REPORT NUMBER SEVENTY

to the

Secretary

U.S. Department of Health and Human Services

(Re: Physicians Regulatory Issues Team, Physician Quality Reporting Initiative, e-Prescribing, Physician Resource Use Measurement and Reporting Program, Quality Improvement Initiative, 10th Scope of Work, Medicare Physician Fee Schedule Final Rule, Outpatient Prospective Payment System and Ambulatory Surgical Center Final Rule, and other matters)

From the

Practicing Physicians Advisory Council

(PPAC)

Hubert H. Humphrey Building

Centers for Medicare & Medicaid Services

Washington, DC

December 7, 2009

SUMMARY OF THE DECEMBER 7, 2009, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the Hubert H. Humphrey Building in Washington, DC, on Monday, December 7, 2009 (see Appendix A). Vincent Bufalino, M.D., chair, welcomed the Council members and speakers. He welcomed two new members: Chiledum A. Ahaghotu, M.D., a urologist and surgeon from Washington, DC, and Richard E. Smith, M.D., an obstetrician-gynecologist from Detroit, Michigan. Dr. Bufalino noted that the presentation on fraud and abuse would be postponed until the March 2010 meeting.

Agenda Item B — Welcome

Liz Richter, Deputy Director of the Center for Medicare Management (CMM) in the Centers for Medicare & Medicaid Services (CMS), welcomed the Council members and emphasized the value of their input. Barry Straube, M.D., Chief Medical Officer and Director of the Office of Clinical Standards and Quality, added that members' comments will be helpful to CMS as it considers policies for 2010 and pending health care reform legislation. Dr. Straube said CMS is preparing a notice of proposed rulemaking regarding adoption of electronic health records under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

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 August 31, 2009, meeting (Report Number 69).

Agenda Item H — Medicare Physician Fee Schedule Notice of Proposed Rulemaking

69-H-1: PPAC recommends that CMS fully implement the data from the American Medical Association's (AMA's) Physician Practice Information Survey (PPIS) to more accurately calculate practice expense relative value units (RVUs) and more fairly calculate reimbursement for all medical specialties. The data should be fully implemented in 2010.

CMS Response: The response to this recommendation is outlined in the Medicare Physician Fee Schedule (MPFS) Final Rule published in the *Federal Register* Notice on October 30, 2009. We will thoroughly address this recommendation during the MPFS presentation at the December 7, 2009, PPAC meeting.

69-H-2: PPAC recommends that CMS review the AMA PPIS' extrapolation of geographic data when it becomes available.

CMS Response: The PPIS was not designed to capture geographic cost differences; it was designed to collect national practice expense data that could be

used for the allocation of direct and indirect practice costs. CMS purchased certain specialty-level aggregate cost survey data from the AMA under a separate contract. To the extent the AMA would consider making geographic cost data available to CMS, it would be reviewed and considered along with any other information provided.

69-H-3: PPAC recommends that, if CMS decides to form a supervisory body to oversee the AMA's Relative Value Scale Update Committee, PPAC be considered as the appropriate group to perform that role.

CMS Response: The response to this recommendation is outlined in the MPFS Final Rule published in the *Federal Register* Notice on October 30, 2009. We will thoroughly address this recommendation during the MPFS presentation at the December 7, 2009, PPAC meeting.

69-H-4: Any move to decrease compensation for consultative services will adversely affect access to these services and severely affect the quality of care for beneficiaries. Therefore, PPAC recommends that CMS reevaluate studies that determine the actual cost of providing consultative care and provide the findings to PPAC.

CMS Response: The response to this recommendation is outlined in the MPFS Final Rule published in the *Federal Register* Notice on October 30, 2009. We will thoroughly address this recommendation during the MPFS presentation at the December 7, 2009, PPAC meeting.

69-H-5: PPAC believes that 1) recent CMS statements questioning the quality of current academic anesthesiology practice are unfounded and 2) that the intent of Section 139 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was simply to restore full payment to academic anesthesiology training programs based on current practice. Therefore, PPAC recommends that CMS implement Section 139 of MIPPA without the additional criteria requiring that only one individual teaching anesthesiologist (the one who initially started the case) be present during all of the key and critical portions of the anesthesia procedure.

CMS Response: The response to this recommendation is outlined in the MPFS Final Rule published in the *Federal Register* Notice on October 30, 2009. We will thoroughly address this recommendation during the MPFS presentation at the December 7, 2009, PPAC meeting.

Agenda Item K — Fraud and Abuse Update and Recovery Audit Contractor (RAC) Update
69-K-1: PPAC recommends that CMS provide to PPAC at the next meeting statistics on fraud and abuse involving physicians in the Medicare program.

CMS Response: When CMS or its contractors have reason to believe that potential fraud exists, the agency refers such instances to the Office of the Inspector General to further investigate and determine if fraud has occurred. CMS cannot make a determination of fraud but can only ascertain if there is potential fraud and then refer cases to the Office of the Inspector General and the Department of Justice for a final determination and further action. Potential fraud with physicians has not been a significant issue for CMS. CMS does not maintain data or statistics specific to physicians pertaining to fraud and abuse. Our fraud investigations have been primarily on type of service rather than type of provider.

69-K-2: PPAC recommends that CMS provide PPAC information on its mechanism for oversight of investigations by RACs and the guidelines for when investigations should be terminated when no problems are found.

CMS Response: The RAC Statement of Work included many changes that CMS will use to monitor a RAC's performance. The RACs typically do not complete investigations but when necessary provide their findings to the Program Integrity Group for their consideration and determination of next steps. The RACs review claims data to determine the probability of an improper payment. Sometimes this can be completed without medical record review and sometimes additional documentation is necessary. The RACs must have all new issues approved by CMS prior to review. Part of the approval process is the review of the edit parameters being used by the RAC. CMS agrees with PPAC that a review should not continue or even begin if improper payments are not probable. At this time there are no set limitations on the RACs regarding when a review should cease. Since the RACs are paid on a contingency basis, it is not cost effective for the RAC to continue to request documentation on claims that do not have a high probability of an improper payment. In addition, CMS believes the medical record request limits prohibit the RAC from reviewing a large percentage of a physician's records. However, as the program expands nationwide, CMS will monitor the impact of complex medical review on physicians to determine if other limits need to be put into place.

69-K-3: PPAC recommends that CMS establish a neutral arbitrator at CMS, outside the RACs, to whom physicians or other providers can appeal for assistance when a RAC investigation seems unreasonable.

CMS Response: If a provider disagrees with a RAC claim determination the provider should contact the RAC. The RAC contact information can be found at: http://www.cms.hhs.gov/RAC/Downloads/RAC%20contact%20information.pdf. If the provider wishes to speak directly with the RAC Contractor Medical Director, the RACs are required to ensure that the RAC Medical Director is available to speak with the provider. Providers may also utilize the RAC discussion period, which affords the provider the opportunity to rebut the initial claim determination prior to funds being recouped. If the provider is unable to resolve the issue by speaking with the RAC staff, RAC Contractor Medical

Director, or through utilizing the discussion period, a provider can contact the appropriate CMS RAC Project Officer. The chart below provides the contact information for the RAC Project Officers. In the event the provider feels that a neutral arbitrator is needed, CMS would recommend that the physician appeal the improper payment determination through the administrative appeals process. Information related to the administrative appeals process can be found at http://www.cms.hhs.gov/OrgMedFFSAppeals/. The Medicare administrative appeals process is independent from the identification of the improper payment.

RAC	CMS Contact Person	Phone
Region A: DCS	Ebony Brandon	410-786-1585
Region B: CGI	Scott Wakefield	410-786-4301
Region C: Connolly Healthcare	Amy Reese	410-786-8627
Region D: HDI	Kathleen Wallace	410-786-1534

Agenda Item M — Wrap Up
69-M-1: PPAC recommends that CMS explain its use of a 10-percent threshold for attribution of care in its resource utilization reports (RURs), instead of the 25–30 percent recommended by the Leapfrog Group and the National Committee for Quality Assurance and the 35-percent threshold that the Medicare Payment Advisory Commission (MedPAC) employed in its analysis.

CMS Response: In developing and testing physician RURs, CMS is considering a variety of ways to attribute resource use to physicians. We agree that there is currently no consensus on what methodology should be used. For example, as PPAC indicates, MedPAC previously published studies using 35 percent of evaluation and management (E&M) services as a minimum threshold. However, more specifically, MedPAC used a *single* attribution method with a 35-percent threshold of E&M dollars; that is, if a physician was responsible for at least 35 percent of the E&M dollars in a given episode, MedPAC attributed that episode, and *all* its costs, to that physician. MedPAC cautioned that policymakers should not interpret their use of a 35-percent threshold of E&M dollars as a recommendation. In contrast, for the Phase I reports where CMS used a 10-percent threshold, CMS used a *multiple* attribution method in which the total costs were attributed to each physician responsible for the care provided, based on the percentage of E&M services that each physician furnished to the patient. For the Phase I reports, we chose to test the multiple attribution approach because it recognizes that treating physicians frequently have incomplete control over treatment by specialists and other physicians. We believe our program complements the earlier work by MedPAC. As we further refine the Physician

Resource Use Measurement and Reporting Program, we intend to further explore these methodological issues and welcome further suggestions from PPAC, MedPAC, and others.

69-M-2: PPAC recommends that CMS provide data on the number of appeals and percentage of overturned cases of RAC determinations, by RAC and, if possible, by the site of the appellant's practice, at least annually.

CMS Response: CMS is required to provide an annual Report to Congress. The number of appeals by RAC, the number of appeals by Medicare Administrative Contractor jurisdiction, and the percentage of RAC determinations that are overturned will be included in the annual report. CMS may be able to provide information related to the number of appeals and percentages based on the State of the appellant's practice. CMS will explore the feasibility of reviewing site of service information.

69-M-3: PPAC recommends that CMS provide data from the validation contractor reports for each of the RACs at least annually.

CMS Response: The validation contractor is required to complete an accuracy score for each RAC. The accuracy score will be based on a sample of improper payments identified by the RAC and the accuracy of the determination. CMS will include the accuracy scores (which will be an annual percentage) in the annual Report to Congress. The fiscal year (FY) 2009 Report to Congress will be mostly narrative focusing on implementation activities. The first accuracy scores will be reported in the FY 2010 Report to Congress. The report is posted annually on the CMS website at www.cms.hhs.gov/rac after the beginning of the calendar year.

Janice Ann Kirsch, M.D., suggested that, in addition to the data from the AMA's PPIS, CMS consider the AMA's report analyzing physician practice expenses by location. Jeffrey A. Ross, D.P.M., M.D., pointed out that PPAC has asked repeatedly for more specific information from CMS about the role of physicians in fraud and abuse, to no avail. Ms. Richter offered to seek out information on medical reviews that lead CMS to request repayments. She also proposed that CMS staff members who deal with medical reviews give a presentation at the next PPAC meeting, in addition to the fraud and abuse program update, so that PPAC can consider the broader issue of mistaken payments.

NEW BUSINESS

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

William Rogers, M.D., Director of PRIT, said his office has succeeded in facilitating crossover claims between Medicare and Medicaid programs in New Jersey and New York; the issue is still being addressed in South Carolina (Presentation 1). Dr. Rogers said that Medicare Advantage organizations and their providers will not be required to

undergo further training on fraud, waste, and abuse if they have already met certification requirements. He said that Medicare will pay physicians who treat the family members of another physician in their practice but will not pay for other services ordered for those family members, which is the most CMS can do without changing the entire rule. In addition, CMS pushed its deadline for physician enrollment in the Provider Enrollment, Chain, and Ownership System (PECOS) to April 24, 2010, so that all providers have time to enroll or re-validate their enrollment. After that date, Medicare will not pay for services provided by physicians who are not enrolled. Dr. Rogers said PRIT is addressing a new rule that redefines how the date and place of service should be documented and billed, which may pose challenges for radiologists and pathologists. Also, PRIT is communicating with physicians about the upcoming changes to billing for consultations.

Several PPAC members said they are not enrolled in PECOS and have not received any communication about the requirement to enroll. Others said the enrollment process and forms are burdensome, complicated, time-consuming, and unclear. Several pointed out that the transition to national provider identifier numbers resulted in significant payment delays and raised concerns that enrolling in PECOS would cause the further payment problems.

Recommendations
70-D-1: PPAC recommends that the CMS requirement that physicians be enrolled in PECOS be delayed for 18 months.

70-D-2: PPAC recommends that CMS review the PECOS enrollment form with an independent, unbiased consultant and make the form more user-friendly.

Arthur D. Snow, M.D., noted that the changes regarding date and place of service could mean that some clinicians are not paid for services provided to a beneficiary who has since died. Jonathan E. Siff, M.D., pointed out that the change will also complicate documentation and could pose clinical problems.

Recommendation
70-D-3: PPAC recommends that CMS table its requirement to modify the billing for date and place of service.

A number of members stated that in rural areas, beneficiaries may not have access to physicians or medical services outside of a family member's practice. In some urban areas, almost all the physicians may be linked to one another through a large group practice; thus, most patients would be considered a family member of a physician in one's own practice.

Recommendation
70-D-4: PPAC recommends that CMS reevaluate its policy on paying for treatment of family members, specifically the decision not to cover services ordered.

Agenda Item E —Physicians Quality Reporting Initiative (PQRI), E-Prescribing, and Physician Resource Use Measurement and Reporting Program Update

Michael Rapp, M.D., J.D., Director of the Quality Measurement and Health Assessment Group in the Office of Clinical Standards and Quality, provided data comparing participation in PQRI in 2007 and 2008 (Presentation 2). He noted that when CMS analyzed the results for physicians who submitted information covering 10 or more months of service, about 75–80 percent of physicians succeeded in earning the incentive payment.

Dr. Rapp said that CMS responded to concerns raised by the AMA and others about the feedback reports on PQRI participation. Individual physicians can request a feedback report through their carrier, eliminating the need to obtain the security clearance required to get the report online. Also, CMS has established a PQRI help desk to answer questions. Dr. Rapp reviewed the changes to the PQRI for 2010, noting that CMS did not finalize its proposal to make some PQRI data available to the public.

Colleen Bruce, J.D., Health Insurance Specialist in the Division of Practitioner Services, described CMS' program to provide feedback to physicians via RURs (Presentation 3). From the Phase I of the program, CMS learned that 1) physicians find the reports too lengthy but appreciate all the information in them, 2) cost information alone is not meaningful without correlating information on quality, and 3) physicians are concerned about the methods used for risk-adjustment and attribution. In Phase II of the program, CMS may incorporate into the RURs quality information gathered from other CMS programs.

Sheila Roman, M.D., M.P.H., Medical Officer for the Hospital & Ambulatory Policy Group, said CMS is reaching out to stakeholders to learn how to improve the RURs. She asked for input from PPAC on refining the methodology while cautioning that no approach will be perfect. Dr. Roman added that CMS hopes to create its own episode grouper technology for Medicare claims.

In response to Dr. Bufalino, Dr. Rapp said the Secretary of the Department of Health and Human Services (HHS) has the authority to change the criteria for earning incentive payments through the PQRI, but only Congress can change the amount of the incentive. Several PPAC members commented that the incentive payments do not offset the cost of participating.

Christopher Standaert, M.D., said the RURs do not provide sufficient information about the methodology used and so present a misleading picture. Ms. Roman said she would take up that concern as CMS revised the RURs for the next phase and would report back to PPAC at a future meeting. In response to Dr. Ahaghotu, Ms. Bruce outlined the method of attribution of costs to individual physicians.

Agenda Item G — Quality Improvement Initiative

Dr. Straube offered an overview of the CMS strategy for quality improvement, describing how individual initiatives, such as PQRI, fit in to the big picture (Presentation 4). He explained that CMS is engaged in traditional quality improvement efforts that go beyond collecting and reporting data (such as the focus on reducing hospital-acquired infections). In addition, CMS is focusing on transparency (through public reporting of data) and incentives to encourage better quality care. Dr. Straube outlined various CMS efforts to address quality improvement on multiple fronts. He said some evidence supports that quality improvement efforts can result in shorter hospital stays and fewer readmissions, thus cutting costs and making a business case for investing in quality improvement.

In response to Dr. Ahaghotu, Dr. Straube said that CMS is attempting to identify and address health care disparities in every initiative and program. Dr. Ross cited recent studies indicating the cost-benefit of preventive services, and Dr. Straube agreed, noting that Congress is seeking to broaden access to care for all citizens. In response to Dr. Ross, Dr. Straube acknowledged that hospital-acquired infections and complications will never be completely eradicated, but efforts to reduce them have met with some success. Dr. Standaert pointed out that most of CMS' value-based purchasing programs, such as PQRI, are constructed for hospital models and then applied to physicians, who function in a completely different way and lack the administrative infrastructure needed to participate in the programs successfully.

Agenda Item H — 10th Scope of Work

Paul McGann, M.D., Deputy Chief Medical Officer of the Office of Clinical Standards and Quality, described the role of the Quality Improvement Organizations, whose work is governed by three-year contract cycles (Presentation 5). The ninth scope-of-work contract represents a renewed emphasis on better contract management and attempts to break down the silos of care that prevent providers from implementing effective quality improvement. The 10th scope-of-work contract will be awarded in August 2011 and will be organized around the same principles as the ninth: beneficiary protection, preventive care, patient safety, and regional/local projects (on such issues as care transitions, diabetes self-management, and chronic kidney disease).

Dr. Kirsch pointed out that the so-called Welcome to Medicare prevention-oriented examination is underused, as Dr. McGann said, because it is so rigidly structured. She encouraged CMS to look at how it reimburses for preventive care such as breast and pelvic examinations and to better align payment with the ideal intervals for preventive care. Dr. Straube added that HHS has no intention of changing its current coverage for mammography, regardless of recent findings questioning the effectiveness of mammography for screening for breast cancer before age 50.

Agenda Item I — Swearing-In Ceremony

Charlene Frizzera, Acting Administrator of CMS, swore in the new PPAC members. She stressed that CMS values and listens to the input from the Council. Ms. Frizzera noted that CMS tracks the current health care reform debate in Congress by dividing issues into

two “buckets”: those affecting the day-to-day operations of Medicare and Medicaid and larger issues that reflect broad political concerns.

Morning Wrap-Up and Recommendations

Dr. Bufalino asked members for additional recommendations related to presentations made throughout the morning.

Recommendations

70-A.M.-1: PPAC recommends that if hospital-acquired complications occur despite providers taking reasonable precautions to prevent them, reimbursement should not be denied. PPAC further recommends that CMS review the policy regarding reimbursement when hospital-acquired complications occur.

70-A.M.-2: PPAC recommends that CMS revise its 10-percent threshold multiple attribution method for RURs so that providers who provide E&M services to a beneficiary before or after a hospitalization split no more than 20 percent of the total cost of care for that beneficiary; the other 80 percent (or more) of the cost should be attributed to the attending physicians and surgeons involved in the beneficiary’s care.

70-A.M.-3: PPAC recommends that CMS reconsider its presentation of numerical data in the RURs to accurately reflect the statistical validity of that data.

70-A.M.-4: PPAC recommends that CMS include in the RURs reporting on factors that affect the costs of patient care, i.e., patient complexity and comorbidity, local practice costs, setting of care, and similar factors.

70-A.M.-5: PPAC recommends that CMS propose that Congress authorize at least a 5-percent incentive payment for successful completion of PQRI reporting in 2011.

70-A.M.-6: PPAC recommends that CMS be required to adequately inform the provider community about the requirement to enroll in the PECOS system.

Agenda Item K — MPFS Final Rule

Marc Hartstein, Deputy Director of the Hospital & Ambulatory Policy Group, said the Final Rule contains a large negative update as a result of the conversion factor; overall, fees are expected to decrease by 21.2 percent for calendar year (CY) 2010 (Presentation 6). The Final Rule removes physician-administered drugs from the calculation of the sustainable growth rate, but that change will not affect the 2010 update. In addition, the Final Rule eliminates the use of consultation codes in all settings except telehealth; instead, providers will use the billing codes for the initial hospital or nursing facility care.

Mr. Hartstein said the practice expense RVUs will be updated using the AMA’s PPIS data over a four-year transition period. Practice expenses for independent diagnostic

testing facilities and independent laboratories will be calculated using supplemental survey data. By statutory requirement, CMS will calculate oncology practice expenses using oncology-specific supplemental survey data.

Cassandra Black, Director of the Division of Practitioner Services, said CMS will gradually raise the utilization rate for equipment that costs more than $1 million (except therapeutic equipment) from 50 percent to 90 percent over four years. To update the malpractice RVUs, CMS will adopt new data and use actual premium data for independent diagnostic testing facilities. Ms. Black described the revisions to the proposed rule on payment and handoffs involving teaching anesthesiologists and certified registered nurse-anesthetists (who are treated separately according to MIPPA provisions).

Several members asked for clarification on a number of points, particularly the elimination of consultation codes, which poses complications for beneficiaries who have both private insurance and Medicare. Mr. Hartstein said CMS would provide educational materials about the coding change before the rule is implemented.

Recommendations

70-K-1: PPAC recommends that CMS delay for at least one year implementation of its regulatory policy that prohibits paying for consultation services, which will allow time for education about and clarification of the changes.

70-K-2: PPAC recommends that CMS recommend to Congress to avoid the 21-percent cut on January 2010 and advise Congress to reform the seriously flawed sustainable growth rate formula. PPAC further recommends that CMS recommend that Congress provide physicians with reimbursement that keeps up with the costs of practicing medicine.

70-K-3: PPAC recommends that CMS reconsider its decision to eliminate consultation codes and remain consistent with AMA's Current Procedural Terminology guidelines and MedPAC recommendations.

Agenda Item L — Outpatient Prospective Payment System/Ambulatory Surgical Center Final Rule

Carrie Bullock, M.H.S., Acting Deputy Director of the Division of Outpatient Care, outlined the Final Rule (Presentation 7). In CY 2010, CMS will pay for drugs, biologicals, and radiopharmaceuticals at a rate of average sales price plus four percent for all those that cost more than $65 per day, which includes a redistribution of $200 million in pharmacy overhead costs currently attributed to packaged drugs (those that cost less than $65 per day that are packaged with the costs of the procedure). Ms. Bullock described several other components of the Final Rule, most of which mirror the changes proposed and described to the Council at the August PPAC meeting.

Agenda Item O — Wrap Up and Recommendations

The Council reviewed the written testimony from the AMA (Presentation 8). Dr. Bufalino asked for additional recommendations from the Council.

Recommendation
70-O-1: PPAC recommends that CMS rapidly clarify the procedures for using E&M codes in a clinical setting involving the appropriate use of a consultation code that is covered by an additional insurance carrier.

The Council members reviewed the day's recommendations. Dr. Kirsch asked that CMS consider scheduling the March 2011 PPAC meeting closer to the AMA's annual Washington meeting. Dr. Standaert requested an update on the RACs at the March 2010 PPAC meeting. Recommendations of the Council are listed in Appendix B. Dr. Bufalino adjourned the meeting.

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

PPAC Members at the December 7, 2009, Meeting

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

Chiledum A. Ahaghotu, M.D.
Urologist/Surgeon
Washington, DC

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

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

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

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

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

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

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

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

Richard E. Smith, M.D.
Obstetrician-Gynecologist
Detroit, Michigan

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

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

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

CMS Staff Present

Liz Richter, Deputy Director
Center for Medicare Management

Ken Simon, M.D., M.B.A., Executive Director
Practicing Physicians Advisory Council
Center for Medicare Management

Barry Straube, M.D., Chief Medical Officer, Director
Office of Clinical Standards and Quality

Presenters

Cassandra Black, Director
Division of Practitioner Services
Hospital & Ambulatory Policy Group
Center for Medicare Management

Colleen Bruce, J.D., Health Insurance Specialist
Division of Practitioner Services
Hospital & Ambulatory Policy Group
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Carrie Bullock, M.H.S., Acting Deputy Director
Division of Outpatient Care
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Charlene Frizzera, Acting Administrator
Centers for Medicare & Medicaid Services

Marc Hartstein, Deputy Director
Hospital & Ambulatory Policy Group
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Paul McGann, M.D., Deputy Chief Medical Officer
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Michael Rapp, M.D., J.D., Director
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William Rogers, M.D., Director
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Sheila Roman, M.D., M.P.H., Medical Officer
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Dana Trevas, Rapporteur
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John O'Leary, Sound Engineer
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APPENDICES

Appendix A: Meeting agenda
Appendix B: Recommendations from the December 7, 2009, meeting

The following documents were presented at the PPAC meeting on December 7, 2009:

Presentation 1: PRIT Update
Presentation 2: PQRI and E-Prescribing Update
Presentation 3: Physician Resource Use Measurement and Reporting Program Update
Presentation 4: Quality Improvement Initiative
Presentation 5: Strategic Planning in the Quality Improvement Organization Program
Presentation 6: Medicare Physician Fee Schedule Final Rule with Comment Period
Presentation 7: OPPS/ASC Fee Schedule Final Rule
Presentation 8: Statement of the American Medical Association

Appendix A

Practicing Physicians Advisory Council
Hubert H. Humphrey Building
Room 505A
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201
12-7-2009

08:30-08:40	**A. Opening Remarks**	**Vincent J. Bufalino, M.D., Chairman, Practicing Physicians Advisory Council**
08:40-08:50	**B. Welcome**	**Liz Richter, Deputy 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**
09:10-09:30	**D. PRIT Update**	**William Rogers, M.D., Director, Physicians Regulatory Issues Team, Office of External Affairs**
09:30-10:30	**E. 2010 PQRI and E-Prescribing Update**	**Michael Rapp, M.D., J.D., Director, Quality Measurement and Health Assessment Group, Office of Clinical Standards and Quality**
	Physician Resource Use Measurement And Reporting Program Update	**Sheila Roman, M.D., MPH, Medical Officer, Hospital & Ambulatory Policy Group, Center for Medicare Management**
		Colleen Bruce, J.D., Health Insurance Specialist, Division of Practitioner Services, Hospital & Ambulatory Policy Group, Center for Medicare Management

10:30-10:45	**F. Break** (*Chair Discretion)*	
10:45-11:30	**G. Quality Improvement Initiative**	**Barry Straube, M.D., Chief Medical Officer, Director, Office of Clinical Standards & Quality**
11:30-12:15	**H. 10th Scope of Work Update**	**Paul McGann, M.D., Deputy Chief Medical Officer, Office of Clinical Standards & Quality**
12:15-01:15	**I. Lunch**	
01:15-01:45	**J. Swearing-in Ceremony**	**Charlene Frizzera, Acting Administrator, Centers for Medicare & Medicaid Services**
01:45-02:15	**K. Medicare Physician Fee Schedule (MPFS) Final Rule**	**Cassandra Black, Director, Division of Practitioner Services, Hospital & Ambulatory Policy Group, Center for Medicare Management** **Marc Hartstein, Deputy Director, Hospital & Ambulatory Policy Group, Center for Medicare Management**
02:15-02:45	**L. OPPS/ASC Fee Schedule Final Rule**	**Carrie Bullock, M.H.S., Acting Deputy Director, Division of Outpatient Care, Hospital & Ambulatory Policy Group, Center for Medicare Management**
02:45-03:00	**M. Break** *(Chair Discretion)*	

03:00-03:45	**N. Fraud and Abuse Update**	**Kim Brandt, Director, Program Integrity Group, Office of Financial Management**
03:45-04:15	**O. Wrap Up and Recommendations**	

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC)
RECOMMENDATIONS
Report Number Seventy
December 7, 2009

Agenda Item D — Physicians Regulatory Issues Team Update

70-D-1: PPAC recommends that the Centers for Medicare & Medicaid (CMS) requirement that physicians be enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS) be delayed for 18 months.

70-D-2: PPAC recommends that CMS review the PECOS enrollment form with an independent, unbiased consultant and make the form more user-friendly.

70-D-3: PPAC recommends that CMS table its requirement to modify the billing for date and place of service.

70-D-4: PPAC recommends that CMS reevaluate its policy on paying for treatment of family members, specifically the decision not to cover services ordered.

Morning Wrap-Up and Recommendations

70-A.M.-1: PPAC recommends that if hospital-acquired complications occur despite providers taking reasonable precautions to prevent them, reimbursement should not be denied. PPAC further recommends that CMS review the policy regarding reimbursement when hospital-acquired complications occur.

70-A.M.-2: PPAC recommends that CMS revise its 10-percent threshold multiple attribution method for resource use reports (RURs) so that providers who provide evaluation and management services to a beneficiary before or after a hospitalization split no more than 20 percent of the total cost of care for that beneficiary; the other 80 percent (or more) of the cost should be attributed to the attending physicians and surgeons involved in the beneficiary's care.

70-A.M.-3: PPAC recommends that CMS reconsider its presentation of numerical data in the RURs to accurately reflect the statistical validity of that data.

70-A.M.-4: PPAC recommends that CMS include in the RURs reporting on factors that affect the costs of patient care, i.e., patient complexity and comorbidity, local practice costs, setting of care, and similar factors.

70-A.M.-5: PPAC recommends that CMS propose that Congress authorize at least a 5-percent incentive payment for successful completion of Physician Quality Reporting Initiative reporting in 2011.

70-A.M.-6: PPAC recommends that CMS be required to adequately inform the provider community about the requirement to enroll in the PECOS system.

Agenda Item K — Medicare Physician Fee Schedule Final Rule

70-K-1: PPAC recommends that CMS delay for at least one year implementation of its regulatory policy that prohibits paying for consultation services, which will allow time for education about and clarification of the changes.

70-K-2: PPAC recommends that CMS recommend to Congress to avoid the 21-percent cut on January 2010 and advise Congress to reform the seriously flawed sustainable growth rate formula. PPAC further recommends that CMS recommend that Congress provide physicians with reimbursement that keeps up with the costs of practicing medicine.

70-K-3: PPAC recommends that CMS reconsider its decision to eliminate consultation codes and remain consistent with American Medical Association's Current Procedural Terminology guidelines and Medicare Payment Advisory Commission recommendations.

Agenda Item O — Wrap Up and Recommendations

70-O-1: PPAC recommends that CMS rapidly clarify the procedures for using evaluation and management codes in a clinical setting involving the appropriate use of a consultation code that is covered by an additional insurance carrier.