

REPORT NUMBER FIFTY-NINE

to the

Secretary

U.S. Department of Health and Human Services

**(Re: Physician Quality Reporting Initiative, Transparency Initiative, National
Provider Identifiers, Physicians Regulatory Issues Team Update, Recovery Audit
Contracts, Hospital Conditions of Participation, and other matters)**

From the

Practicing Physicians Advisory Council

(PPAC)

Hubert H. Humphrey Building

Centers for Medicare and Medicaid Services

Washington, DC

March 5, 2007

SUMMARY OF THE MARCH 5, 2007 MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the Hubert H. Humphrey building in Baltimore, MD, on Monday, March 5, 2007 (see Appendix A). The chair, Anthony Senagore, M.D., welcomed the Council members and gave an overview of the agenda. He thanked the five members whose terms would be completed following this meeting for their service to the Council: Joe Johnson, D.C.; Carlos Hamilton, Jr., M.D.; Dennis Iglar, M.D.; Laura Powers, M.D.; and Robert Urata, M.D.

Agenda Item B — Welcome

Herb Kuhn, Acting Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS), thanked all the Council members for their time and commitment. He said CMS recognizes that the current projected cuts for Medicare are not sustainable. Mr. Kuhn announced that Tom Gustafson, Ph.D., Acting Director of the Center for Medicare Management, will retire shortly, and Liz Richter, currently Director of the Hospital and Ambulatory Policy Group, will succeed him. Mr. Kuhn said that Dr. Gustafson's contributions have improved the agency and its policies.

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 December 4, 2006, meeting (Report Number 58).

58-C-1: PPAC recommends that CMS consider updating annually the proportion of physician reimbursement that reflects the cost of professional liability insurance (PLI).

CMS Response: CMS agrees with PPAC regarding the importance of updating the Physician Fee Schedule to reflect the cost of PLI. However, operational requirements make it difficult to update the data more often than once every 3 years. In order to update the PLI, CMS must conduct a multi-step process:

- CMS receives bids from vendors to obtain a contract.
- The contractor obtains data from the various State departments of insurance (DOI). When a State's DOI does not have data or fails to provide data, the contractor must work with the private insurance industry to obtain data on at least 51-percent market share from that state. The collection of data takes a minimum of 6 months.
- Once the data are collected, they are standardized, analyzed, and transformed into PLI relative value units (RVUs). This data collection process takes a minimum of a year to complete.

- This information is then integrated into the CMS notice of proposed rulemaking in an effort to allow specialty societies and the public the opportunity to comment. That takes another year.
- The new rates are implemented the following year.

The Physician Fee Schedule methodology requires these changes be done in a budget-neutral manner. If the PLI from many or all specialty groups increases, the increase in everyone's rates raises the national average so that the individual specialty society increase is typically marginal. CMS welcomes suggestions on alternative data sources or methods to update the fee schedule for PLI.

58-C-2: PPAC recommends that CMS provide the Council at its next meeting a detailed explanation of how CMS monitors access to care for Medicare beneficiaries.

CMS Response: National statistics suggest that Medicare beneficiaries have access to needed care. Nationally, only 4 percent of Medicare beneficiaries reported trouble getting care in 2005. The proportion reporting trouble getting care has not changed since 2000, which was the last time we examined the statistic. However, with the potential reduction in physician payments in the future, there is reason to be concerned about whether access to care will be negatively affected.

As a result of similar concerns in the past, CMS instituted several monitoring activities that continue to be available. Given the difficulty in accurately documenting access problems, a multi-pronged approach is required. The multi-pronged approach includes claims data at the national and county levels, beneficiary surveys, and reports to the Medicare 1-800 number of access problems. CMS will use these data sources to detect potential access problems.

Using claims data we are able to track at the State level physician participation by examining how many distinct billing physicians appear in fee-for-service (FFS) claims data. In addition, we are able to track physician caseloads by examining the number of distinct beneficiaries per billing physician in the FFS claims data. We are able to track physician density by examining the number of billing physicians per 1,000 FFS Medicare beneficiaries. Finally, we are able to track dollar volume by examining Medicare payments per billing physician and per FFS beneficiary.

The State-level physician participation and caseload file is not available until the claims data are complete, about 12 months after close of a calendar year. In the interest of having more timely statistics, we developed national data on a quarterly basis for many specific types of physician services. While this data system only provides information at the national level, it can be used as a warning

system to capture real-time changes in utilization patterns that might suggest declining access.

In addition to this national real-time data system, we have developed a real-time county-level tracking system that contains utilization statistics for a subset of key services. This system provides real time county-level data that can be used as a warning system. We can examine whether there are shifts in the proportion of total visits that are for new versus established patients, coupled with an increase in the proportion of visits to the emergency department.

The data systems mentioned to this point are based on services that have already been rendered and captured through claims. As such, they do not directly address beneficiaries' experiences with the health care system or physicians' perspectives about their willingness to treat Medicare patients. To address the beneficiary perspective, two beneficiary surveys are available; the Medicare Beneficiary Survey (MCBS) and the Consumer Assessment of Health Plan Survey (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. The CAHPS, which has been available since 2000, is also a national survey, but the larger sample size allows for the generation of statistics at a more local level. To address the physicians' perspectives on their willingness to treat Medicare beneficiaries, CMS has relied on the periodic physician survey administered by the Center for Studying Health System Change.

58-F-1: PPAC recommends that CMS determine the optimal means for physician documentation and compliance for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims submission to decrease the administrative burden for practicing physicians.

CMS Response: CMS thanks PPAC for its recommendation on this topic. Over the past few years, CMS has considered ways to streamline the process in a manner that maintains effective medical-necessity documentation while reducing administrative burden on practicing physicians. CMS successfully eliminated the use of the manual wheelchair, motorized wheelchair, and power-operated vehicle Certificate of Medical Necessity (CMN). Thus, to minimize the documentation requirements for providers while assuring that documentation is adequate, physicians and treating practitioners will now prepare written prescriptions (as required by the Medicare Modernization Act [MMA], Section 302) and submit copies of relevant existing documentation from the beneficiary's medical record, rather than having to transcribe medical record information onto a separate form, such as a CMN. Further information about the conditions of payment of power mobility devices, including power wheelchairs and power-operated vehicles final rule is available online at

http://www.cms.hhs.gov/CoverageGenInfo/06_wheelchair.asp#TopOfPage

58-F-2: PPAC recommends that lower-cost durable medical equipment items, e.g., orthotics, crutches, canes, and cast braces, be exempt from the competitive bidding process when health care providers capable of prescribing DMEPOS act as the supplier for those items.

CMS Response: This issue was addressed in the notice of proposed rulemaking for the DMEPOS competitive bidding program. We will further address the issue in the final rule, where we will respond to public comments in the near future. We thank the PPAC for their recommendation and input on this topic.

58-F-3: PPAC recommends that CMS consider implementing a competitive bidding process for other medical supplies, e.g. disposable equipment used in the operating room and implantable devices, such as cardiac stents, to save health care dollars.

CMS Response: CMS will take this suggestion under advisement as we consider legislation that might be recommended as part of the President's program. Statutory authority would be necessary to implement this recommendation.

58-G-1: To avoid the looming crisis in beneficiaries' access to providers, PPAC recommends that the Secretary of the Department of Health and Human Services and CMS leadership work with Congress to avert the reimbursement cuts planned for 2007 and beyond, implement a positive payment update that covers increases in physicians' practice costs, and repeal the sustainable growth rate (SGR) methodology and replace it with a system that adequately keeps pace with health care costs.

CMS Response: We are fully cognizant of the potential implications of more than 9 years of negative physician updates. We remain concerned regarding those trends and are closely monitoring physicians' participation in the Medicare program, as well as beneficiaries' access to care. The formula for the SGR and the physician update are defined by statute. We are working closely and collaboratively with medical professionals and the Congress on the most effective Medicare payment methodologies to compensate physicians for providing services to Medicare beneficiaries. We are committed to developing systems that enable us to encourage quality and to improve care without increasing overall Medicare costs.

58-H-1: PPAC recommends that CMS establish a process to consult with national medical specialty societies and the ambulatory surgical care community to develop and adopt a systematic and adaptable means of fairly reimbursing ambulatory surgical centers (ASCs) for all safe and appropriate services, allowing for changes in technology and current-day practices.

CMS Response: The calendar year (CY) 2008 proposed rule for the revised ASC payment system was published on August 23, 2006, and provided for a 90-day comment period on the proposal. The proposal included a significant expansion of the list of surgical procedures for payment in ASCs and a proposed approach to updating the ASC payment system annually, through notice and comment rulemaking in coordination with the Outpatient Prospective Payment System (OPPS) proposed and final rules. We received thousands of public comments to the CY 2008 ASC proposed rule, including many comments from the ASC community and national medical specialty societies. We are currently considering all public comments in the development of the final rule for the CY 2008 revised ASC payment system. We believe the process of annual notice and comment rulemaking provides meaningful opportunity for broad public input into the ASC update each year and permits us to adapt the payment policies of the ASC payment system to changes in technology and contemporary surgical practice on a regular basis. CMS uses a well-established roll-out process to ensure that the affected parties are informed of the updates and activities of the agency. CMS is committed to a transparent and interactive process with the public in developing rules and is guided by the Administrative Procedure Act to obtain input to assist us in developing policies that improve the quality of care for Medicare beneficiaries provided by clinicians participating in the program.

58-H-2: PPAC recommends that CMS apply any payment policies uniformly to both ASCs and hospital outpatient departments as appropriate.

CMS Response: The CY 2008 proposed rule for the revised ASC payment system was published on August 23, 2006, and provided for a 90-day comment period on the proposal. We are currently considering all public comments in the development of the final rule for the CY 2008 revised ASC payment system. As part of the development of the final rule, we are also considering the recommendations of organizations on the structure and payment policies of the revised payment system, including PPAC, the Government Accountability Office, the Medicare Payment Advisory Commission (MedPAC), and others. We appreciate PPAC's recommendation regarding consistent payment policies for ASCs and hospital outpatient departments and will take the recommendation into account as we finalize the policies of the revised ASC payment system.

58-J-1: PPAC recommends that CMS identify actionable items based on best practices identified by the Medicare Contractor Provider Satisfaction Survey (MCPSS) process to improve the provider–contractor relationship.

CMS Response: CMS acknowledges the recommendation, and the Agency recognizes the potential value of actionable item information to our contractors. In our continued effort to improve the provider–contractor relationship, CMS intends to use the MCPSS scores for monitoring contractor performance on an ongoing, operational basis as outlined in the MMA, Section 911 (b)(3)(B). We will develop

contractor performance requirements and standards for measuring provider satisfaction levels. CMS also plans to use the MCPSS as a metric in the Medicare Administrative Contractor (MAC) award fee plans for future award fee determinations.

CMS encourages the sharing of best practices; however, given the competitive MAC environment, this act is voluntary and not a contractor requirement. At the same time, the competitive environment provides incentives for contractors to implement process improvements based on provider feedback so that they can gain the best competitive position possible.

All contractors receive reports that provide disaggregate data for each of the seven business functions and provider groups. Contractors can compare their business scores to the average aggregate scores and develop process improvement initiatives. CMS will continue to work closely with and get input from contractors to make enhancements to the online reporting tool so that it is able to support process improvements.

CMS will continue to enhance the analytical tools so our FFS contractors can identify specific areas where they should concentrate or reduce their efforts based on the significant value or importance to the provider community. This mechanism will significantly enhance our contractors' ability to improve the services they provide to our Medicare physician and provider community.

58-K-1: PPAC recommends that CMS determine the relative benefits of pursuing the G code submission process in light of the considerable benefits associated with the episode grouper methodology.

CMS Response: CMS is evaluating the potential benefits of episode grouper technology for capturing and measuring resource use at the individual physician level. Our evaluation of the Ingenix and Medstat groupers (the two predominant grouper software products on the market) includes consideration of Medicare-specific data issues, clinical logic, risk adjustment, and relevance to physician profiling reports. After our evaluation is complete in mid-2007, we will better understand the potential uses of episode grouper technology. In the meantime, CMS is coordinating with a number of entities, including MedPAC, the AQA Alliance, and the National Quality Forum, on our episode grouper evaluation and resource use measurement activities.

58-K-2: PPAC recommends that CMS support development of outcome databases as an alternative to performance measures in the Agency's quality and cost measures initiative.

CMS Response: CMS is using G-codes and Current Procedural Terminology (CPT) category-II codes for the collection of physician self-reported quality

information. This claims-based quality reporting system is expected to be a temporary approach to data collection for physician quality measures. We have been exploring the use of clinical databases (also called outcomes databases or registries) to facilitate the collection of a more robust set of data elements to populate quality measures. We will be accelerating our consideration of clinical databases for data collection in response to the statutory mandate in the Tax Relief and Health Care Act of 2006, Section 101(b)(4), which requires CMS to address a mechanism for registry-based quality reporting. One approach under consideration is that CMS would specify standardized reporting requirements for data elements and then any registry that could meet the specifications could report physician quality data directly to the Agency. This approach to data collection would raise the value of clinical databases and thereby encourage their development.

58-O-1: PPAC recommends that CMS change calculations to use the unadjusted work RVUs in calculating indirect practice expense for the 2007 Physician Fee Schedule.

CMS Response: In the 2007 Physician Fee Schedule Final Rule, CMS stated it did not believe it would be appropriate to allow the increases in work RVUs for certain services as a result of the 5-Year Review to reduce aggregate payments for practice expenses and professional liability under the Medicare Physician Fee Schedule. We believed it was most appropriate to use the budget-neutralized work RVUs in the calculation of indirect practice expenses because this methodology appropriately maintains the current relationships between the work, practice expenses, and professional liability (malpractice insurance expense) components of the Physician Fee Schedule. We also believe it is important to apply the revised, budget-neutrality work RVUs consistently with the Physician Fee Schedule framework. It would not be consistent to apply one set of work RVUs for work payments, but a different set for purposes of calculating indirect practice expenses. Therefore, we based the calculation of both the work payments and the indirect practice expenses on the revised, budget-neutralized work RVUs in the final rule.

58-O-2: PPAC recommends that CMS use its statutory authority to remove Medicare-covered drugs from the SGR calculation.

CMS Response: CMS has carefully reviewed our authority to make administrative changes in the SGR, most notably the feasibility of removing Part B drugs from the SGR. We believe it would be statutorily difficult to make such a change and even if we were to do so, it would not provide a reprieve to the negative updates projected for the coming years.

58-O-3: PPAC recommends that CMS adjust the SGR calculation to account for increased spending due to national coverage decisions (NCDs), just as it does for Medicare Advantage payments.

CMS Response: CMS adjusts a factor of the SGR to reflect the change in the number of FFS enrollees. When the number of beneficiaries enrolled in Medicare Advantage changes and, consequently, the amount Medicare pays to Medicare Advantage plans changes, the SGR is adjusted accordingly. National coverage decisions do not affect the number of enrollees in FFS, and therefore CMS cannot adjust the SGR to reflect NCDs in the same manner.

While CMS may establish an NCD for a new item or service, the NCD does not necessarily increase Medicare spending to the extent that the service has or would have been covered at local carrier discretion in the absence of an NCD. Because Medicare might cover these services without an NCD, it is unclear whether there are any additional costs associated with the NCDs.

At the request of the Council, Dr. Simon agreed to present at the May 2007 PPAC meeting the status of a CMS pilot project in five states evaluating the feasibility of using alternative sources of data on PLI rates. Dr. Simon also agreed to describe to the Council how CMS tracks and evaluates beneficiaries' access to care.

Recommendation

59-C-1: PPAC recommends that CMS provide the Council with a semiannual update of Medicare beneficiaries' access to physician care in America.

NEW BUSINESS

Agenda Item D — 2007 Physician Quality Reporting Initiative (PQRI)

Tom Valuck, M.D., J.D., Director, Special Office for Value-Based Purchasing, described the PQRI, which was mandated by the Tax Relief and Health Care Act of 2006 to replace the Physician Voluntary Reporting Program (Presentation 1). He explained that physicians would qualify for a bonus payment of 1.5 percent, subject to a cap, on the basis of claims received by the National Claims History file by February 29, 2008. For 2008, the bonus payments will come out of the Part B trust fund. Providers will use CPT category-II codes and, as needed, G codes, on claims to identify actions taken to meet specified quality measures. The final set of quality measures and reporting requirements takes effect July 1, 2007.

Recommendations

59-D-1: PPAC recommends that CMS require fiscal intermediaries to transmit claims to the National Claims History file within 1 business day of receipt, so that any claim received by a fiscal intermediary by February 28, 2008, is transmitted

to the National Claims History file by February 29, 2008, and therefore is eligible for inclusion in the calculation of the bonus payment.

59-D-2: PPAC recommends that CMS review future models of aggregation of Part A and Part B into a global system of care.

59-D-3: PPAC recommends that CMS consider the implications of simultaneous implementation of the new 1500 form in conjunction with reporting CPT category-II codes and, more importantly, the issue of potential edits related to those submissions, to ensure accurate and timely payment of medical services.

59-D-4: PPAC requests that CMS staff explain at the next PPAC meeting the source of funds that will be used to pay for bonuses for 2008 and beyond.

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

Agenda Item E — National Provider Identifier (NPI) Update

Cathy Carter, Director, Business Applications Management Group, Office of Information Services, and Nicole Cooney, Health Insurance Specialist, Division of Provider Information Planning and Development, Provider Communications Group, illustrated the status and outreach efforts of the NPI program (Presentations 2a, 2b). About 13 percent of claims currently include an NPI number, and it is estimated that about 80 percent of Medicare physicians have been assigned an NPI. As of May 23, 2007, all providers (except small health plans) must use NPIs on all claims. The Agency is determining how to make a directory of NPIs available to providers and administrators who need them, for example, to make referrals. (CMS refers to the directory as the data dissemination notice.)

Recommendations

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

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

59-E-3: PPAC recommends that CMS establish a minimum 1-year contingency plan for implementing NPI numbers.

Agenda Item G — Transparency Initiative

Andrew Croshaw, M.B.A., Senior Executive Advisor to the Secretary of the Department of Health and Human Services, explained the Secretary's goal of creating an integrated health care system by making quality and cost information more transparent; implementing interoperable electronic systems; and aligning incentives for consumers, purchasers, and providers to seek value (Presentation 3).

Recommendations

59-G-1: PPAC recommends that CMS promote the same level of transparency for health plans as for physicians and other providers. Specifically, PPAC asks that health plans become more transparent about pricing information, physician fees, insurance claims processing and payment practices, the practice of re-underwriting, and identification of intermediaries that offer health plans unauthorized discounts and reductions in physicians' payments.

59-G-2: PPAC recommends that, to be effective and fair, CMS apply transparency initiatives to all sectors of the health care market.

59-G-3: PPAC recommends that CMS dissuade health plans from implementing policies or quality initiatives that focus on cost without regard to quality.

Agenda Item H — Recovery Audit Contract (RAC) Update

Connie Leonard, Project Officer, and Melanie Combs, R.N., Senior Technical Advisor, both of the Division of Demonstrations Management, Financial Services Group, reported the amount of overpayments and underpayments assessed and collected (or repaid) by RACs in 2006 and the lessons learned so far (Presentation 4). Claims from physicians, ambulatory clinics, and laboratories combined accounted for only 6 percent of improper payments, while claims from hospitals and skilled nursing facilities made up 78 percent of improper payments. The Agency is considering expanding the RAC program to more states and prohibiting RACs from collecting a contingency fee if a provider successfully appeals an overpayment.

Recommendations

59-H-1: PPAC recommends that, due to the demonstrated insignificant amount of overpayments recovered from physicians, RAC audits of physician practices be discontinued.

59-H-2: PPAC recommends that if a RAC audit is appealed and the provider prevails, RAC reimburse the provider 25 percent of the originally requested overpayment amount to offset the cost of the appeals process to the provider.

Presentation of Certificates to Outgoing Council Members

Dr. Gustafson presented certificates signed by Leslie Norwalk, Esq., Acting Administrator, to the outgoing members of the Council in recognition of their valuable

contributions and service to PPAC. He said he appreciates physicians taking time away from their families and practices to participate, because the Agency relies on their input to strengthen its programs.

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

William Rogers, M.D., Director of PRIT, gave an update on issues recently addressed by PRIT (Presentation 5). For example, CMS is evaluating whether physicians on active military duty may bill government payers for reimbursement for their services. Also, PRIT is working to simplify the online enrollment process (the 855 form) and attempting to clarify the definition of consultation. Proposed changes regarding volunteer faculty for graduate medical education are detailed in the CMS proposed rule for long-term care hospitals (*Federal Register*, Feb. 1, 2007, vol. 72, No. 21).

Recommendation

59-J-1: PPAC recommends that CMS hold a briefing within the next 10 days on the formula described in the proposed rule published in the *Federal Register* on February 1, 2007, about graduate medical education volunteer preceptors and transmit the information to the Accreditation Council for Graduate Medical Education and all residency review committees.

Agenda Item K — Hospital Conditions of Participation Update

Jeannie Miller, Director, Division of Institutional Quality Standards, Clinical Standards Group, described recent revisions to the hospital conditions of participation (Presentation 6). The revisions address completing and updating documentation of history and physical examinations, documenting and signing orders, storing and securing drugs and biologicals, personnel authorized to complete post-anesthesia evaluations, and the use of seclusion and restraints. Ms. Miller encouraged all providers to read the preamble to the patient rights regulation regarding seclusion and restraint.

Recommendation

59-K-1: PPAC recommends that CMS evaluate the implications of additional documentation requirements proposed by local carriers that supersede the base recommendations by CMS. In particular, PPAC recommends that CMS evaluate recent determinations that require specific documentation of negative findings as part of the review of systems.

Agenda Item M — Testimony

Charles F. Koopman, M.D., F.A.C.S., of the American Academy of Otolaryngology — Head and Neck Surgery testified that CMS should not require that a claim include specific documentation supporting negative findings in addition to positive findings from the review of systems to qualify as a level-4 or level-5 evaluation and management visit (Presentation 7). He asked CMS to allow physicians to document positive findings and state simply that findings were negative for all other systems, as is customary.

Stephen Permut, M.D., J.D., of the American Medical Association, outlined concerns about the SGR methodology, issues to be resolved before the PQRI and NPI take effect, and suggestions for RAC physician communications (Presentation 8).

Recommendation

59-M-1: PPAC appreciates the legislation passed to avert the 5-percent cut to Medicare physician payment rates planned for 2007 but remains concerned about planned cuts totaling almost 40 percent over 8 years. To avert the steep cuts and avoid the looming crisis in health care access for seniors, PPAC recommends the Secretary of the Department of Health and Human Services and CMS leadership work with Congress to repeal the SGR methodology this year and replace it with a system that adequately keeps pace with medical practice cost increases. If repeal of the SGR is not possible this year, PPAC recommends that CMS use its statutory authority to remove Medicare-covered drugs from the SGR calculation.

Comments from Outgoing Council Members

Dr. Johnson said he appreciated the opportunity to serve. Dr. Powers described ongoing concerns of physicians and hoped the Council would continue to guide the Agency in addressing these concerns. Dr. Urata noted that while the process of changing Medicare is very slow, he believes the process itself is a good one.

Agenda Item N — 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.

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

PPAC Members at the March 5, 2007, Meeting

Anthony Senagore, M.D., *Chair*
Surgeon
Cleveland, Ohio

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

Jose Azocar, M.D.
Internist
Springfield, Massachusetts

Laura Powers, M.D.
Neurologist
Knoxville, Tennessee

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

Gregory Przybylski, M.D.
Neurosurgeon
Knoxville, Tennessee

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

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

Carlos Hamilton, Jr., M.D.
Endocrinologist
Houston, Texas

M. Leroy Sprang, M.D.
Obstetrician–Gynecologist
Evanston, Illinois

Joe W. Johnson, D.C.
Chiropractor
Paxton, Florida

Robert Urata, M.D.
Family Practitioner
Juneau, Alaska

Geraldine O'Shea, D.O.
Internist
Jackson, California

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

CMS Staff Present

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

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

David C. Clark, RPH, Director
Office of Professional Relations
Center for Medicare Management

Connie Leonard, RAC Project Officer
Division of Demonstrations Management
Financial Services Group
Centers for Medicare and Medicaid Services

Melanie Combs, Senior Technical Advisor
Division of Demonstrations Management
Financial Services Group
Centers for Medicare and Medicaid Services

Jeannie Miller, Director
Division of Institutional Quality Standards
Clinical Standards Group

Nicole Cooney, Health Insurance Specialist
Division of Provider Information Planning and
Development
Provider Communications Group

Liz Richter, Director
Hospital and Ambulatory Policy Group
Center for Medicare Management

Andrew Croshaw, M.B.A., Senior Executive
Advisor to the Secretary

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

Thomas Gustafson, Ph.D., Acting Director
Center for Medicare Management

Ken Simon, M.D., Executive Director, PPAC
Center for Medicare Management

Tom Valuck, M.D., J.D., Director
Special Program Office for Value-Based
Purchasing
Centers for Medicare and Medicaid Services

Public Witnesses:

Charles F. Koopman, M.D., F.A.C.S.
American Academy of Otolaryngology — Head
and Neck Surgery

Stephen Permut, M.D., J.D.
American Medical Association

Dana Trevas, Rapporteur
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting agenda

Appendix B: Recommendations from the March 5, 2007, meeting

The following documents were presented at the PPAC meeting on March 5, 2007, and are appended here for the record:

Presentation 1: 2007 Physician Quality Reporting Initiative

Presentation 2a: Medicare Fee for Service National Provider Identifier (NPI) Implementation Initiative

Presentation 2b: National Provider Identifier (NPI) Outreach

Presentation 3: Better Care, Lower Costs: Value-Driven Health Care

Presentation 4: Recovery Audit Contractors (RACs) FY 2006 Findings and Expansion Strategy

Presentation 5: PRIT Update

Presentation 6: Revisions to the Hospital Conditions of Participation

Presentation 7: Statement of the American Academy of Otolaryngology — Head and Neck Surgery to the Practicing Physicians Advisory Council

Presentation 8: Statement of the American Medical Association to the Practicing Physicians Advisory Council

Appendix A

**Practicing Physicians Advisory Council
Hubert H. Humphrey Building
Room 705A
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201
March 5, 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 Tom Gustafson, Ph.D., Acting Director, Center for Medicare Management
08:50-09:10	C. PPAC Update	Kenneth Simon, M.D., M.B.A. Executive Director, Practicing Physicians Advisory Council, Center for Medicare Management
09:10-10:00	D. 2007 Physician Quality Reporting Initiative	Thomas Valuck, M.D., J.D. Director, Special Program Office for Value-Based Purchasing, Centers for Medicare and Medicaid Services
10:00-10:45	E. NPI Update	Cathy Carter, Director, Business Applications Management Group, Office of Information Services

and

**Nicole Cooney, Health Insurance Specialist
Division of Provider Information Planning and Development, Provider Communications Group**

10:45-11:00 F. Break (Chair discretion)

11:00-11:45 G. Transparency Initiative
Andrew Croshaw, M.B.A. Senior Executive Advisor to the Secretary, Department of Health and Human Services

11:45-12:30 H. Recovery Audit Contracts (RAC) Update
Connie Leonard, RAC Project Officer, Division of Demonstrations Management, Financial Services Group
Melanie Combs, RN, Senior Technical Advisor, Division of Demonstrations Management, Financial Services Group

12:30-1:30 I. Lunch

1:30-1:50 J. PRIT Update
William Rogers, M.D., Director, Physicians Regulatory Issues Team, Office of External Affairs, Centers for Medicare and Medicaid Services

1:50-2:35 K. Hospital Conditions of Participation Update
Jeannie Miller, Director, Division of Institutional Quality Standards, Clinical Standards Group

2:35-2:50	L. Break (Chair discretion)	
2:50-3:05	M. Testimony	<p>Charles F. Koopman, M.D., FACS, Coordinator for Practice Affairs for the AAO-HNS, American Academy of Otolaryngology Head and Neck Surgery</p> <p>Stephen R. Permut, M.D., J.D., American Medical Association</p>
3:05- 3:30	N. Wrap Up/ Recommendations	

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC) RECOMMENDATIONS Report Number Fifty-Nine March 5, 2007

Agenda Item C — PPAC Update

59-C-1: PPAC recommends that CMS provide the Council with a semiannual update of Medicare beneficiaries' access to physician care in America.

Agenda Item D — 2007 Physician Quality Reporting Initiative

59-D-1: PPAC recommends that CMS require fiscal intermediaries to transmit claims to the National Claims History file within one business day of receipt, so that any claim received by a fiscal intermediary by February 28, 2008, is transmitted to the National Claims History file by February 29, 2008, and therefore is eligible for inclusion in the calculation of the bonus payment.

59-D-2: PPAC recommends that CMS review future models of aggregation of Part A and Part B into a global system of care.

59-D-3: PPAC recommends that CMS consider the implications of simultaneous implementation of the new 1500 form in conjunction with reporting Current Procedural Terminology (CPT) category-II codes and, more importantly, the issue of potential edits related to those submissions, to ensure accurate and timely payment of medical services.

59-D-4: PPAC requests that CMS staff explain at the next PPAC meeting the source of funds that will be used to pay for bonuses for 2008 and beyond.

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

Agenda Item E — National Provider Identifier (NPI) Update

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

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

59-E-3: PPAC recommends that CMS establish a minimum 1-year contingency plan for implementing NPI numbers.

Agenda Item G — Transparency Initiative

59-G-1: PPAC recommends that CMS promote the same level of transparency for health plans as for physicians and other providers. Specifically, PPAC asks that health plans become more

transparent about pricing information, physician fees, insurance claims processing and payment practices, the practice of re-underwriting, and identification of intermediaries that offer health plans unauthorized discounts and reductions in physicians' payments.

59-G-2: PPAC recommends that, to be effective and fair, CMS apply transparency initiatives to all sectors of the health care market.

59-G-3: PPAC recommends that CMS dissuade health plans from implementing policies or quality initiatives that focus on cost without regard to quality.

Agenda Item H — Recovery Audit Contract (RAC) Update

59-H-1: PPAC recommends that, due to the demonstrated insignificant amount of overpayments recovered from physicians, RAC audits of physician practices be discontinued.

59-H-2: PPAC recommends that if a RAC audit is appealed and the provider prevails, RAC reimburse the provider 25 percent of the originally requested overpayment amount to offset the cost of the appeals process to the provider.

Agenda Item J — Physicians Regulatory Issues Team Update

59-J-1: PPAC recommends that CMS hold a briefing within the next 10 days on the formula described in the proposed rule published in the *Federal Register* on February 1, 2007, about graduate medical education volunteer preceptors and transmit the information to the Accreditation Council for Graduate Medical Education and all residency review committees.

Agenda Item K — Hospital Conditions of Participation Update

59-K-1: PPAC recommends that CMS evaluate the implications of additional documentation requirements proposed by local carriers that supersede the base recommendations by CMS. In particular, PPAC recommends that CMS evaluate recent determinations that require specific documentation of negative findings as part of the review of systems.

Agenda Item M — Testimony

59-M-1: PPAC appreciates the legislation passed to avert the 5-percent cut to Medicare physician payment rates planned for 2007 but remains concerned about planned cuts totaling almost 40 percent over 8 years. To avert the steep cuts and avoid the looming crisis in health care access for seniors, PPAC recommends the Secretary of the Department of Health and Human Services and CMS leadership work with Congress to repeal the sustainable growth rate (SGR) methodology this year and replace it with a system that adequately keeps pace with medical practice cost increases. If repeal of the SGR is not possible this year, PPAC recommends that CMS use its statutory authority to remove Medicare-covered drugs from the SGR calculation.