

REPORT NUMBER FIFTY-SEVEN

to the

Secretary

U.S. Department of Health and Human Services

**(Re: Physicians Regulatory Issues Team Update, Medically Unlikely Edits,
Development of Pay-for-Performance Cost Measures, Medicare Advantage
Program, Physician Fee Schedule, Outpatient Prospective Payment System,
Ambulatory Surgery Centers, and other matters)**

From the

Practicing Physicians Advisory Council

(PPAC)

Hubert H. Humphrey Building

Washington, DC

August 28, 2006

SUMMARY OF THE AUGUST 28, 2006, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the Department of Health and Human Services' Hubert H. Humphrey Building in Washington, D.C., on Monday, August 28, 2006 (see Appendix A). The chair, Anthony Senagore, M.D., welcomed the Council members and said he believed their input affects the Agency's instructions and regulations.

Agenda Item B — Welcome

Herb Kuhn, Director of the Center for Medicare Management, said the Agency appreciates the practical experience the Council members bring to bear and said the Council contributes to the transparency of CMS deliberations. He noted that the terms of five Council members expire following the February 2007 meeting and CMS is accepting nominations for those spots through September 15. Mr. Kuhn gave the Council members an overview of some of the proposed rules that are open for comment. He added that CMS is expanding its efforts to measure quality by proposing that hospitals that are required to provide quality data on inpatient services (or risk a 2-percent reimbursement penalty) also provide such data for their outpatient services.

OLD BUSINESS

Agenda Item C — Update

Ken Simon, M.D., M.B.A., Executive Director of PPAC, presented the responses from CMS to PPAC recommendations made at the May 22, 2006, meeting (Report Number 56).

56-F-1: PPAC recommends that CMS change the name of the Medically Unbelievable Edits (MUE) program to remove the term "unbelievable." Some suggestions include replacing the word "unbelievable" with the word(s) "unlikely," "unusual," "unexpected associations," or "inaccurate."

CMS Response: CMS adopted the PPAC's recommendation and has changed the name of this initiative to Medically Unlikely Edits. All public communication from this date forward will reference the new title.

56-F-2: PPAC recommends that CMS allow modifiers for services that may be clinical outliers and develop an appeals process for claims denied under the MUE program.

CMS Response: CMS is considering the need of a modifier to allow for the medically necessary exception to an MUE. CMS will make a decision about the need for a modifier based on the number of potential claims that would ever be subject to an MUE. If that number is small enough it may negate the need for a claims modifier. Additionally, CMS has agreed that there will be an appeals

process for MUEs, including an appeals process for individual claims determinations and for an MUE itself.

56-F-3: PPAC recommends that when CMS publishes the proposal for an MUE subset to be implemented in January 2007, CMS provide background information on the context and rationale for the MUE program and specific data on the estimated percentage of errors that CMS hopes to address. The information and data should be disseminated through educational vehicles of the American Medical Association (AMA) and national and state specialty societies, as well as the usual CMS communication channels.

CMS Response: CMS accepts this PPAC recommendation and will include additional information about the rationale and/or supporting data for the MUEs. The MUE set that will be implemented in January 2007 will be based on anatomical criteria and will therefore not have a basis in data.

56-N-1: PPAC recommends that CMS continue to use its influence with Congress to encourage changes in physician reimbursement, particularly the sustainable growth rate, the outcome of which will enhance the Agency's ability to improve the quality of care for its beneficiaries.

CMS Response: CMS is committed to promoting high quality physicians' services for Medicare beneficiaries and remains actively involved with both Congress and the physician community on this important topic. Our goal is to design a payment system that aligns reimbursement with quality and efficiency so physicians are encouraged to provide care focused on prevention and treating complications; care focused on the most effective, proven treatments available. CMS will work with physicians and their leadership in an open and transparent way in order to support the best approaches to provide high quality health care services without creating additional costs for taxpayers and Medicare beneficiaries.

56-N-2: PPAC commends CMS for using the input of the AMA's Physician Consortium for Performance Improvement in the quality measures for the Physician Voluntary Reporting Program. PPAC recommends that all physician measures used by CMS be developed by physician specialties through the Consortium, endorsed by the National Quality Forum, and implemented across public and private programs by working through the Ambulatory Care Quality Alliance.

CMS Response: CMS appreciates the leadership role that the AMA Physician Consortium for Performance Improvement has played as a developer of physician quality measures and the role of the Ambulatory Care Quality Alliance and National Quality Forum in consensus endorsement. CMS agrees with the importance of using measures that have gone through a standardized development

process supported by broad consensus, such as is provided by the organizations named.

56-O-1: PPAC recommends that CMS continue to evaluate and correct disparities in payment to academic anesthesia programs to bring them in line with similar payment methodologies used by other teaching physicians.

CMS Response: CMS will continue to evaluate payments for teaching anesthesia services. The CMS Deputy Administrator and technical staff met with representatives of the American Society of Anesthesiologists as recently as April of this year to discuss this issue. We have previously formally requested comment on payment for teaching anesthesiologists, most recently in the proposed rule updating the physician fee schedule for calendar year 2006. In the final rule, published in the *Federal Register* on November 21, 2005, we discussed comments we received. We noted the growth in teaching anesthesia programs between 2000 and 2006 and the lack of information suggesting problems with securing access to anesthesia services. We reiterated our belief that the critical portions of the teaching anesthesia service and the teaching surgical service are not the same. We noted the lack of suggestions regarding sources of savings to fund any change in policy in this area. We stated that we would continue to review the information and relevant data presented by the commenters and consult with the stakeholders before advancing any formal proposal for changes in the payment for teaching anesthesiologists.

56-O-2: PPAC recommends that CMS resolve the issues related to electronic resubmission of denied claims as described in Transmittal 104 released by CMS on February 11, 2005, reflecting issues related to the International Statistical Classification of Diseases, 9th Revision (ICD-9) code.

CMS Response: CMS will work with Medicare contractors and provider groups to establish a process by which providers can submit previously denied claims electronically if 1) the contractor denied the claims because of simple clerical mistakes and 2) the claims are accompanied by an indicator that the provider has previously submitted them. CMS will select a sample of those claims for review by contractors' appeals staff to insure that the corrections are consistent with CMS policy.

NEW BUSINESS

Agenda Item C – PPAC Update

The Council members expressed concern about the CMS response to recommendation **56-O-1** regarding payment to academic anesthesia programs.

Recommendation

57-C-1: Because 1) the number of academic anesthesia physician training programs has declined by approximately 30 since the inception of the anesthesia teaching rule (although anesthesia nurse training programs have increased) and 2) hospitals are subsidizing academic anesthesia training programs by as much as \$400,000 to \$1 million per program per year, PPAC recommends that CMS reevaluate its decision to equalize reimbursement for academic anesthesia physician training programs.

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

William Rogers, M.D., Director of PRIT, gave an update on issues addressed by PRIT (Presentation 1). He clarified that if a physician anticipates becoming involved in an appeals process for denial of prescription drug coverage under Part D, the patient can designate the physician as an appointed representative in advance of the denial. CMS is accepting comments about a proposal to publish in the physician fee schedule the relative value units (RVUs) for neurosurgery Current Procedural Terminology (CPT) codes for which Medicare does not reimburse. Dr. Rogers said PRIT clarified that while referring physicians are required to write an order for consultation, the consulting physician is not required to verify documentation of the order. CMS is evaluating proposals provided by stakeholders to clarify the rules regarding volunteer faculty for graduate medical education. The Council remains concerned about disparate payment for academic anesthesia training programs. Karen Williams, M.D., agreed to provide CMS more data about the existing training programs.

Recommendations

57-D-1: PPAC recommends that CMS publish all of the RVUs forwarded by the RVU Update Committee, even when CMS makes a noncoverage decision for physician services.

57-D-2: PPAC thanks CMS for its 3 years of hard work on the issue of volunteer faculty in graduate medical education. PPAC recommends that CMS expedite and raise the priority for resolving the rule on volunteer faculty in graduate medical education in ambulatory settings. PPAC also requests that CMS update the Council on progress on this issue at the next PPAC meeting.

Agenda Item F — Medicare Pricing for Fee-for-Service and Advantage Plans

Sol Mussey, A.S.A., Director of the Medicare and Medicaid Cost Estimates Group; Kent Clemens, F.S.A., Actuary in the Medicare and Medicaid Cost Estimates Group; and John Shatto, F.S.A., Deputy Director, Parts C and D, Actuarial Group in the Office of the Actuary, described how Medicare Advantage payment rates are established (Presentation 2). Mr. Clemens clarified that CMS projects costs for the upcoming year, then factors its projections into the calculations used to determine the physician fee schedule.

The Council asked that CMS present at a future meeting an analysis of the overall cost savings to Medicare of covered preventive services, using bone density screening by

dual-energy x-ray absorptiometry (DEXA) and subsequent decrease in bone fractures as an example. The analysis should also address how DEXA utilization rates affect the sustainable growth rate.

Agenda Item G — Five-Year Review/Physician Fee Schedule/Practice Expense — Impact of Deficit Reduction Act (DRA) Provisions on Imaging Services

John Warren, Director of the Division of Ambulatory Services, and Edith Hambrick, M.D., J.D., Medical Officer, described proposed changes to the physician fee schedule, results of the five-year review of RVUs, and changes related to the DRA (Presentation 3). Mr. Warren explained that because the revalued RVUs for physician work would exceed the amount CMS can pay because of budget neutrality restrictions, CMS proposes to apply a 10-percent adjustment to the work value before calculating the conversion factor. The Council members felt the proposed methodology would defeat the intended purpose of revaluing the RVUs and downplay the fact that physicians would be underpaid for their work effort. Mr. Warren noted that CMS has proposed a 5.1-percent negative update to the physician fee schedule for 2007. The comment period for the proposed physician fee schedule ends October 10, 2006.

Recommendations

57-G-1: PPAC recommends that CMS use an adjustment to the conversion factor instead of a 10-percent work value adjustment to maintain budget neutrality for the 2007 physician fee schedule.

57-G-2: PPAC thanks the Secretary of the Department of Health and Human Services and CMS leadership for previous efforts to prevent a negative update to the physician fee schedule. PPAC requests that CMS continue to use its influence with Congress to implement for 2007 the 2.8-percent update recommended by the Medicare Payment Advisory Commission (MedPAC) and replace the flawed payment formula with one that takes into account actual health care inflation costs.

57-G-3: PPAC recommends that CMS provide the Council with updated information on the implications of changes to the physician fee schedule for subsequent beneficiary access to physician services.

57-G-4: PPAC recommends that CMS use reliable, accurate, current, geographically-relevant information to establish the true cost of professional liability insurance.

57-G-5: PPAC recommends that CMS consider the appropriateness of including professional liability insurance as a component of the RVU system and whether professional liability insurance should be incorporated into indirect practice expense calculations.

Agenda Item H — Outpatient Prospective Payment System (OPPS)/Ambulatory Surgery Center (ASC) Update

Joan Sanow, Deputy Director of the Division of Outpatient Services, summarized proposed changes to the reimbursement methodology used for the OPSS (Presentation 4). She explained a preliminary proposal to revise the list of procedures that would be reimbursed by Medicare when performed in an ASC. Ms. Sanow noted that for 2007, CMS proposes to base reimbursement for brachytherapy sources on median costs determined by CMS claims data.

Recommendation

57-H-1: PPAC recommends that CMS abandon the proposed methodology for determining the median cost of brachytherapy sources and reexamine the claims data on which the proposed system is based.

Remarks from the Administrator and Deputy Administrator

Mark B. McClellan, M.D., Ph.D., Administrator, thanked the Council members for their contributions to CMS policy. Asked whether CMS is considering proposing a standardized format for electronic health records, Dr. McClellan said the agency is working with various organizations and conducting pilot projects on standardizing electronic reporting for quality measures. He noted that CMS is working with Congress on the issue of support for academic anesthesia training programs. He also said CMS is seeking a solution to the issue of volunteer faculty in graduate medical education. Dr. McClellan reiterated that physician-administered drugs cannot be removed from the sustainable growth rate calculation, adding that, at this point, even if they were, the change would not result in a significant improvement in physician payment rates. Dr. McClellan acknowledged that pay-for-performance measures should take into account patient health outcomes and said CMS is seeking ways to improve beneficiaries' health while reducing overall costs.

Leslie V. Norwalk, Esq., Deputy Administrator, said CMS looks to the Council to identify issues of concern to practicing physicians. Asked how physicians could emphasize to Congress the effects of decreased physician payment on beneficiary access, Ms. Norwalk suggested physicians work with their state and national medical organizations to gather more data to inform the debate. She pointed out that CMS has established demonstration projects to identify when services provided by physicians result in reduced overall costs to Medicare. Ms. Norwalk said that New Orleans may serve as a proving ground for new approaches to Medicare policy, as the entire health care infrastructure there must be rebuilt from scratch.

Agenda Item J — MUE Program

Lisa Zone, Deputy Director of the Program Integrity Group in the Office of Financial Management, said CMS is proposing to enact a set of 2,800 MUEs based solely on anatomical considerations (Presentation 5). CMS proposes updating the list of MUEs every quarter, with a comment period for each update. Ms. Zone said CMS hopes

medical specialty societies and others will provide input on MUEs during the comment periods.

Agenda Item K — Pay for Performance: Cost Measurement Development

Tom Valuck, M.D., J.D., Medical Officer for the Center for Medicare Management, described how CMS is approaching pay-for-performance measures (Presentation 6). He explained the Agency's collaboration with other organizations on quality measurement and its pilot efforts to present meaningful physician resource use data to physicians. Dr. Valuck also described how episode grouper software could be used to assess quality of care.

Recommendations

57-K-1: PPAC commends CMS for establishing demonstration projects that would allow cash to flow from one silo to another. PPAC recommends that CMS consider more such projects, specifically those that could shift dollars saved through physician actions from Medicare Part A to Part B and that CMS educate physicians in the relevant geographic areas about the demonstration projects.

57-K-2: PPAC recommends that CMS support establishment of quality and/or pay-for-performance systems whose primary goal is to improve health care and health outcomes of the Medicare population. These programs will need additional resources to support implementation and to reward those physicians who voluntarily participate. The Council believes that pay for performance should not be budget neutral.

Agenda Item M — Electronic Prescribing

Don Romano, Director of the Division of Technical Payment Policy, explained how CMS is addressing electronic prescribing systems and electronic health records in the context of physician referrals to health care entities with which they have a financial relationship (Presentation 7). Because the statutory language of the Medicare Modernization Act is very narrow, the exception for electronic prescribing is also very narrow, Mr. Romano noted. The exception for electronic health records addresses electronic prescribing more broadly. The latter expires December 31, 2013, because it is anticipated that electronic health records will be recognized as a routine cost of doing business by then.

Agenda Item O — Testimony

Paul Martin, D.O., of the American Osteopathic Association, presented recommended guidelines for CMS as it develops its pay-for-performance and quality measurement initiatives (Presentation 8). The organization based its recommendations on its successful experience with its Clinical Assessment Program.

Agenda Item P — Wrap Up and Recommendations

Dr. Senagore noted that the next PPAC meeting would take place December 4, 2006, in Baltimore. He then adjourned the meeting. Recommendations of the Council are listed in Appendix B.

Report prepared and submitted by
Dana Trevas, Rapporteur

PPAC Members at the August 28, 2006, Meeting

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

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

Jose Azocar, M.D.
Internist
Springfield, Massachusetts

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

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

Laura Powers, M.D.
Neurologist
Knoxville, Tennessee

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

Gregory Przybylski, M.D.
Neurosurgeon
Knoxville, Tennessee

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

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

Dennis K. Iglar, M.D.
Family Practice
Oconomowoc, Wisconsin

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

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

CMS Staff Present:

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

Leslie V. Norwalk, Esq., Deputy Administrator
Centers for Medicare and Medicaid Services

Kent Clemens, F.S.A., Actuary
Medicare and Medicaid Cost Estimates Group

William Rogers, M.D., Director
Physicians Regulatory Issues Team

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

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

Edith Hambrick, M.D., J.D., Medical Officer
Center for Medicare Management

Joan Sanow, Deputy Director
Division of Outpatient Services
Center for Medicare Management

Mark B. McClellan, M.D., Ph.D., Administrator
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John Shatto, F.S.A., Deputy Director
Parts C and D, Actuarial Group
Office of the Actuary

Sol Mussey, A.S.A., Director
Medicare and Medicaid Cost Estimates Group

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

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

John Warren, Director
Division of Ambulatory Services
Center for Medicare Management

Lisa Zone, Deputy Director
Program Integrity Group
Office of Financial Management

Public Witnesses:

Paul Martin, D.O.
American Osteopathic Association

Dana Trevas, Rapporteur
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting agenda

Appendix B: Recommendations from the August 28, 2006, meeting

The following documents were presented at the PPAC meeting on August 28, 2006, and are appended here for the record:

Presentation 1: PRIT Update

Presentation 2: Medicare Pricing for Fee-for-Service Advantage Plans

Presentation 3: Five-Year Review, Physician Fee Schedule, Practice Expense — Impact of DRA Provisions on Imaging Services

Presentation 4: OPPS/ASC Update

Presentation 5: Update on MUEs

Presentation 6: Pay for Performance: Cost Measurement Development

Presentation 7: Electronic Prescribing

Presentation 8: Statement of the American Osteopathic 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
August 28, 2006**

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, Director Tom Gustafson, Ph.D, Deputy Director, Center for Medicare Management, Centers for Medicare and Medicaid Services
08:50-09:15	C. PPAC Update	Kenneth Simon, M.D., M.B.A. Executive Director, Practicing Physicians Advisory Council
09:15-09:45	D. PRIT Update	William Rogers, M.D., Director, Physicians Regulatory Issues Team, Office of Public Affairs, Centers for Medicare and Medicaid Services
09:45-10:00	E. Break (Chair Discretion)	
10:00-10:45	F. Medicare Pricing for Fee-for- Service and Advantage Plans	Sol Mussey, ASA Director, Medicare & Medicaid Cost Estimates Group

Kent Clemens, FSA

		<p>Actuary, Medicare & Medicaid Cost Estimates Group</p> <p>John Shatto, FSA Deputy Director, Parts C and D, Actuarial Group, Office of the Actuary</p>
10:45-11:30	<p>G. Five Year Review/Physician Fee Schedule/Practice Expense --Impact of DRA Provisions On Imaging Services</p>	<p>John Warren, Director, Division of Ambulatory Services, Center for Medicare Management</p> <p>Edith Hambrick, M.D. Medical Officer, Center for Medicare Management</p>
11:30-12:15	<p>H. OPPTS/ ASC: Update</p>	<p>Jim Hart, Director, Division of Outpatient Services, Center for Medicare Management</p> <p>Edith Hambrick, M.D. Medical Officer Center for Medicare Management</p>
12:15-1:15	<p>I. Lunch</p>	
1:15-2:00	<p>J. Update on Medically Unlikely Edits</p>	<p>Lisa Zone Deputy Director Program Integrity Office of Financial Management</p>
2:00-2:45	<p>K. Pay for Performance: Cost Measurement Development</p>	<p>Tom Valuck, M.D., J.D. Medical Officer, Center for Medicare Management</p>

2:45-3:00	L. Break (Chair Discretion)	
3:00-3:20	M. Electronic Prescribing	Don Romano, Director, Division of Technical Payment Policy Center for Medicare Management
3:20-3:45	N. Testimony	Dr. Paul Martin, D.O. American Osteopathic Association; and Others
3:45-4:15	O. Wrap Up/Recommendations	

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC) RECOMMENDATIONS Report Number Fifty-Seven August 28, 2006

Agenda Item C – PPAC Update

57-C-1: Because 1) the number of academic anesthesia physician training programs has declined by approximately 30 since the inception of the anesthesia teaching rule (although anesthesia nurse training programs have increased) and 2) hospitals are subsidizing academic anesthesia training programs by as much as \$400,000 to \$1 million per program per year, PPAC recommends that CMS reevaluate its decision to equalize reimbursement for academic anesthesia physician training programs.

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