

REPORT NUMBER SIXTY-SIX

to the

Secretary

U.S. Department of Health and Human Services

(Re: Physician Fee Schedule Final Rule, Physicians Regulatory Issues Team, Stark Reform, Outpatient Prospective Payment System and Ambulatory Surgical Centers Fee Schedule Final Rule, Recovery Audit Contractors, Value-Based Purchasing Efficiency Measures, Physician Quality Reporting Initiative, Medically Unlikely Edits, and other matters)

From the

Practicing Physicians Advisory Council

(PPAC)

Hubert H. Humphrey Building

Centers for Medicare and Medicaid Services

Washington, DC

December 8, 2008

SUMMARY OF THE DECEMBER 8, 2008, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the Hubert H. Humphrey Building in Washington, DC, on Monday, December 8, 2008 (see Appendix A). Vincent Bufalino, M.D., chair, welcomed the Council members and thanked them for taking time away from their practices to provide insight into the issues under consideration by the staff of the Centers for Medicare and Medicaid Services (CMS).

Agenda Item B — Welcome

Jeffrey Rich, M.D., Director of the Center for Medicare Management (CMM), said it has been a privilege to work with the Council. The views of practicing physicians are greatly appreciated as CMS refines its extraordinarily complex payment structures, he noted. CMS will deliver a formal report to Congress in May 2010 on applying value-based purchasing concepts to physician care. Dr. Rich anticipated significant health care system reform in the years to come and said value-based purchasing, if done well, can accelerate those reforms.

Herb Kuhn, Deputy Administrator of CMS, who arrived later in the day, added that the President-elect and the next Congress are very interested in value-based purchasing approaches. Input from PPAC and others is vital in helping CMS think through its programs, said Mr. Kuhn, and he thanked the Council members for their service.

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 18, 2008, meeting (Report Number 65).

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

65-E-1: PPAC recommends that CMS provide the 2007 Physician Quality Reporting Initiative (PQRI) data set files to the American Medical Association (AMA) and other interested health care professionals so that all can better understand possible barriers and stimuli to physician reporting and assist in increasing the number of physicians who successfully participate in PQRI.

CMS Response: To ensure the privacy and appropriate use of Medicare data, there is a standard process for requesting Medicare data files. The Research Data Assistance Center can assist anyone seeking Medicare data. Information regarding this process is available at:

[www.cms.hhs.gov/ResearchGenInfo/02_ResearchDataAssistanceCenter\(RESDAC\).asp#TopOfPage](http://www.cms.hhs.gov/ResearchGenInfo/02_ResearchDataAssistanceCenter(RESDAC).asp#TopOfPage).

65-E-2: PPAC recommends that CMS work with the physician community to evaluate and address continued barriers to participation in the PQRI program.

CMS Response: CMS is evaluating the 2007 PQRI program to identify and address potential barriers to participation. Since 2007, CMS has significantly expanded PQRI reporting options, including registry-based reporting and reporting on measures groups. We are currently testing and evaluating PQRI data submission using electronic health records systems and anticipate introducing this reporting option in the future. As required by the Medicare Improvements for Patients and Providers Act (MIPPA), for 2010, we plan to introduce group level reporting. We intend to actively engage the physician community in considering expanded options for participating in the PQRI program.

65-E-3: PPAC recommends that CMS provide in the Final Rule a thorough explanation of why some measures proposed by the AMA Physician Consortium for Performance Improvement were not included in the 2009 PQRI measures set.

CMS Response: The Medicare Physician Fee Schedule Final Rule was published November 19, 2008, and we refer the Council to that document for discussion of the measures that were adopted. We will continue to seek and consider suggestions from physician organizations and other stakeholders regarding physician performance measures.

65-E-4: PPAC recommends that CMS provide more comprehensive guidelines and instructions to providers regarding National Provider Identifiers (NPIs) and other identification numbers to prevent rejection and delay of claims and require that carriers provide liaisons to assist providers in submitting claims.

CMS Response: While we recognize that some providers and suppliers experienced claims processing difficulties at the NPI compliance date on May 23, 2008, and shortly thereafter, we believe that the majority of these billing issues have been resolved. CMS is committed to educating all enrolled providers and suppliers about the correct way to submit claims to the Medicare program and will continue to provide targeted education to those providers and suppliers with specific billing concerns.

Agenda Item F — Physician Fee Schedule Update

65-F-1: PPAC recommends that rather than extend the inpatient hospital-acquired conditions (HACs) policy to other settings, such as physician offices, CMS focus its efforts on encouraging compliance with evidence-based guidelines developed by health care professionals.

CMS Response: CMS is focusing on enhancing the value of services provided to Medicare beneficiaries using tools under Medicare statutory authority, including payment incentives. The primary goal of the HACs payment provision is to enhance the quality of care for Medicare beneficiaries by providing financial incentives to promote compliance with evidence-based guidelines developed by health care professionals. We believe that not paying more for selected

complications will encourage evidence-based practice in Medicare payment settings beyond Inpatient Prospective Payment System (IPPS) hospitals. We discussed expansion of the principles behind the HACs payment provision to the physician office setting in the calendar year (CY) 2009 Medicare Physician Fee Schedule rulemaking. We will be evaluating the experience in the IPPS setting to inform potential expansion of the HACs policy to other Medicare payment systems, which would likely occur through notice and comment rulemaking.

65-F-2: PPAC recommends that CMS reexamine the HACs policy in the hospital setting to focus on evidence-based data that does or does not support recommendations for nonpayment of certain conditions.

CMS Response: CMS, in partnership with the Centers for Disease Control and Prevention, undertook a rigorous process to evaluate candidate conditions for the HACs payment provision. That process included a day-long public listening session and three rounds of public comment through IPPS rulemaking. The statutory selection criteria require that the selected conditions be considered reasonably preventable through the application of evidence-based guidelines. In light of the public comments, we considered and selected the conditions to meet the statutory criteria.

65-F-3: PPAC recommends that CMS not adopt the proposed changes to retroactive billing, and instead keep the currently allowed retroactive billing for 27 months.

CMS Response: CMS published the CY 2009 Medicare Physician Fee Schedule Final Rule on November 19, 2008. As part of this Final Rule, we established an effective date of billing for physicians, certain non-physician practitioners (NPPs), and physician and NPP organizations as the later of: 1) the filing of a Medicare enrollment application that was subsequently approved by a Medicare contractor or 2) the date an enrolled physician or NPP first started furnishing services at a new practice location. This rule also permits physicians and NPPs to retrospectively bill for services rendered up to 30 days prior to the effective date if the physician or NPP meets all program requirements. In addition, it permits physicians and NPPs to retrospectively bill for services furnished up to 90 days prior when there is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. §§5121-5206, the Stafford Act). We are not changing the current retrospective billing practice for enrolled providers. We are limiting retrospective billing to 30 days (90 days when a disaster is declared under the Stafford Act) prior to submitting an enrollment application for newly enrolled physicians, NPPs, or physician or NPP organizations, or to 30 days (90 days when a disaster is declared under the Stafford Act) prior to the date an enrolled physician or NPP first started furnishing services at a new practice location.

65-F-4: PPAC recommends that CMS abandon its proposal to treat physician offices as independent diagnostic testing facilities (IDTFs) and instead focus on ensuring smooth implementation of new accreditation procedures mandated by Congress.

CMS Response: We appreciate the Council's recommendation. Physicians, NPPs, and physician or NPP organizations will not be required to enroll as an IDTF or meet the IDTF performance standards when providing diagnostic testing within their practice settings based upon the provisions of the CY 2009 Medicare Physician Fee Schedule. With the enactment of section 135 of MIPPA and after careful review and consideration of public comments, we deferred the implementation of this proposal while we continue to review the public comments received on this provision, and we will consider finalizing this provision in a future rulemaking effort if deemed necessary. Section 135 of MIPPA requires that the Secretary establish an accreditation process for those entities furnishing advanced diagnostic testing procedures, which include diagnostic magnetic resonance imaging, computed tomography, nuclear medicine (including positron emission tomography), and other such diagnostic testing procedures described in section 1848(b)(4)(B) of the act (excluding X-ray imaging, ultrasonography, and fluoroscopy) by January 1, 2012. Accordingly, we are not adopting our proposal to require physicians and NPPs to meet certain quality and performance standards when providing diagnostic testing services, except mammography services, within their medical practice setting and have removed the paperwork burden and regulatory impact analysis associated with this provision in the Final Rule with comment period.

Agenda Item J — Recovery Audit Contractor (RAC) Update

65-J-1: PPAC recommends that CMS require RACs to provide data on overpayments collected for durable medical equipment (DME) claims and differentiate between physicians and commercial suppliers of DME.

CMS Response: CMS appreciates this recommendation and understands the need to be as specific as possible when reporting data so we can implement effective corrective actions. We are currently exploring what steps are necessary to differentiate between overpayments collected on DME claims from physicians and commercial suppliers. We anticipate that this may take at least a year to implement and begin reporting.

Agenda Item L — DME Update

65-L-1: PPAC recommends that 1) the Secretary of the Department of Health and Human Services (HHS) and CMS immediately halt the durable medical equipment, prosthetics, and orthotics supplies (DMEPOS) accreditation requirement for physicians and licensed health care professionals and 2) the Secretary of HHS and CMS exercise its newly expanded authority to exempt physicians and licensed health care professionals from quality standards and accreditation requirements considering the licensing, accreditation, and other

quality requirements that physicians and licensed health care professionals must meet.

CMS Response: CMS provided guidance at a special Open Door Forum on September 3, 2008, related to the exempted professionals and “other persons” as defined in section 154(b) of MIPPA. A slightly revised version of this guidance is available on the CMS website at:

www.cms.hhs.gov/MedicareProviderSupEnroll/03_DeemedAccreditationorganizations.asp#topofPage

All related information is listed on the DMEPOS accreditation web page.

Agenda Item P — Wrap Up and Recommendations

65-P-1: PPAC recommends that CMS 1) prohibit any contractor from auditing physicians on consultations until a clear policy is in effect and 2) continue an open dialogue on concerns raised by the AMA on medical consultation reimbursement.

CMS Response: In order to reduce Medicare’s improper claim payment rate, CMS believes it is important not to prohibit contractors from auditing physicians’ consultation services. However, CMS will conduct oversight to ensure that each contractor who chooses to audit physician consultation services is doing so consistent with the Medicare consultation policies. In addition, CMS will continue an open dialogue with all interested parties on the Medicare policies for consultation services.

65-P-2: PPAC recommends that, if possible, CMS provide data on trends of providers who are showing decreasing trends in beneficiary care.

CMS Response: CMS tends to monitor beneficiary reported experiences on their ability to access needed care. Using longitudinal data from the Consumer Assessment of Health Plans Survey (CAHPS), we will be able to examine and monitor at the State level whether beneficiaries are reporting changes in their access to care. In addition, over the next year, CMS expects to design and implement a new claims-based monitoring system to track physician visit rates for new and established patients by geographic area and specialty. This claims-based monitoring system can be used to signal underlying access issues.

65-P-3: PPAC recommends that CMS not expand the HACs nonpayment policy from inpatient hospital settings until the hospital policy has been evaluated and analyzed, in particular determining the impact of the policy regarding the following issues:

1. Quality of care delivered to patients, especially in proportion to the additional costs to the Medicare program to comply with the HACs requirements
2. Need for appropriate risk-adjustment techniques

3. How attribution issues will be determined with respect to when, where, and why a condition occurred
4. Reasonable number of expected incidences in which these conditions will occur in individual hospitals, especially with regard to high-risk patients, when evidence-based guidelines are followed

CMS Response: CMS has expressed interest in various payment rules in expanding the HACs concept of not paying for selected complications that are not present on inpatient hospital admission. Discussion pieces addressing various issues for consideration by stakeholders were included in the CY 2009 Outpatient Prospective Payment System (OPPS) and Physician Fee Schedule rules. CMS will discuss its analysis of the inpatient policy during FY 2010 IPPS rulemaking. Issues related to quality, cost, risk adjustment, attribution, and reasonable preventability were discussed during FY 2009 IPPS rulemaking, and we anticipate that those topics will be discussed again during FY 2010 IPPS rulemaking. All stakeholders, including physicians and physician associations, are invited to attend a listening session regarding inpatient and outpatient hospital HACs to be held on December 18, 2008.

Regarding the CMS policy on nonpayment for HACs, Council members stated that from a scientific perspective, many physicians do not agree that surgical site infection is “reasonably preventable” to the extent that the incidence can be reduced to zero.

In response to a question about the availability of PQRI data, Dr. Rich said CMS had worked with AMA and others to conduct an exhaustive analysis of the PQRI data that was posted on the CMS website in early December.

NEW BUSINESS

Agenda Item D —PRIT Update

William Rogers, M.D., Director of PRIT, said his office was focusing on provider enrollment problems in California that occurred during the transition to the regional Medicare Administrative Contractors (MACs) (Presentation 1). The problems were related to an unanticipated backlog, and Dr. Rogers did not think the same issues would arise during the transitions of the other three regional MACs. Dr. Rich added that CMS is committed to processing all the provider enrollment forms from the California MAC by December 31, 2008.

Dr. Rogers said PRIT is conducting outreach about the new electronic prescribing incentive program. A Council member countered that posting information on the web is not outreach but rather requires physicians or their staff to invest time. She said implementing an electronic prescribing system would likely cost four times more than she would receive in incentive payments. Dr. Rogers said CMS has no control over the

incentive amount prescribed by Congress. The electronic prescribing initiative currently does not apply to Drug Enforcement Administration Schedule-II drugs at present.

Agenda Item E — Medicare Physician Fee Schedule Final Rule

Cassandra Black, Director of CMM's Division of Practitioner Services, recounted some of the policy issues addressed in the Physician Fee Schedule Final Rule (Presentation 2). For example, CMS accepted the recommendations of the AMA's Relative Value Scale Update Committee for 204 codes and will continue to work with AMA and others to identify misvalued codes. A Council member emphasized that "misvalued" codes can be either overvalued or undervalued.

Ms. Black said CMS is making the transition to new geographic practice cost indices (GPCIs) and discussed reconfiguring payment localities in a document published in August. The issue has generated many comments, mostly from California, and Ms. Black anticipated more discussion and opportunities for public comment to come. A Council member pointed out that AMA and others are seeking to gather more accurate data on physician practice expenses.

In an effort to update the relative-value units (RVUs) for professional liability, CMS will hire a contractor to research available sources of data on which to base an update for 2010. A Council member thanked CMS for addressing the professional liability RVUs but did not believe the contractor would succeed in finding relevant data. If the contractor does not find data, he suggested CMS recognize that there are *no* data; thus, CMS should not decide that it cannot update the RVUs because there are no *new* data.

Recommendations

66-E-1: PPAC recommends that CMS expand its review of the practice-expense GPCIs beyond taking testimony on geographic localities.

66-E-2: PPAC recommends that CMS reevaluate its formula for practice-expense GPCIs to use actual practice expense data to make determinations, reporting back to the Council on its findings at the Council's June 2009 meeting.

Agenda Item F — Internet-Based Provider Enrollment, Chain, and Ownership System (PECOS) (Item added late, does not appear on agenda)

James Bossenmeyer, Director of the Division of Provider/Supplier Enrollment, Office of Financial Management, announced that CMS is phasing in its Internet-based PECOS system over the next 2 months to allow physicians to enroll or update their Medicare enrollment information electronically (Presentation 3). A help desk is available to assist users with navigation and access problems.

Agenda Item G —OPPS/Ambulatory Surgical Center (ASC) Fee Schedule Final Rule

Carol Bazell, M.D., M.P.H., Director, Division of Outpatient Care, CMM, offered some highlights of the OPPS and ASC Final Rule (Presentation 4). She noted that CMS will

begin voluntary validation testing for hospital quality reporting beginning in 2009. In 2009, hospitals will be required to report on 11 quality measures to earn the full payment in 2010, four more than required in 2008. The proposed rule requested comments on a number of measures CMS is considering for future years. One Council member said hospitals are already having difficulty understanding and reporting on some of the current quality measures.

Dr. Bazell emphasized that the Final Rule signals CMS' intent to expand the policy of nonpayment of HACs to outpatient settings but no specific policy was adopted. Council members raised many concerns about attribution (i.e., how to determine who is responsible for the patient's HAC and thus should bear the financial burden) and reiterated that some conditions can't be avoided despite best efforts. Dr. Bazell said CMS welcomes input from the physician community. She added that currently, CMS determines whether a condition was "reasonably preventable" on a case-by-case basis. It is possible, she said, that CMS will consider a minimum rate of HACs that is acceptable.

Dr. Bazell described how CMS determines what procedures make up the inpatient list (i.e., procedures CMS does not pay for when performed in an outpatient setting). She encouraged physicians to work with their specialty societies to present CMS with supporting background and data on procedures that should be removed from the inpatient list.

Agenda Item H — Stark Reform

Lisa Ohrin, Acting Director of CMM's Division of Technical Payment Policy, provided detailed background on the Medicare regulations on physician self-referral and anti-markup provisions (Presentation 5). CMS recognized that a specific exception to existing regulations was needed to allow implementation of appropriate hospital incentive and gainsharing programs that are intended to improve quality and reduce costs. CMS did not finalize the exception that it proposed in the Physician Fee Schedule Final Rule and reopened the comment period to gather more detailed input. Ms. Ohrin described the criteria that CMS applies to determine when anti-markup limitations apply to diagnostic testing.

Agenda Item J — Value-Based Purchasing Efficiency Measures and PQRI in 2009

Thomas Valuck, M.D., J.D., CMM Medical Officer and Senior Advisor, described the challenges CMS faces in developing a program to provide feedback on physician resource use as mandated by MIPPA (Presentation 6a). Lisa Grabert, M.P.H., Health Insurance Specialist in CMM's Hospital and Ambulatory Policy Group, outlined the initial steps in gathering information and presenting it in a useful format. Determining attribution (assigning resource cost to a physician or group of physicians) remains a challenge, and CMS is seeking input on that issue, among others.

Council members pointed out that CMS claim forms do not facilitate reporting all of a patient's diagnoses. As a result, CMS may have an incomplete picture of a patient's risk factors, and the risk-adjustment methodologies applied may not be appropriate. A

Council member cautioned that the resulting feedback form may ultimately be perceived as a way to compare physician performance according to the “scores” assigned by CMS.

Dr. Valuck noted that CMS will hold a listening session on value-based purchasing on December 9, 2008, and requests comments by December 16, 2008. He emphasized that CMS will accept comments throughout the planning process. Commenters may wish to provide preliminary comments by December 16 and follow up with more detailed comments or address less pressing issues later on.

Michael Rapp, M.D., J.D., Director of the Quality Measurement and Health Assessment Group in the Office of Clinical Standards and Quality, gave a brief update on PQRI issues, noting that CMS will reevaluate data reported in 2007 to resolve technical problems that may have prevented physicians from receiving a bonus payment for 2007 reporting (Presentation 6b). As a result, some physicians who did not qualify for the bonus payment for 2007 will receive bonus payments for their efforts.

Dr. Rapp detailed electronic prescribing incentive program that begins in 2009. He said that electronic health records systems certified by the Certification Commission for Healthcare Information Technology (CCHIT) contain mechanisms for electronic prescribing that CMS considers qualified. Neither CMS nor any independent body certifies standalone electronic prescribing software (although CCHIT may do so in 2009), so physicians should ask vendors for details to determine whether software is “qualified” for electronic prescribing.

The 2-percent incentive to physicians who successfully report on electronic prescribing will be phased out over time and replaced with a penalty for failing to report. Under MIPPA, CMS is required to post the names of those who report successfully on its website. Dr. Rapp anticipated that CMS will establish an exemption for providers for whom electronic prescribing would not be feasible or would pose a hardship.

A Council member said the time required to report measures on PQRI substantially outweighed the potential bonus; the reporting process is needlessly complicated and time-consuming; the rules for successful reporting are arcane; and the website is too difficult to navigate. Dr. Rapp said the procedure had been simplified but also said CMS has no authority to increase the incentive amount. A Council member added that a standalone electronic prescribing system costs about \$8,000 to implement and \$3,000–\$4,000 per year to maintain.

Recommendations

66-J-1: PPAC recommends that CMS provide PPAC with regular updates on planning for the Physician Resource Use Measurement and Reporting Program.

66-J-2: PPAC recommends that CMS report on its use of downstream diagnoses that are not captured among the first four diagnoses in the claims database.

Agenda Item K — RAC Update

Melanie Combs-Dyer, R.N., Senior Technical Advisor in the Division of Recovery Audit Operations, offered a brief overview of the RAC demonstration, noting that, to date, 6.8 percent of RAC determinations have been overturned on appeal (Presentation 7). LT Terrence Lew, Health Insurance Specialist in the Division of Recovery Audit Operations, explained that the plan to establish four permanent RACs is on hold while the Government Accountability Office reviews a formal protest. To minimize the burden of RAC audits on physicians, CMS limited the number of records RACs can request from providers and how far back RACs may look (chronologically). The RACs are required to post on their websites the issues they are reviewing, and a CMS panel must approve any new issues that a RAC wishes to pursue. LT Lew added that CMS will hire a contractor to validate the results of the RAC determinations and will publish accuracy rates.

A Council member pointed out that the RAC program places a disproportionate financial burden on small practices and solo practitioners by failing to reimburse physicians for the cost of providing medical records and by allowing RACs to request up to 10 medical records every 45 days from solo practitioners.

Another Council member said the percentage of all determinations overturned on appeal gives an incomplete picture and asked for the total number of determinations that were appealed. Another asked whether only the highest-dollar determinations were being appealed and whether the cost of appealing is prohibitive to individual physicians. It was not clear whether detailed data on determinations and appeals among physicians were available, but LT Lew said future data collection could include provider types. Ms. Combs-Dyer agreed to provide updated data on appeals by the next PPAC meeting.

Agenda Item M — Medically Unlikely Edits Update

Brenda Thew, Director of the Division of Benefit Integrity Management Operations in the Office of Financial Management, explained how CMS determines what claims may be medically unlikely, ultimately relying on the clinical judgment of CMS physicians and coding specialists for the most complicated determinations (Presentation 8). The process involves input and expertise from national physician and health care organizations. Ms. Thew distinguished between the process of periodically reviewing data to refine the list of medically unlikely claims and the appeals process, in which providers submit appeals for claims denied. CMS believes that applying the medically unlikely edits will result in more accurate coding and fewer payment errors while facilitating payment of medically reasonable and necessary services.

Agenda Item N — Testimony

William Dolan, M.D., of the AMA, said only half of the physicians who reported PQRI measures in 2007 received bonuses, and called for program reform (Presentation 9). He said CMS should not limit the ability of physicians to bill retroactively while their enrollment applications are being processed. He added that CMS should encourage practitioners to comply with evidence-based guidelines rather than penalize them when HACs occur that may or may not be reasonably preventable.

Agenda Item O — Wrap Up and Recommendations

Dr. Bufalino asked for additional recommendations from the Council. Recommendations of the Council are listed in Appendix B.

Recommendations

66-O-1: PPAC recommends that CMS not expand the list of HACs until evaluation shows that the current program to address HACs is achieving the goals outlined by CMS. PPAC requests that CMS present an analysis of the program at the June 2009 meeting.

66-O-2: PPAC recommends that CMS revise its policy of nonpayment of HACs to allow payment when the condition occurs despite the fact that the provider responsible for that condition followed the pertinent evidence-based guidelines.

66-O-3: PPAC recommends that CMS provide physicians with real-time (e.g., same calendar year) information to determine whether they are properly reporting data to the PQRI so that physicians have an opportunity to adjust their reporting to meet the program requirements.

66-O-4: PPAC recommends that CMS delay implementation of any new information technology requirements until an independent study can assess whether doing so would have the catastrophic effect of putting physicians out of business and accentuate the already severe problem of patient access to care.

66-O-5: PPAC recommends that the cost of implementing any information technology changes requested by CMS be fully funded by CMS.

66-O-6: PPAC recommends that CMS clarify the appeals process for RAC determinations.

66-O-7: PPAC commends CMS and recommends that CMS proceed expeditiously to develop medically reasonable approaches of valuing decreases in HACs instead of the unreasonable approach of eliminating HACs.

66-O-8: PPAC recommends that CMS require RACs to reimburse all providers for the cost of fulfilling RAC medical record requests.

66-O-9: PPAC recommends that CMS limit the number of medical records that a RAC can request from a solo practitioner to three records every 45 days for each NPI.

66-O-10: PPAC commends CMS for progress on the PQRI and recommends that CMS continue to work toward greater transparency in all aspects of developing the PQRI, especially data used for measure selection and the implementation of processes.

66-O-11: PPAC recommends that CMS strongly consider the ultimate use of the physician resource use reports in the medical marketplace when designing the physician resource use measures and report and that plans for this effort be reported to PPAC.

66-O-12: PPAC recommends that CMS make an effort to obtain data on the cost to providers and institutions of appealing a RAC determination.

66-O-13: PPAC recommends that CMS provide data on the amounts of RAC determinations that were appealed in the RAC demonstration, particularly in relation to the amounts of RAC determinations of improper payments in general.

66-O-14: PPAC recommends that CMS withdraw changes to the Medicare enrollment process proposed in the Physician Fee Schedule Final Rule until related physician payment problems and persistent delays are resolved nationwide.

Dr. Simon announced the PPAC meeting dates for 2009:

- March 9
- June 1
- August 31
- December 7

Dr. Bufalino adjourned the meeting.

Report prepared and submitted by
Dana Trevas, Rapporteur
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PPAC Members at the December 8, 2008, Meeting

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

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

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

Pamela Howard, M.D.
Surgeon
Allentown, Pennsylvania

Roger L. Jordan, O.D.
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Janice Ann Kirsch, M.D.
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Arthur D. Snow, M.D.
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Christopher Standaert, M.D.
Physical Medicine/Rehabilitation
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Karen S. Williams, M.D.
Anesthesiologist
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CMS Staff Present

Herb Kuhn, Deputy Administrator
Centers for Medicare and Medicaid Services

Jeffrey Rich, Director
Center for Medicare Management

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

Presenters

Carol Bazell, M.D., M.P.H., Director
Division of Outpatient Care
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Cassandra Black, Acting Director
Division of Practitioner Services
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James Bossenmeyer, Director
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Melanie Combs-Dyer, RN, Senior Technical
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LT Terrence Lew, Health Insurance Specialist
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Lisa Ohrin, Acting Director
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Michael Rapp, M.D., J.D., Director
Quality Measurement and Health Assessment
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William Rogers, M.D., Director
Physicians Regulatory Issues Team
Office of External Affairs
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Brenda Thew, Director
Division of Benefit Integrity Management
Operations
Office of Financial Management

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

Public Testimony

William A. Dolan, M.D.
American Medical Association

Dana Trevas, Rapporteur
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting agenda

Appendix B: Recommendations from the December 8, 2008, meeting

The following documents were presented at the PPAC meeting on December 8, 2008, and are appended here for the record:

Presentation 1: PRIT Update

Presentation 2: Medicare Physician Fee Schedule Final Rule

Presentation 3: Internet-Based Provider Enrollment, Chain, and Ownership System

Presentation 4: OPPS/ASC Fee Schedule Final Rule

Presentation 5: Stark Reform

Presentation 6a: Value-Based Purchasing Efficiency Measures

Presentation 6b: PQRI in 2009

Presentation 7: RAC Update

Presentation 8: Medically Unlikely Edits Update

Presentation 9: 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
12-08-08**

08:30-08:40	A Open Meeting	Vincent J. Bufalino, M.D., Chairman, Practicing Physician Advisory Council
08:40-08:50	B. Welcome	Jeffrey Rich, M.D., Director, Center for Medicare Management, Centers for Medicare & Medicaid
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., Physicians Regulatory Issues Team, Office of External Affairs
09:30-10:15	E. Medicare Physician Fee Schedule Final Rule	Cassandra Black, Director, Division of Practitioner Services, Center for Medicare Management
10:15-10:30	F. Break	
10:30-11:15	G. OPPS/ASC Fee Schedule Final Rule	Carol Bazell, M.D., MPH, Director, Division of Outpatient Services, Center for Medicare Management

11:15-12:00	H. Stark Reform	Lisa Ohrin, Acting Director, Division of Technical Payment Policy, Center for Medicare Management
12:00-1:00	I. Lunch	
1:00-2:15	J. Value-based Purchasing Efficiency Measures	Thomas Valuck, M.D., J.D., Medical Officer & Senior Advisor, Center Medicare Management Lisa Grabert, MPH, Health Insurance Specialist, Hospital & Ambulatory Policy Group, Center for Medicare Management
	PQRI in 2009	Michael Rapp, M.D., J.D., Director, Quality Measurement and Health Assessment Group, Office of Clinical Standards and Quality
2:15-3:00	K. RAC Update	Melanie Combs-Dyer, R.N., Senior Technical Advisor, Division of Demonstrations Management, Financial Services Group Amy Reese, Health Insurance Specialist, Division of Recovery Audit Operations, Financial Services Group Lt. Terrence Lew, Health Insurance Specialist, Division of Recovery Audit Operations, Financial Services Group

3:00-3:15	L. Break	
3:15-3:45	M. Medically Unlikely Edits Update	Brenda Thew, Director Division of Benefit Integrity Management Operations, Office of Financial Management
3:45-4:00	N. Testimony William A. Dolan, M.D. American Medical Association	
4:00-4:15	O. Wrap Up/Recommendations	

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC) RECOMMENDATIONS December 8, 2008

Agenda Item E — Medicare Physician Fee Schedule Final Rule

66-E-1: PPAC recommends that the Centers for Medicare and Medicaid Services (CMS) expand its review of the practice-expense geographic practice cost indices (GPCIs) beyond taking testimony on geographic localities.

66-E-2: PPAC recommends that CMS reevaluate its formula for practice-expense GPCIs to use actual practice expense data to make determinations, reporting back to the Council on its findings at the Council's June 2009 meeting.

Agenda Item J — Value-Based Purchasing Efficiency Measures and Physician Quality Reporting Initiative (PQRI) in 2009

66-J-1: PPAC recommends that CMS provide PPAC with regular updates on planning for the Physician Resource Use Measurement and Reporting Program.

66-J-2: PPAC recommends that CMS report on its use of downstream diagnoses that are not captured among the first four diagnoses in the claims database.

Agenda Item O — Wrap Up and Recommendations

66-O-1: PPAC recommends that CMS not expand the list of hospital-acquired conditions (HACs) until evaluation shows that the current program to address HACs is achieving the goals outlined by CMS. PPAC requests that CMS present an analysis of the program at the June 2009 meeting.

66-O-2: PPAC recommends that CMS revise its policy of nonpayment of HACs to allow payment when the condition occurs despite the fact that the provider responsible for that condition followed the pertinent evidence-based guidelines.

66-O-3: PPAC recommends that CMS provide physicians with real-time (e.g., same calendar year) information to determine whether they are properly reporting data to the PQRI so that physicians have an opportunity to adjust their reporting to meet the program requirements.

66-O-4: PPAC recommends that CMS delay implementation of any new information technology requirements until an independent study can assess whether doing so would have the catastrophic effect of putting physicians out of business and accentuate the already severe problem of patient access to care.

66-O-5: PPAC recommends that the cost of implementing any information technology changes requested by CMS be fully funded by CMS.

66-O-6: PPAC recommends that CMS clarify the appeals process for recovery audit contractor (RAC) determinations.

66-O-7: PPAC commends CMS and recommends that CMS proceed expeditiously to develop medically reasonable approaches of valuing decreases in HACs instead of the unreasonable approach of eliminating HACs.

66-O-8: PPAC recommends that CMS require RACs to reimburse all providers for the cost of fulfilling RAC medical record requests.

66-O-9: PPAC recommends that CMS limit the number of medical records that a RAC can request from a solo practitioner to three records every 45 days for each National Provider Identifier.

66-O-10: PPAC commends CMS for progress on the PQRI and recommends that CMS continue to work toward greater transparency in all aspects of developing the PQRI, especially data used for measure selection and the implementation of processes.

66-O-11: PPAC recommends that CMS strongly consider the ultimate use of the physician resource use reports in the medical marketplace when designing the physician resource use measures and report and that plans for this effort be reported to PPAC.

66-O-12: PPAC recommends that CMS make an effort to obtain data on the cost to providers and institutions of appealing a RAC determination.

66-O-13: PPAC recommends that CMS provide data on the amounts of RAC determinations that were appealed in the RAC demonstration, particularly in relation to the amounts of RAC determinations of improper payments in general.

66-O-14: PPAC recommends that CMS withdraw changes to the Medicare enrollment process proposed in the Physician Fee Schedule Final Rule until related physician payment problems and persistent delays are resolved nationwide.