download the entire file and apply some data manipulation tactics.

Agenda Item O — Testimony

Jonathan Myles, M.D., of the College of American Pathologists, requested more input into and information about the MUE process (Presentation 9). Dr. Myles also asked that CMS reconsider the indirect practice expense methodology.

The Council reviewed written testimony from the American Urological Association (Presentation 10), the American Medical Association (Presentation 11), and the Association of American Medical Colleges (Presentation 12).

Agenda Item P — Wrap Up and Recommendations

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

Recommendation

61-P-1: PPAC recommends that CMS strongly protest the cessation or curtailing of PPAC activities and continue to support quarterly PPAC meetings. PPAC requests that CMS keep the Council informed on the status of efforts to curtail or disband the Council, including the possible ramifications of disbanding the PPAC.

Report prepared and submitted by
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PPAC Members at the August 27, 2007, Meeting

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Geraldine O'Shea, D.O.
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Jonathan E. Siff, M.D.
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Arthur D. Snow, M.D.
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Anesthesiologist
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CMS Staff Present

Amy Bassano, Director
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Office of Financial Management

Kim Brandt, Director
Program Integrity Group
Office of Financial Management

David C. Clark, RPH, Director
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Melanie Combs, RN, Senior Technical Advisor
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Rosemarie Hakim, Ph.D., Epidemiologist
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Karen Jackson, Director

Medicare Contractor Management Group
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Herb Kuhn, Acting Deputy Administrator
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Patricia Peyton, Health Insurance Analyst
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Liz Richter, Acting Director
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William Rogers, M.D., Director
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Ken Simon, M.D., Executive Director, PPAC
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Brenda Thew, Director

Division of Benefit Integrity Management
Operations
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Don Thompson, Acting Deputy Director
Hospital and Ambulatory Policy Group

Public Witnesses:

Earl Berman, M.D., Contractor Medical Director
PRG Shultz

Jonathan Myles, M.D.
College of American Pathologists

Dana Trevas, Rapporteur
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting agenda

Appendix B: Recommendations from the August 27, 2007, meeting

The following documents were presented at the PPAC meeting on August 27, 2007, and are appended here for the record:

- Presentation 1: PRIT Update
- Presentation 2: Coverage with Evidence Development
- Presentation 3: Recovery Audit Contractors (RACs) FY 2006 Findings and Expansion Plans
- Presentation 4: Medically Unlikely Edits (MUEs)
- Presentation 5: 2008 Physician Fee Schedule Notice of Proposed Rulemaking
- Presentation 6: Proposed CY 2008 Medicare Update: Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System
- Presentation 7: CMS Plans for MCPSS
- Presentation 8: NPPES Data Dissemination Notice
- Presentation 9: Statement to the Practicing Physicians Advisory Council of the College of American Pathologists
- Presentation 10: American Urological Association Comments for August 27, 2007, PPAC Meeting
- Presentation 11: Statement of the American Medical Association to the Practicing Physicians Advisory Council
- Presentation 12: Statement of the Association of American Medical Colleges to the Practicing Physicians Advisory Council

Appendix A

**Practicing Physicians Advisory Council
CMS Single Site Location
Multipurpose Room
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244
August 27, 2007**

08:30-08:40	A. Open Meeting	Anthony Senagore, M.D., M.B.A., Chairman, Practicing Physicians Advisory Council
08:40-08:50	B. Welcome	Herb Kuhn, Acting Deputy Administrator, Centers for Medicare & Medicaid Services Elizabeth Richter Acting Director, Center for Medicare Management, Centers for Medicare and Medicaid Services
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 Public Affairs, Centers for Medicare and Medicaid Services
9:30-10:15	E. Coverage with Evidence Development	Rosemarie Hakim, Ph.D., Epidemiologist, Division of Operations and Inform- ation Management, Office of Clinical Standards and Quality

10:15-10:30	F. Break (Chair discretion)	
10:30-11:00	G. RAC Update	<p>James J. Lee, D.O. Contractor Medical Director, Connolly Healthcare</p> <p>Earl Berman, M.D., FACP, MALPS, Contractor Medical Director, PRG-Shultz</p> <p>Connie Leonard, Project Officer, RAC Division of Medicare Overpayments, Office of Financial Management</p> <p>Melanie Combs, RN, Senior Technical Advisor, Division of Demonstrations Management, Financial Services Group</p>
11:00-11:45	H. MUE	<p>Kim Brandt, Director, Program Integrity Group Office of Financial Management</p> <p>Brenda Thew, Director, Division of Benefit Integrity Management Operations, Office of Financial Management</p>
11:45-12:15	I. Physician Proposed Rule	Amy Bassano, Director Division of Practitioner Services, Center for Medicare Management
12:15-1:15	J. Lunch	

1:15-2:00	K. OPPS & ASC Proposed Rule	Don Thompson, Acting Deputy Director, Hospital and Ambulatory Policy Group, Center for Medicare Management
2:00-2:45	L. MCPSS	Geraldine Nicholson, Director, Provider Communications Group Center for Medicare Management Karen Jackson, Director Medicare Contractor Management Group, Center for Medicare Management
2:45-3:00	M. Break	
3:00-3:45	N. NPI Data Dissemination Notice	James Bossenmeyer, Director, Division of Provider/Supplier Enrollment, Office of Financial Management Patricia Peyton, Health Insurance Analyst, Division of Provider/Supplier Enrollment, Office of Financial Management
3:45-4:00	O. Testimony - Jonathan Myles, M.D. College of American Pathologists (CAP)	
4:00-4:30	P. Wrap Up/Recommendations	

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC) RECOMMENDATIONS Report Number Sixty-One August 27, 2007

Agenda Item E — Coverage with Evidence Development

61-E-1: PPAC recommends that CMS increase awareness and education among medical specialty communities regarding the availability of coverage with evidence development and funding of clinical trials.

Agenda Item G — Recovery Audit Contractor (RAC) Update

61-G-1: PPAC recommends that CMS continue to work collaboratively with the American Medical Association to disconnect payment denials for anesthesia when a RAC retroactively determines that surgery was unnecessary.

61-G-2: PPAC recommends that CMS direct the RAC program to create clear, uniform notification and demand letters. The objective of the letters should be to decrease confusion and inefficiency and increase clarity and compliance.

61-G-3: PPAC recommends that CMS and its contractors consider the medical necessity of each service provided downstream of a denied service on the original merits based on the information that was available to the downstream provider at the time the downstream service was provided.

61-G-4: PPAC recommends that CMS direct the RACs to provide to PPAC data reflecting the percentage of physician chart audits that result in payment modification.

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Agenda Item H — Medically Unlikely Edits (MUEs)

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Agenda Item I — Physician Proposed Rule

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61-I-2: PPAC recommends that CMS provide the geographic practice expense data that will be used to calculate the proposed geographic adjustment factor changes so that PPAC can verify the

agency's calculations. PPAC recommends that CMS update the payment localities every 3 years using the 5-percent threshold. PPAC recommends that CMS maintain reimbursement in counties remaining in the original payment localities by establishing a geographic payment floor.

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

61-L-1: PPAC recommends that CMS incorporate into the MCPSS a measure to assess satisfaction of physicians who have participated in the RAC program.

Agenda Item P — Wrap Up/Recommendations

61-P-1: PPAC recommends that CMS strongly protest the cessation or curtailing of PPAC activities and continue to support quarterly PPAC meetings. PPAC requests that CMS keep the Council informed on the status of efforts to curtail or disband the Council, including the possible ramifications of disbanding the PPAC.