

# **REPORT NUMBER SIXTY-THREE**

to the

**Secretary**

**U.S. Department of Health and Human Services**

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**(Re: Physicians Regulatory Issues Team, Recovery Audit Contractors, National  
Provider Identifier, Health Assessment Tools, Hospital and Physician Quality  
Measures, the Office of the National Coordinator for Health Information  
Technology, and other matters)**

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From the

**Practicing Physicians Advisory Council**

**(PPAC)**

**Hubert H. Humphrey Building**

**Centers for Medicare and Medicaid Services**

**Washington, DC**

**March 3, 2008**

## SUMMARY OF THE MARCH 3, 2008, MEETING

### **Agenda Item A — Introduction**

The Practicing Physicians Advisory Council (PPAC) met at the Hubert H. Humphrey Building in Washington, DC, on Monday, March 3, 2008 (see Appendix A). The chair, Anthony Senagore, M.D., welcomed the Council members. He announced that this meeting marked the last term for himself and fellow Council members Jose Azocar, M.D., Geraldine O'Shea, D.O., and Peter Grimm, D.O. Dr. Senagore welcomed future members of the Council who attended the meeting as observers. Helena Wachslight Rodbard, M.D., resigned from the Council.

### **Agenda Item B — Welcome**

Herb Kuhn, Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS), thanked the departing members for their service. He noted that CMS provided the Medicare Payment Advisory Commission (MedPAC) with its projections for the Sustainable Growth Rate (SGR) for 2009 and he anticipates much debate on that topic. Jeffrey Rich, M.D., Director of the Center for Medicare Management, recognized the importance of the Council in providing needed input to CMS.

## OLD BUSINESS

Ken Simon, M.D., M.B.A., Executive Director of PPAC, presented the responses from CMS to PPAC recommendations made at the December 3, 2007, meeting (Report Number 62).

### **Agenda Item D — Physician Fee Schedule Final Rule**

**62-D-1:** PPAC recommends that CMS use the Physician Assistance and Quality Initiative (PAQI) Fund to partially offset the planned negative update for 2008 and allow all physicians to benefit from the fund.

**CMS Response:** Section 101(a)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (S. 2499, P.L. 110-173) revised the PAQI Fund. In coordination with Division G of the Consolidated Appropriations Act, 2008 (H.R. 2764, P.L. 110-161), no PAQI Fund money is available for Medicare physician fee schedule payments in 2008 or 2009. The \$4.96 billion remaining in the PAQI Fund is currently designated for expenditures during 2013 and is only available for an adjustment to the update of the conversion factor.

Section 101(b) extended the Physician Quality Reporting Initiative (PQRI) into 2008. Eligible participating professionals will be paid from the Federal Supplemental Medical Insurance Trust Fund an amount equal to 1.5 percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges for covered professional services furnished during the reporting period.

**Agenda Item E — Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Centers (ASCs) Final Rule**

**62-E-1:** PPAC recommends that CMS develop a simpler, better, alternative approach to the ASC payment system planned to take effect in 2008—such as paying ASCs a defined, flat percentage of what is paid to hospitals for each procedure—that would not vary every year.

**CMS Response:** In developing the new ASC payment system, we needed to balance the desire for a simpler system with the need to establish the system within the statutory framework. The MMA [Medicare Modernization Act]-mandated revised ASC payment system implemented for calendar year (CY) 2008 was designed to align the ASC payment policies with those under the hospital OPSS as closely as feasible. The revised ASC relative payment weights are based on the relative payment weights for ambulatory payment classification groups used for Medicare payments to hospital outpatient departments under the OPSS. However, the ASC payment system diverges from the OPSS system in a few notable ways: 1) The MMA required that the revised ASC payment system be implemented as budget neutral for CY 2008. 2) The statute requires a zero-percent update to the ASC payment system until CY 2010. 3) CMS is providing a 4-year transition to the revised ASC rates for those services paid in CY 2007 to ASCs.

**62-E-2:** PPAC is concerned that Medicare patients receiving brachytherapy for prostate cancer at an ASC will be denied care as of January 1, 2008, because the Final Rule does not require payment of such sources. PPAC recommends that CMS address this issue immediately, for example, by maintaining the current methodology or implementing a temporary solution to allow patients to receive timely care.

**CMS Response:** According to CMS final ASC payment policy, ASCs receive separate payment for brachytherapy sources that are provided integral to a covered surgical procedure. Moreover, a question-and-answer document clarifying the physician self-referral policy is posted on the CMS physician self-referral website to make clear that the implantation of brachytherapy sources qualifies for the physician self-referral exception for implants under 42 C.F.R. 411.355(f). Because sources of brachytherapy qualify for this exception, a urologist would not be prohibited from referring a patient to an ASC in which the urologist has an ownership or investment interest for a brachytherapy procedure.

**Agenda Item J — Stark Update**

**62-J-1:** PPAC urges CMS not to issue additional rules that further complicate the Stark self-referral rules by adding more layers of confusion and regulation that discourage efficient and innovative quality health care.

**CMS Response:** CMS strives to ensure that its physician self-referral regulations are not unduly complex and do not unnecessarily discourage efficient and innovative quality health care.

**62-J-2:** PPAC recommends that CMS delay implementation of the anti-markup provisions to evaluate the substantial impact of these changes on health care providers, especially those in group practice.

**CMS Response:** In a Final Rule published January 3, 2008, CMS delayed the implementation of the revisions to 414.50 except for the anti-markup provision relating to the purchased technical component of diagnostic tests and the anti-markup provision relating to the technical component and professional component of anatomical pathology diagnostic testing performed in space that is used as a centralized building (as defined in 411.351) for purposes of complying with the physician self-referral rules and that does not qualify as a “same building” (as defined in 411.351).

**Agenda Item M — American Medical Association Testimony**

**62-M-1:** PPAC recommends that CMS reinstate the fax exception for e-prescribing and work with Congress to provide financial incentives to facilitate wider adoption of e-prescribing.

**CMS Response:** In response to industry concerns that the exemption for computer-generated faxes was hindering the movement toward computer-to-computer e-prescribing, we proposed in the June 2007 Physician Fee Schedule Notice of Proposed Rulemaking (72 FR 38195-38196) to eliminate it effective January 2009. In the Physician Fee Schedule Final Rule with comment (72 FR 66396), we did not eliminate the exemption entirely, allowing computer-generated faxes to be used during periods of network failure.

During the time period allotted for comment following the issuance of the June 2007 proposed rule we received one comment that indicated that the elimination of the exemption could be problematic in performing certain e-prescribing functions. Absent receipt of any other negative industry feedback during this comment period we proceeded to work toward the elimination of the exemption (except, as noted above, in cases of network failure) to be effective January 2009. However, we have since been informed by various stakeholders that the elimination of the exemption for computer-generated faxes would have an adverse effect in certain instances, and they have provided us with more specific information regarding its economic and workflow impacts that were not forthcoming during the public comment period. In particular, pharmacies have indicated that they use computer-generated faxes for a significant volume of refill requests, and that eliminating the exemption would require them to revert to paper faxes when the prescribing physician does not have e-prescribing capability.

We are now in the process of examining and considering these data, and we expect to address this issue through the rulemaking process prior to the January 2009 effective date, once again affording an opportunity for public comment.

At this time, funds have not been appropriated by Congress to provide direct grants and/or other incentives to providers to implement e-prescribing under Medicare Part D. However, other incentives, such as regulations that provide exceptions to the anti-kickback statute and the Stark Federal Physician Self-Referral law, are in place and can pave the way for industry to share technology and other health information technology resources among entities. We also note that providers may participate in, and receive incentives through, the 2008 PQRI. This project includes measures for patient compliance with therapy, which can be supported through the utilization of e-prescribing transactions such as fill status notification.

CMS announced a 5-year demonstration project on February 20, 2008, that will provide incentive payments to encourage small and medium sized primary care physician practices to use electronic health records. This project is a major step toward moving to an electronic reporting system aimed at reducing medical errors and improving quality of care.

**62-M-2:** PPAC recommends that CMS report to PPAC its plan of action to correct patient access cuts forecast by the American Medical Association resulting from unsustainable cuts to physician Medicare reimbursement.

**CMS Response:** CMS is aware of the potential implications of the negative updates on access to care. We are monitoring beneficiary access to care in the Medicare program.

To address the beneficiary perspective on access to care, two beneficiary surveys are available; the Medicare Beneficiary Survey (MCBS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). These surveys provide information on whether the respondents are experiencing difficulty obtaining needed services. The MCBS is a national survey that has been continuously available since 1991. CAHPS is also a national survey, but the larger sample size allows for the generation of statistics at a more local level. To address physicians' perspectives on their willingness to treat Medicare beneficiaries, CMS has relied historically on the periodic physician survey administered by the Center for Studying Health System Change and will continue to do so if the Center for Studying Health System Change continues to administer this survey.

**62-M-3:** PPAC recommends that CMS allow carriers flexibility to ensure enrollment applications do not stall or result in unnecessary rejections, especially given the untold numbers of practitioners who are being asked to reenroll.

**CMS Response:** CMS has instructed its Medicare fee-for-service contractors to process complete Medicare provider/supplier enrollment applications that contain all supporting documentation, including the electronic funds transfer authorization agreement (CMS-588) and licensing information, within prescribed processing timeframes. CMS requires that its contractors process 80 percent of initial enrollment applications within 60 days or less and 80 percent of changes in 45 days or less. In order for a contractor to meet this standard, providers and suppliers must submit a complete application at the time of filing.

For an enrollment application to be considered complete, 1) all applicable sections of the CMS-855 and fields, including check boxes, within a section must be filled-out at the time of filing; 2) the application must contain an original signature and date of signature; and 3) it must contain all supporting documentation listed in section 17 of the enrollment application.

CMS is also developing an Internet-based enrollment process. By establishing an Internet-based enrollment process, CMS will allow providers and suppliers (except suppliers of durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS]), the option of enrolling or making a change in their Medicare enrollment information via the Internet.

**62-M-4:** PPAC recommends that CMS carefully monitor the industry's overall ability to use only National Provider Identifier (NPI) numbers by May 23, 2008, particularly the readiness of Medicare and those billing Medicare.

**CMS Response:** CMS will continue to monitor industry NPI readiness, including Medicare fee-for-service readiness. We monitor NPI metrics very closely and stand prepared to address any problems as they arise.

#### **Agenda Item P — Wrap Up and Recommendations**

**62-P-1:** PPAC recommends that CMS report the analyzed results of data from the 2007 PQRI at the May 2008 PPAC meeting and additional data at the August 2008 PPAC meeting.

**CMS Response:** CMS plans to report the analyzed results of the 2007 PQRI at the first PPAC meeting following completion of analysis of the final results, which will probably be available by the August 2008 meeting.

**62-P-2:** PPAC recommends that CMS implement a rapid and direct NPI outreach plan with emphasis on small and rural providers and reconsider the revalidation process that began in October 2007 until the enrollment problems associated with NPI-Medicare matching are thoroughly resolved.

**CMS Response:** CMS is committed to ensuring that all Medicare physicians and other health care professionals, including small and rural practitioners, are kept

fully aware of all aspects of NPI implementation. To meet this commitment, CMS has built an extensive information delivery network through which consistent and accurate information is delivered to the broadest Medicare fee-for-service provider audience possible. Our three primary sources for delivering information are the Medicare fee-for-service contractors who communicate to Medicare billers regularly, CMS Regional Offices, and the CMS Central Office. We have a fourth partner in provider organizations and associations, like the American Medical Association (AMA) and the Medical Group Management Association (MGMA).

CMS has 18 provider-specific listservs with over 130,000 subscribers. Medicare contractors have similar tools along with provider newsletters, provider-specific listservs with over 470,000 subscribers, and ongoing provider education activities. Partnering with national and regional health care provider associations significantly extends our outreach efforts. To date, we have entered into partnerships with 115 national health-care-related associations (including the National Association of Rural Health Clinics, the National Rural Health Association, the AMA, and MGMA), and over 2,000 State/local associations. Our provider partners agree to disseminate Medicare news and NPI-related messages to association members, publish the information in association newsletters, and post links to the information on their websites.

Additionally, we issue our messages through the CMS NPI Outreach Subgroup, which includes staff responsible for Medicare Advantage Plans, Quality Improvement Organizations, State Survey and Medicaid Agencies and the Workgroup for Electronic Data Interchange.

Since initiating NPI-related provider outreach activities more than a year ago, we have distributed 26 NPI-related outreach messages using this extensive network. These messages have included helpful tips and information that providers can use as they implement the NPI in their business practices. All of our current and past communications and “Frequently Asked Questions” can be viewed on the CMS NPI web page at <http://www.cms.hhs.gov/NationalProvIdentStand> on the CMS website.

In terms of educational products, CMS has issued 44 *MLN Matters* national articles. These nationally consistent articles use easy-to-understand language to help health care professionals understand NPI-related policies and are extensively marketed through a dedicated *MLN Matters* listserv with over 32,000 subscribers. We have also created a training package that consists of four PowerPoint presentations on topics such as subparts and data dissemination, as well as fact sheets and tip sheets on various aspects of the NPI Final Rule and its practical applications. All NPI educational resources have been announced, via the network described above, as they have become available, and are easily accessible at [http://www.cms.hhs.gov/NationalProvIdentStand/04\\_education.asp](http://www.cms.hhs.gov/NationalProvIdentStand/04_education.asp) on the CMS website.

Finally, we have hosted six NPI Roundtable conference calls to field questions from health care professionals regarding Medicare's transition to the NPI. These calls have been, and will continue to be, open to the public and announced through the mechanisms described above. We welcome individual providers as well as provider organizations to these calls. NPI news is also discussed on an ongoing basis at CMS Open Door Forums and the parallel Medicare contractor "Ask the Contractor" calls.

Our approach is deliberately redundant to ensure we reach the provider community (e.g., if someone misses the CMS communications, perhaps they will hear it from provider organizations or their contractor). We plan to continue the outreach activities described above. We would welcome further suggestions from you on ways to reach small or rural providers.

**62-P-3:** PPAC recommends that CMS work with Congress to 1) ensure immediate action to produce at least 2 years of positive updates and avert the 15-percent cut to the physician fee schedule over 2008 and 2009 and 2) repeal the SGR altogether and replace it with a system that produces positive physician payment updates that accurately reflect increases in medical practice costs as indicated by the Medicare Economic Index (MEI).

**CMS Response:** The formula for the SGR and the physician update are dictated by statute. We are required to follow this methodology when calculating the payment rates under the physician fee schedule. We look forward to working with Congress, the physician community, and other interested parties as we continue to analyze appropriate alternatives to the current system that could ensure appropriate payments while promoting high quality care, without increasing Medicare costs.

**62-P-4:** PPAC recommends that CMS apply the budget neutrality adjustment to the conversion factor for 2008 and subsequent years.

**CMS Response:** Section 1848(c)(2)(B)(ii)(II) of the Act requires a budget neutrality adjustment. Regardless of whether the work budget neutrality adjustor that is a product of the 50 Year Review of Work is applied to the work relative value units (WRVUs) or the conversion factor, the values associated with the work will ultimately be decreased. Since the work adjustor is applied across all WRVUs and since the work adjustor is applied outside of the actual WRVUs as an additional adjustment, the application of the work adjustor to the WRVUs does not alter the relativity among WRVUs.

Achieving budget neutrality by adjusting the conversion factor would have the effect of reducing payment for all services on the fee schedule. This would include reductions in relative value units for a number of services that have no

physician work and were, therefore, outside the scope of the 5-Year Review. We believe it would be unfair to impose additional reductions resulting from budget neutrality on codes that have no work values associated with them.

**62-P-5:** PPAC recommends that CMS be aware of areas of concern with proposed DMEPOS regulations, including competitive bidding and requirements to provide assurity bonds to provide DMEPOS service. It is impossible for health care providers to compete against larger businesses whose sole purpose is to supply medical equipment. Therefore, providers should be exempt from the accreditation process on the basis of their training and from the competitive bidding process. PPAC urges CMS to remedy this situation by amending the Final Rule.

**CMS Response:** The law did not give CMS the 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 received, or retainer provider or supplier number used to submit claims for reimbursement for any item or service for which payment may be made under Medicare. 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.

**62-P-6:** PPAC recommends that CMS reevaluate and reduce the 1.4-percent productivity adjustment to the 2008 MEI and the reduction for future years.

**CMS Response:** The Office of the Actuary (OACT) has concluded that the reevaluation is accurate. OACT reevaluates the appropriateness of the productivity adjustment in the MEI each year and it has concluded that the adjustment is valid.

The MEI has contained a productivity adjustment since its inception in 1973. The rationale and technical appropriateness of the current MEI productivity adjustment has been well documented in the *Federal Register*. Moreover, CMS recently partnered with the Assistant Secretary of Planning and Evaluation to sponsor an analysis of physician-specific productivity. The results of this effort were presented at a conference of stakeholders in October 2006. A highly-respected panel of experts concluded that the use of the 10-year moving average for private, non-farm business-sector multifactor productivity was not an unreasonable proxy for physician-specific productivity. Papers from this research effort are expected to be published in the forthcoming winter 2007/2008 edition of the *Health Care Financing Review*. CMS will continue to monitor, on an ongoing basis, the reasonableness of the use of this economy-wide measure of multifactor productivity for purposes of adjusting the MEI.

The Council noted that although CMS had not yet published any results from the PQRI, the Physician Performance Improvement Center has made available to physicians raw data from the program through November 2007.

*Recommendation*

**63-C-1:** 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.

## 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). He said simplifying the provider enrollment procedure by instituting an online mechanism is taking longer than expected, but the system is expected to cut processing times in half. PRIT is considering how to improve notification so that providers who receive a refund or recoupment check can easily identify the specific claim with which the check correlates.

### **Agenda Item E — NPI Update**

Cathy Carter, Director of the Business Applications Management Group in the Office of Information Services, explained that as of March 1, claims that do not include an NPI number will be rejected (Presentation 2a, b). As of May 23, 2008, claims may include only NPI numbers (and no legacy numbers). CMS has mobilized resources to address the projected increase in claims rejected because no NPI number is included.

*Recommendation*

**63-E-1:** 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.

### **Agenda Item G — Recovery Audit Contractor (RAC) Update**

Melanie Combs, RN, Senior Technical Advisor in the Division of Demonstrations Management of the Financial Services Group, noted that the RAC demonstration project ends March 28, 2008 (Presentation 3). Four permanent RACs will be named this spring. Assessment of claims for evaluation and management (E&M) coding errors was beyond the scope of the demonstration RACs but will be allowed for the permanent RACs.

Ms. Combs said that of 358,765 claims for which overpayment collection was initiated (through September 30, 2007), a provider appealed the collection in 11 percent of cases. Of cases appealed, 44 percent were overturned, but overturned appeals make up only 5 percent of all overpayment collections sought. Ms. Combs added that CMS has hired RAC validation contractors to assess the quality and accuracy of RAC determinations.

*Recommendations*

**63-G-1:** PPAC recommends that CMS make available the specific rules for evaluating E&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&M rules will be applied.

**63-G-2:** PPAC recommends that CMS report back to the Council a detailed analysis of data from the RAC audits and the RAC validation contractors to refine claims identification on the basis of unique, specific practice patterns and to provide education to improve the accuracy of claims submission.

**63-G-3:** PPAC recommends that CMS streamline the process for physician appeals of RAC audit determinations.

**Agenda Item H — Hospital Measures Physician & Quality**

Michael Rapp, M.D., J.D., Director of the Quality Measurement and Health Assessment Group in the Office of Clinical Standards and Quality, explained some changes to the PQRI program for 2008 (Presentation 4). He noted that suggestions for measures to add for the 2009 program should be sent to CMS by March 21, 2008, to ensure they are considered for the notice of proposed rulemaking that is published in late July or early August. Dr. Rapp said about 16 percent of eligible physicians participated in the PQRI for 2007. He hoped that participation would increase as the program and the measures used become more stable.

**Agenda Item J — Update on Health Assessment Tools**

Robert Connolly, M.S.W., Health Insurance Specialist, and Debora A. Terkay, R.N., M.S., Nurse Consultant, both from the Office of Clinical Standards and Quality in the Quality Measurement and Health Assessment Group, described updated assessment tools that CMS will put in place through 2009 (Presentation 5). Mr. Connolly explained changes to the Minimum Data Set that would be incorporated in version 3.0, to be implemented in October 2009. Ms. Terkay outlined revisions to the Outcome and Assessment Information Set (OASIS), version C, which also will be implemented in 2009. She also described the assessment tool that would be used for a post acute care payment reform demonstration project.

**Agenda Item K — Office of the National Coordinator for Health Information Technology (ONCHIT)**

David R. Hunt, M.D., Chief Medical Officer of the Office of the National Coordinator for Health Information Technology, gave an overview of the challenges of using health information technology to improve the health care system (Presentation 6). He emphasized the need for interoperability standards to enable data transfer across systems and software. Dr. Hunt said ONCHIT is developing guidance on protecting data while enabling the free exchange of information. He anticipated that consumers will assert more ownership and control over their own health information, which may help facilitate information exchange. Dr. Hunt acknowledged the very large investment of money and time required to implement information technology in the office setting but said he believes that productivity ultimately increases as a result.

### **Agenda Item M — Testimony**

The Council reviewed written testimony provided by the AMA (Presentations 7a, 7b).

### **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.

#### *Recommendations*

**63-P-1:** PPAC recommends that CMS clarify and define whether physicians who supply 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.

**63-P-2:** 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.

**63-P-3:** PPAC recommends that CMS require RACs to reimburse physicians for the costs of all medical record requests.

**63-P-4:** PPAC urges CMS to revise the RAC Statement of Work, subsection E-9, “Staff Performing Complex Coverage/Coding Reviews,” to ensure that medical necessity determinations be reviewed by a physician of the same specialty and licensed in the same state as the physician whose claim is under review.

**63-P-5:** 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.

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

**PPAC Members at the March 3, 2008, Meeting**

Anthony Senagore, M.D., Chair  
Vice President of Medical Education  
Spectrum Health  
Grand Rapids, Michigan

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

Jose Azocar, M.D.  
Internal Medicine  
Springfield, Massachusetts

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

Peter Grimm, D.O.  
Radiation Oncologist  
Seattle, Washington

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

Geraldine O'Shea, D.O.  
Internal Medicine  
Jackson, California

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

Gregory J. Przybylski, M.D.  
Neurosurgeon

Edison, New Jersey

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

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

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

M. LeRoy Sprang, M.D.  
Obstetrics/Gynecology  
Evanston, Illinois

**Observing (New Members To Be Sworn in May 2008)**

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

Pamela Howard, M.D.  
Surgeon  
Allentown, Pennsylvania

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

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

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**CMS Staff Present**

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

David Clark, Director  
Division of Provider Relations and Evaluations  
Center for Medicare Management

Jeffrey Rich, M.D., Director  
Center for Medicare Management

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

**Presenters**

Cathy Carter, Director  
Business Applications Management Group,  
Office of Information Services

Melanie Combs, RN, Senior Technical Advisor  
Division of Demonstrations Management,  
Financial Services Group

Robert Connolly, M.S.W., Health Insurance  
Specialist  
Quality Measurement and Health Assessment  
Group, Office of Clinical Standards and Quality  
Centers for Medicare and Medicaid Services

Michael Rapp, M.D., J.D., Director  
Quality Measurement and Health Assessment  
Group, Office of Clinical Standards and Quality  
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

Debora A. Terkay, R.N., M.S. Nurse Consultant  
Office of Clinical Standards and Quality, Quality  
Measurement and Health Assessment Group,  
Division of Ambulatory and Post Acute Care  
Centers for Medicare and Medicaid Services

David R. Hunt, M.D., Chief Medical Officer  
Office of the National Coordinator, Office for  
Health Information Technology Adoption,  
Department of Health and Human Services

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Dana Trevas, Rapporteur  
Magnificent Publications, Inc.

## APPENDICES

Appendix A: Meeting agenda

Appendix B: Recommendations from the March 3, 2008, meeting

*The following documents were presented at the PPAC meeting on March 3, 2008, and are appended here for the record:*

Presentation 1: PRIT Update

Presentation 2a: NPI Update

Presentation 2b: Web Posting: NPI: March 1 Milestone

Presentation 3: RAC Update

Presentation 4: Hospital Measures, Physician and Quality

Presentation 5: Update on Health Assessment Tools

Presentation 6: Office of the National Coordinator for Health Information Technology

Presentation 7a: Statement of the American Medical Association to the Practicing Physicians Advisory Council

Presentation 7b: Correspondence from the American Medical Association to Kerry Weems, Acting Administrator of CMS

**Appendix A**

**Practicing Physicians Advisory Council  
Hubert H. Humphrey Building  
Room 505A  
Centers for Medicare & Medicaid Services  
200 Independence Avenue, SW  
Washington, DC 20201  
March 3, 2008**

<b>08:30-08:40</b>	<b>A. Open Meeting</b>	<b>Anthony Senagore, M.D., M.B.A., Chairman, Practicing Physicians Advisory Council</b>
<b>08:40-08:50</b>	<b>B. Welcome</b>	<b>Herb Kuhn, Deputy Administrator, Centers for Medicare &amp; Medicaid Services</b>  <b>Elizabeth Richter, Deputy Director, Center for Medicare Management</b>
<b>08:50-09:10</b>	<b>C. PPAC Update</b>	<b>Kenneth Simon, M.D., M.B.A., Executive Director, Practicing Physicians Advisory Council, Center for Medicare Management</b>
<b>09:10-09:30</b>	<b>D. PRIT Update</b>	<b>William Rogers, M.D., Director Physicians Regulatory Issues Team, Office of Public Affairs, Centers for Medicare &amp; Medicaid Services</b>
<b>09:30-10:15</b>	<b>E. NPI Update</b>	<b>Cathy Carter, Director Business Applications Management Group, Office of Information Services</b>
<b>10:15-10:30</b>	<b>F. Break (Chair Discretion)</b>	

<b>10:30-11:15</b>	<b>G. Recovery Audit Contractor (RAC) Update</b>	<p><b>Connie Leonard, Project Officer, RAC, Division of Medicare Overpayments Office of Financial Management</b></p> <p><b>Melanie Combs, RN, Senior Technical Advisor, Division of Demonstrations Management, Financial Services Group</b></p>
<b>11:15-12:00</b>	<b>H. Hospital Measures Physician &amp; Quality</b>	<b>Michael Rapp, M.D., J.D., Director, Quality Measurement and Health Assessment Group, Office of Clinical Standards and Quality</b>
<b>12:00-1:15</b>	<b>I. Lunch</b>	
<b>1:15-2:00</b>	<b>J. Update on Health Assessment Tools</b>	<p><b>Debora A. Terkay, RN, MS Nurse Consultant, Office of Clinical Standards and Quality, Quality Measurement and Health Assessment Group, Division of Ambulatory and Post Acute Care</b></p>
<b>2:00-2:45</b>	<b>K. Office of the National Coordinator for Health Information Technology (ONCHIT)</b>	<p><b>David R. Hunt, M.D., Chief Medical Officer, Office of the National Coordinator, Office for Health Information Technology Adoption, Department of Health and Human Services</b></p>
<b>2:45-3:00</b>	<b>L. Break (Chair discretion)</b>	
<b>3:00-3:30</b>	<b>N. Testimony</b>	

**3:30-4:00**

**O. Wrap Up/Recommendations**

## **Appendix B**

### **PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC) RECOMMENDATIONS March 3, 2008**

#### **Agenda Item C — PPAC Update**

**63-C-1:** 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.

#### **Agenda Item E — NPI Update**

**63-E-1:** 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.

#### **Agenda Item G — RAC Update**

**63-G-1:** PPAC recommends that CMS make available the specific rules for evaluating E&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&M rules will be applied.

**63-G-2:** PPAC recommends that CMS report back to the Council a detailed analysis of data from the RAC audits and the RAC validation contractors to refine claims identification on the basis of unique, specific practice patterns and to provide education to improve the accuracy of claims submission.

**63-G-3:** PPAC recommends that CMS streamline the process for physician appeals of RAC audit determinations.

#### **Agenda Item P — Wrap Up and Recommendations**

**63-P-1:** PPAC recommends that CMS clarify and define whether physicians who supply 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.

**63-P-2:** 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.

**63-P-3:** PPAC recommends that CMS require RACs to reimburse physicians for the costs of all medical record requests.

**63-P-4:** PPAC urges CMS to revise the RAC Statement of Work, subsection E-9, “Staff Performing Complex Coverage/Coding Reviews,” to ensure that medical necessity determinations be reviewed by a physician of the same specialty and licensed in the same state as the physician whose claim is under review.

**63-P-5:** 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.