

# **REPORT NUMBER SIXTY-FOUR**

to the

**Secretary**

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

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**(Re: Physicians Regulatory Issues Team, National Provider Identifier, Hospital Value-Based Purchasing, Physician Quality Measures, Physician Compare Website, Electronic Health Records Demonstration, 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**

**May 19, 2008**

## SUMMARY OF THE MAY 19, 2008, MEETING

### **Agenda Item A — Introduction**

The Practicing Physicians Advisory Council (PPAC) met at the Hubert H. Humphrey Building in Washington, DC, on Monday, May 19, 2008 (see Appendix A). The chair, Vincent J. Bufalino, M.D., welcomed the Council members and introduced the new members: Joseph Giaimo, D.O., an internist/pulmonologist from West Palm Beach, FL; Pamela Howard, M.D., a surgeon from Allentown, PA; Janice Ann Kirsch, M.D., an internal medicine specialist from Mason City, IA; Fredrica Smith, M.D., an internist/rheumatologist from Los Alamos, NM; and Christopher Standaert, M.D., a physical medicine/rehabilitation specialist from Seattle, WA.

### **Agenda Item B — Welcome**

Herb Kuhn, Deputy Administrator of the Centers for Medicare and Medicaid Services (CMS), welcomed the Council members. He reiterated CMS' goal of evolving from a passive payer of services to an active purchaser of health care with input from PPAC and others. Jeffrey Rich, M.D., Director of the Center for Medicare Management, also welcomed the Council members.

### **Agenda Item C — Swearing In**

Kerry Weems, Acting Administrator of CMS, thanked the Council members for their commitment. He welcomed the new members and administered the oath to swear them in to the Council.

## OLD BUSINESS

### **Agenda Item D — PPAC Update**

Ken Simon, M.D., M.B.A., Executive Director of PPAC, presented the responses from CMS to PPAC recommendations made at the March 3, 2008, meeting (Report Number 63).

#### **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 Physicians Quality Reporting Initiative (PQRI) participation and other statistics through November 2007 that were reported by the Physician Performance Information Center.

**CMS Response:** CMS will present to the Council at its May 2008 meeting preliminary data on 2007 PQRI participation.

#### **Agenda Item H – Hospital & Physician Quality Measures**

**63-H-1:** The Council requests that CMS provide at the May 2008 meeting more detailed data on participation and reporting from the 2007 PQRI.

**CMS Response:** CMS accepts PPAC’s recommendations and the requested information on PQRI participation will be presented at the May 19, 2008, meeting.

*Agenda Item E—National Provider Identifier (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.

**CMS Response:** CMS closely monitored reject results following the March 1, 2008, deadline and shared the results with provider associations. We also meet every 2 weeks with some provider associations (e.g., the American Medical Association [AMA] and the Medical Group Management Association [MGMA]) to discuss the status of activities and share information. Rejection rates following the March 1 deadline did not suggest the need for any relief, and individual provider issues were handled on a case-by-case basis. Currently, over 99 percent of all Medicare claims are coming in with an NPI (either NPI-only or NPI/legacy pair). We continue to monitor the data as we move closer to the next deadline, which is May 23, 2008. After May 23, 2008, CMS will reject any claims that contain a legacy identifier in any field on the claim. CMS has issued temporary guidance to Medicare contractors that will facilitate the handling of enrollment application corrections and we have established “NPI Coordination Teams” at each contractor to further prioritize and facilitate corrections.

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

**63-G-1:** PPAC recommends that CMS make available the specific rules for evaluating evaluation and management (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.

**CMS Response:** CMS has not yet made a decision regarding the review by RACs of E&M codes for level of service. Before a RAC would be given the authority to review E&M codes for level of service, CMS will communicate with PPAC and the AMA. If CMS were to decide to allow the review of E&M codes by RACs, CMS would direct the RACs to use the same review methodology utilized by the Comprehensive Error Rate Testing (CERT) contractor, carriers, and Medicare administrative contractors (MACs); that is, to use either the 1995 or 1997 E&M guidelines—whichever is more advantageous to the provider.

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

**CMS Response:** CMS has released to PPAC the FY 07 RAC Status Document (which can also be found at [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC)). CMS will soon be releasing (currently scheduled for May 2008) a more detailed RAC Demonstration Evaluation Report that will include analysis of the RAC demonstration from its inception. CMS will share this report with PPAC once it is released. In addition, CMS will require the future RACs to post to their websites information about the vulnerability areas they have detected including a reference to the specific policy that is being violated. Medicare claims processing contractors can use this information to develop their error rate reduction plans which may involve more data analysis, automated review, complex review, and/or provider education. RAC-issued vulnerability information will help providers ensure that they are submitting correctly coded claims for services that meet Medicare's medical necessity criteria.

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

**CMS Response:** CMS believes that the appeal process for RAC determinations should be the same as the appeal process for carrier and MAC determinations. However, CMS will work to make more information about appeals of RAC determinations available in reports and on the CMS website.

*Agenda Item P – Wrap Up and Recommendations*

**63-P-1:** PPAC recommends that CMS clarify and define whether physicians who supply durable medical equipment, prosthetics, and orthopedics supplies (DMEPOS) as part of their professional service (as opposed to physicians acting as commercial suppliers) are subject to all the requirements of the DMEPOS competitive bidding Final Rule, including the requirement for accreditation.

**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 retain 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 competitive bid 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 this Final Rule.

**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.

**CMS Response:** In those limited situations where Part B practitioners experience severe cash flow interruptions, CMS contractors and Regional Offices should be contacted to discuss how to best resolve the issue until the clinician's NPI number is operational. We may also suggest that providers fully assess their own readiness and the readiness of their clearing house/billing service (if they use one) to ensure they are well prepared for the May 23 deadline.

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

**CMS Response:** The cost of complying with medical record requests is not separately reimbursed because it is bundled into the payment for the medical service that was provided.

**63-P-4:** PPAC urges CMS to revise subsection E-9 on staff performing complex coverage review to ensure denials of Medicare claims based on medical necessity should be reviewed by a physician in the same specialty and licensed in the same state as the physician whose claim was denied.

**CMS Response:** CMS requires that qualified clinicians, such as nurses and therapists, perform medical necessity reviews, consulting with physicians or other specialists as needed. CMS does not believe that mandating 100-percent physician review would yield a better clinical outcome for our Medicare beneficiaries.

**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.

**CMS Response:** CMS will continue to monitor the administrative burden on providers as we evaluate the RAC program. CMS is currently considering changing the minimum per claim amount where a RAC can request a medical record to \$25. RACs could still review claims on an automated basis if the claim was between \$10 and \$25.

Council members asked for more clarification of who is a commercial supplier in the context of providing DMEPOS.

*Action Item*

The agenda for the August 18, 2008, PPAC meeting will include more clarification regarding the provision of DMEPOS as part of the physicians' professional services.

Council members pointed out that CMS calculates physician practice expenses on the basis of older data that do not take into account new costs, such as the expense of providing records for RACs and others.

*Action Item*

Dr. Simon will relate to the Program Integrity Group at CMS concerns that the cost to physicians of providing records for RACs and others is not adequately captured in the physician practice expense calculations.

Council members would like to receive agenda materials earlier so they have more time to review them. Dr. Simon pointed out that the CMS responses to PPAC recommendations require clearance and often cannot be provided in advance. Council members hoped they could have as much of the agenda materials as possible earlier in advance of the meetings.

*Recommendation*

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

## **NEW BUSINESS**

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

Matthew Brown, Health Insurance Specialist for PRIT, gave an update on issues recently addressed by PRIT (Presentation 1). CMS is testing PECOS Web, an online enrollment system; anyone planning to use it can start the registration process now by signing up for Individual Authorized Access to CMS Computer Services—Provider Community (IACS-PC). At the request of MGMA, PRIT clarified the limits of compliance required for requests for chart abstraction by private fee-for-service (PFFS) plans. PRIT would like to hear from physicians who feel they are being asked to provide an unreasonable number of records by a PFFS plan. PRIT also clarified that CMS cannot intervene if a provider refuses to cover a drug prescribed at doses higher than the ranges specified by the U.S. Food and Drug Administration (FDA) on the drug label, but individuals can petition the FDA to change the labeling.

### **Agenda Item G —NPI Update**

Cathy Carter, Director of the Business Applications Management Group in the Office of Information Services, said the transition to use of the NPI is going well, with 99.9 percent of institutional claims and 98.8 percent of professional claims containing an NPI number

(Presentation 2). She believes that when CMS begins rejecting claims that include a legacy number (i.e., an identifier other than the NPI), clearinghouses that submit Medicare claims will remove legacy numbers from claims completely. Clearinghouses submit between 60 and 80 percent of Medicare claims. CMS tested their assumption with a “legacy-free day” on May 7, and contractors reported no significant increases in claim rejections, suspensions, or provider calls. Ms. Carter believes that as of May 23, 2008, by regulation, CMS must reject claims that contain legacy numbers even if they also contain NPIs. Council members were concerned that CMS lacks a mechanism for resubmitting claims rapidly when the only reason for rejection is the presence of a legacy number.

#### *Recommendations*

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

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

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

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

**64-G-5:** PPAC recommends that, if the contingency timeframe terminates on May 23, 2008, as currently planned, CMS closely monitor the rejection rates and claims processing interruptions immediately following the deadline and be prepared to allow claims to be submitted or resubmitted with the NPI and legacy numbers together if there are significant interruptions—that is, if the claims rejection or suspension rates increase more than 5 percent over baseline. PPAC requests that CMS report the results of monitoring to the Council at its August 18, 2008, meeting.

#### *Action Item*

Dr. Simon will work with Ms. Carter to determine 1) the content of the error code that is sent electronically when a claim is rejected because it lacks an NPI number and 2) which items on a claims submission fall into the initial review by CMS claims processing and e-mail the information to the Council members as soon as possible.



### **Agenda Item H — Overview of CMS Quality/Value Agenda**

Barry Straube, M.D., CMS Chief Medical Officer and Director of the Office of Clinical Standards and Quality, summarized data demonstrating that increased spending on health care does not necessarily improve quality of care (Presentation 3). He described CMS' quality improvement roadmap and strategies, including the health care transparency initiative championed by the Bush Administration and Secretary Leavitt's Four Cornerstones of Value-Driven Health Care. Dr. Straube added that Congress and employers are looking to CMS to improve the quality of health care while avoiding unnecessary costs and complications.

#### *Recommendations*

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

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

### **Agenda Item I — Compare Website on Physician Performance**

Dr. Straube noted that for years CMS has made data available for individuals to compare the performance of hospitals, dialysis facilities, and nursing homes. The Physician Compare website currently under discussion would include a physician's participation status in the Medicare program, whether the physician has agreed to participate in PQRI, and whether the physician has received an incentive payment as a result of participating in PQRI. At present, CMS does not intend to post any results from the PQRI measures on the Physician Compare website. Council members pointed out that when the PQRI program was instituted, physicians were not notified that their participation might be reported to the public and viewed as a measure of quality.

### **Agenda Item K — PQRI**

Michael Rapp, M.D., J.D., Director of the Quality Measurement and Health Assessment Group in the Office of Clinical Standards and Quality, described some of the changes to the PQRI mandated by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Presentation 4). New options for participation include reporting measures either for 6 months or the whole year and reporting measures either for a specified number of consecutive patients or for a percentage of all applicable patients. CMS is planning a PQRI registry for reporting, which it is pilot testing with a number of organizations, including some medical specialty societies.

Rachel Nelson of the Quality Measurement and Health Assessment Group provided preliminary data on PQRI participation. She noted that about 16 percent of professionals



eligible to participate did so. Ms. Nelson gave the following observations (based on preliminary findings):

- Practical and policy-related support from professional societies tends to boost participation.
- Billing systems and service vendors can help or hinder the success of claims-based quality measure reporting.
- Uncertainty about the future of the PQRI program is a barrier to participation.
- “Over-reporting,” which is not penalized, seems to be an effective approach to achieving reporting requirements.

#### *Recommendation*

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

#### **Agenda Item L — Hospital Value-Based Purchasing**

Tom Valuck, M.D., J.D., Medical Officer and Senior Advisor to the Center for Medicare Management, explained that CMS is moving from pay-for-reporting efforts to true pay-for-performance initiatives (Presentation 5). The Hospital Quality Initiative will require hospitals to submit data on all applicable measures from a starter set of 10 measures. The hospitals will receive scores that correlate with attainment of goals or improvement and earn incentive payments accordingly.

Dr. Rapp said that, as with PQRI, measures for the Hospital Quality Initiative must be consensus measures endorsed by the National Quality Forum on the basis of their importance, scientific acceptability, feasibility, and usability. CMS further requires that measures be improvable, controllable, and stable. The measures selected were also evaluated for their potential to cause unintended consequences and contribution to a comprehensive approach to quality improvement.

Dr. Valuck said that beginning October 1, 2008, CMS will no longer pay at a higher diagnosis-related group (DRG) level for certain complications that are deemed to be hospital-acquired conditions and are the only complications on the claim. The change is intended to encourage hospitals to do more to protect patient safety and improve assessment and documentation of patient conditions that are present on admission. The agency is seeking public comment on a proposed, expanded list of hospital-acquired conditions that would fall under this rule.

#### *Action Item*

Dr. Simon will determine how individuals can submit comments electronically to CMS on the value-based purchasing efforts.

### **Agenda Item N — Electronic Health Records (EHRs)**

Jody Blatt, Senior Research Analyst and Project Officer of the Division of Payment Policy Demonstrations, Medicare Demonstrations Program Group, in the Office of Research Development and Information, described a demonstration project intended to reward small and medium-sized physician practices for successfully implementing EHRs (Presentation 6). CMS is seeking input on the program structure, particularly what core functions of EHRs are most useful in physician practice and what methods CMS should use to recruit participants. Council members said that, on the basis of their own experience, EHRs are successful when most of the physicians in the office champion the technology and the whole office revamps its processes to support use of the technology.

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

The Council reviewed written testimony provided by the AMA (Presentation 7). Dr. Bufalino asked for additional recommendations from the Council. He then adjourned the meeting. Recommendations of the Council are listed in Appendix B.

#### *Recommendations*

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

**64-P-2:** PPAC recommends that, in view of the fact that medical necessity determination is subjective and requires extensive clinical review, CMS remove medical necessity determination from RACs' purview.

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

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

**64-P-5:** PPAC recommends that CMS not allow the RACs to review E&M services.

**64-P-6:** PPAC recommends that any items selected for reduction or inclusion in value-based purchasing initiatives be open to public comment and that

recommendations be published in the notice of proposed rulemaking so that specialty societies can comment.

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

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

### **PPAC Members at the May 19, 2008, Meeting**

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

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

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

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

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

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

Pamela Howard, M.D.  
Surgeon  
Allentown, Pennsylvania

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

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

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

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

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

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

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

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#### **CMS Staff Present**

Herb Kuhn, Deputy Administrator  
Centers for Medicare and Medicaid Services

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

Kerry Weems, Acting Administrator  
Centers for Medicare and Medicaid Services

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#### **Presenters**

Jody Blatt, Senior Research Analyst, Project Officer  
Division of Payment Policy Demonstrations  
Medicare Demonstrations Program Group  
Office of Research Development and Information  
Centers for Medicare and Medicaid Services

Matthew Brown, Health Insurance Specialist  
Physicians Regulatory Issues Team  
Office of Public Affairs  
Centers for Medicare and Medicaid Services

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

Rachel Nelson  
Quality Measurement and Health Assessment  
Group

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

Barry Straube, M.D., Chief Medical Officer,  
Director  
Office of Clinical Standards and Quality  
Centers for Medicare and Medicaid Services

Tom Valuck, M.D., J.D., Medical Officer, Senior  
Advisor  
Center for Medicare Management

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Dana Trevas, Rapporteur  
Magnificent Publications, Inc.

## APPENDICES

Appendix A: Meeting agenda

Appendix B: Recommendations from the May 19, 2008, meeting

*The following documents were presented at the PPAC meeting on May 19, 2008, and are appended here for the record:*

Presentation 1: PRIT Update

Presentation 2: NPI Update

Presentation 3: Overview of CMS Quality Agenda

Presentation 4: 2008 PQRI

Presentation 5: CMS' Progress Toward Implementing Value-Based Purchasing

Presentation 6: EHR Demonstration

Presentation 7: 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 & Medicaid Services  
200 Independence Avenue, SW  
Washington, DC 20201  
May 19, 2008**

<b>08:30-08:40</b>	<b>A. Open Meeting</b>	<b>Vincent Bufalino, M.D., 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>Jeffrey Rich, M.D., Director, Center for Medicare Management</b>
<b>08:50-09:30</b>	<b>C. Swearing in new PPAC members</b>	
<b>09:30-09:50</b>	<b>D. PPAC Update</b>	<b>Kenneth Simon, M.D., M.B.A., Executive Director, Practicing Physicians Advisory Council, Center for Medicare Management</b>
<b>09:50-10:10</b>	<b>E. PRIT Update</b>	<b>Matthew Brown, Health Insurance Specialist, Physicians Regulatory Issues Team, Office of Public Affairs, Centers for Medicare &amp; Medicaid Services</b>
<b>10:10-10:30</b>	<b>F. Break (Chair discretion)</b>	



<b>10:30–11:00</b>	<b>G. NPI Update</b>	<b>Cathy Carter, Director Business Applications Management Group, Office of Information Services</b>
<b>11:00:11:30</b>	<b>H. Overview of CMS Quality/ Value Agenda</b>	<b>Barry Straube, M.D. CMS Chief Medical Officer Director, Office of Clinical Standards &amp; Quality</b>
<b>11:30-12:00</b>	<b>I. Compare Website on Physician Performance</b>	<b>Barry Straube, M.D. CMS Chief Medical Officer Director, Office of Clinical Standards &amp; Quality</b>
<b>12:00-1:15</b>	<b>J. Lunch</b>	
<b>1:15-2:00</b>	<b>K. PQRI Update</b>	<b>Mike Rapp, M.D., J.D. Director, Quality Measurement and Health Assessment Group, Office of Clinical Standards and Quality</b>
<b>2:00-2:45</b>	<b>L. Hospital Value-Based Purchasing</b>	<b>Tom Valuck, M.D., J.D. Medical Officer &amp; Senior Advisor Center for Medicare Management</b>
		<b>Mike Rapp, M.D., J.D. Director, Quality Measurement and Health Assessment Group, Office of Clinical Standards and Quality</b>
<b>2:45-3:00</b>	<b>M. Break (Chair discretion)</b>	

<b>3:00-3:45</b>	<b>N. Electronic Health Record</b>	<b>Jody Blatt, Senior, Research Analyst and Project Officer, Division of Payment Policy Demonstrations, Medicare Demonstrations Program Group, Office of Research Development &amp; Information</b>
<b>3:45-4:15</b>	<b>O. Wrap Up/Recommendations</b>	

## **Appendix B**

### **PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC) RECOMMENDATIONS May 19, 2008**

#### **Agenda Item D — PPAC Update**

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

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### **Agenda Item K — Physicians Quality Reporting Initiative (PQRI)**

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## **ACTION ITEMS**

The agenda for the August 18, 2008, PPAC meeting will include more clarification regarding the provision of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) as part of the physicians' professional services.

Dr. Simon will relate to the Program Integrity Group at CMS concerns that the cost to physicians of providing records for RACs and others is not adequately captured in the physician practice expense calculations.

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Dr. Simon will determine how individuals can submit comments electronically to CMS on the value-based purchasing efforts.