

REPORT NUMBER SIXTY-SEVEN

to the

Secretary

U.S. Department of Health and Human Services

**(Re: Physicians Regulatory Issues Team, Value-Based Purchasing, Recovery Audit
Contractors, Local and National Coverage Determinations, Medicare Appeals
Process, and other matters)**

From the

Practicing Physicians Advisory Council

(PPAC)

Hubert H. Humphrey Building

Centers for Medicare and Medicaid Services

Washington, DC

March 9, 2009

SUMMARY OF THE MARCH 9, 2009, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the Hubert H. Humphrey Building in Washington, DC, on Monday, March 9, 2009 (see Appendix A). Vincent Bufalino, M.D., Chair, welcomed the Council members and thanked them for making time to attend the meeting.

Agenda Item B — Welcome

Liz Richter, Acting Director of the Center for Medicare Management (CMM) in the Centers for Medicare and Medicaid Services (CMS), said she appreciates the input of the Council members. She explained that the agency is in transition, and she will let PPAC know as soon as new staff members are confirmed to their positions. She introduced Stewart Streimer, Acting Deputy Director of CMM. Ms. Richter said she was pleased that the day's agenda would provide information on topics of interest specifically identified by the Council.

OLD BUSINESS

Agenda Item C — PPAC Update

Ken Simon, M.D., M.B.A., Executive Director of PPAC, presented the responses from CMS to PPAC recommendations made at the December 8, 2008, meeting (Report Number 66).

Agenda Item E — Medicare Physician Fee Schedule Final Rule

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

CMS Response: As discussed in the calendar year (CY) 2009 Medicare Physician Fee Schedule (MPFS) final rule, CMS is conducting a study of alternative locality structures. Our current study is focused on reviewing the possible alternative approaches for reconfiguring MPFS payment localities.

An interim report of the contractor's research and county-level data for each option is complete and posted on the CMS website. We expect to receive a final report from the contractor in summer 2009. When the final report is received, we will post it on our website and discuss the findings at a future PPAC meeting.

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 second meeting in 2009.

CMS Response: The practice-expense GPCI is composed of three categories: 1) employee wages, 2) rent, and 3) medical equipment and office supplies. CMS has

specified that data must be available nationwide and accessible to the public to be used in the calculation of the GPCIs.

The employee wages component uses census data on the actual wages of the types of medical and clerical workers found in physicians' offices. The rent category is based on the Department of Housing and Urban Development (HUD) residential apartment rental data because no acceptable national source of commercial rent data were available. The census and HUD residential data are available to the public. Medical equipment, supplies, and miscellaneous expenses were found to have a national market not varying significantly geographically and, therefore, have the same national value of 1.000 in all areas.

The next GPCI update will be discussed in the 2011 MPFS rulemaking cycle conducted during 2010. We will solicit public comment during this period.

Agenda Item J — Value-Based Purchasing Efficiency Measures and Physicians Quality Reporting Initiative 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.

CMS Response: CMS has been and expects to continue working collaboratively with the physician community on development, implementation, and maintenance of the Physician Resource Use Measurement and Reporting Program. In addition to face-to-face sessions with individual physicians and groups of physicians to gauge reaction and gather input about the reports, CMS has also engaged the American Medical Association (AMA) and medical specialty societies in an ongoing series of discussions about the program. We look forward to further collaboration with the physician community, including regularly updating PPAC.

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.

CMS Response: For each MPFS claim, CMS accepts up to eight ICD-9-CM diagnosis codes on the header on the electronic claims format and up to four ICD-9-CM diagnosis codes on the header on the paper claims format for billing particular items or services provided to a Medicare beneficiary on a particular date of service. The diagnosis codes are placed at the claim level, and the clinician must point to the relevant primary diagnosis from those claim-level diagnoses on each line item on the claim. In other words, the clinician must point to the diagnosis that supports the reason for the service or procedure on that line. For the Physician Resource Use Measurement and Reporting Program, we are using all of the claims related to an episode of care across settings, so we have access to the ICD-9-CM diagnosis codes from all of the claims within the episode, including but not limited to the MPFS claims. The patient-level risk adjustment methodology takes into account all diagnosis codes within an episode for an acute condition or during a calendar year for a chronic condition. Appendix B lists the

relevant Medicare payment systems and the number of ICD-9-CM diagnosis codes we capture for claims within those payment systems.

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.

CMS Response: In the Inpatient Prospective Payment System (IPPS) fiscal year (FY) 2009 final rule, CMS presented candidate HACs for potential consideration during future rulemaking. CMS has also discussed in various payment rules the potential for expanding the HAC concept to settings of care beyond inpatient hospitalization. CMS is pursuing an evaluation of the initial impact of the inpatient HAC payment policy, subject to the availability of resources. At this time, it does not appear that preliminary data will be available for the June 1, 2009, meeting or by the end of the year. However, even prior to completion of the evaluation, we know that the HAC policy has achieved the goal of heightening attention to patient safety, generally. It has specifically resulted in attention to prevention of selected HACs that have been highlighted in the IPPS final rule. As program evaluation results become available, we will share them with PPAC.

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.

CMS Response: The statutory authority for the HAC policy requires prospective selection of conditions that may be considered reasonably preventable through the application of evidence-based guidelines. Reasonably preventable does not mean absolutely preventable, and CMS recognizes that HACs may occur when evidence-based guidelines are followed. We note that the statute does not require that a condition be “always preventable” in order to qualify as a HAC, but rather that it be “reasonably preventable,” which necessarily implies something less than 100 percent.

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

CMS Response: CMS is unable to provide contemporaneous feedback reports at the individual level. However, we have committed to provide aggregate level reports quarterly, by measure, as to the reasons for invalid quality data code reporting, as such information becomes available. We are providing such information for the first three quarters of 2008 in February 2009 and the fourth quarter of 2008 in May 2009. We anticipate providing such information for the

first quarter of 2009 by August 2009, based on availability of claims data for the first quarter of 2009.

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.

CMS Response: CMS supports the adoption of health information technology (HIT) including, electronic health records (EHR), and electronic prescribing (e-prescribing). The PQRI and the e-prescribing incentive programs provide financial incentives to physicians and other eligible professionals but do not require use of HIT.

Congress recently passed the American Recovery and Reinvestment Act of 2009 (ARRA), which the President signed into law on February 17. Among other health care provisions, ARRA provides funding to encourage the adoption of HIT. For physicians, ARRA provides financial incentives beginning with 2011 for eligible professionals who are meaningful EHR users, followed by financial penalties beginning with 2015 for eligible professionals who are not meaningful EHR users. CMS will be working closely with the Department and affected stakeholders to implement these new provisions.

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

CMS Response: As mentioned above in the response to recommendation 66-O-4, recent legislation provides financial incentives to encourage the use of HIT.

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

CMS Response: CMS has included an overview of the appeals process on the March 9, 2009, PPAC meeting agenda. Members of the CMS Enrollment and Appeals Group will provide an overview to the Council on providers' appeal rights, which are the same for RAC determinations as they are for any other Medicare determination.

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

CMS Response: In the Hospital Value-Based Purchasing Plan Report to Congress (available at: <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf>), CMS discussed a performance-based payment

model that would adjust hospital payments based on measured rates of performance. We received comments from stakeholders during the December 18, 2008, HAC Listening Session that the use of rate-based measures of complications to adjust hospital payments through the value-based purchasing model would be preferable to a claim-by-claim payment adjustment for HACs.

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

CMS Response: CMS will take this recommendation under advisement for FY 2010.

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.

CMS Response: CMS appreciates the Council's feedback on the difficulty many providers face in responding to medical record requests. We believe that the request guidelines as currently established are fair and that they represent a reasonable balance between the need to supply the RACs with an adequate universe of claims to review and the need to protect providers from undue administrative burden. However, we will carefully monitor the effects of the record requests during the remainder of FY 2009 and will consider the Council's recommendation for FY 2010.

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.

CMS Response: CMS is appreciative of the commendation and is committed to engaging physician and other eligible professionals to improve the program. CMS appreciates the input received from PPAC and others. CMS, in early 2008 and 2009, has requested suggestions for measures. Selection of the measures is carried out through notice and comment rulemaking as required by the PQRI authorizing legislation.

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.

CMS Response: The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 requires CMS to disseminate resource use reports to physicians on a confidential basis. MIPPA also required CMS to develop a plan for value-based purchasing for physicians and other professionals (Physician VBP Plan)

and submit the plan in a report to Congress. The Physician VBP Plan will address payment incentives and public reporting of both quality and cost of care, as was discussed in a recently released Issues Paper (available at: <http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Paper.pdf>). While the current use of physician resource use information is for confidential reporting, CMS is considering ultimately using the information for payment incentives and public reporting.

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.

CMS Response: The requested data are not currently available, although CMS will consider including this subject in the annual RAC provider survey. However, the results may be of questionable validity due to the myriad of ways that provider organizations can account for appeals-related expenses.

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.

CMS Response: CMS released a variety of appeal-related statistics for the demonstration project in its June 2008 evaluation report. These figures were updated in September 2008 with data through June 2008 and again in January 2009 with data through August 2008; additional updates will be provided until all appeals have been completed.

As of August 31, 2008, 118,051 (22.5 percent) of the 525,133 RAC overpayment determinations had been appealed. Of these, 40,115 (34.0 percent) were ultimately decided in the provider's favor. This figure represents 7.6 percent of the total RAC determinations.

CMS has made numerous enhancements to the RAC data warehouse for the permanent program, including the way that data are captured across the appeals process. We anticipate the ability to provide robust appeals data upon request by PPAC or other constituencies, and we appreciate the opportunity to respond to this recommendation.

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.

CMS Response: The effective date for provisions found in the CY 2009 MPFS is January 1, 2009, unless otherwise specified. Since CMS did not establish a delayed effective date for any changes in the Medicare provider enrollment provisions, the effective date of the enrollment provisions is also January 1, 2009.

We are in the process of developing implementation instructions for Medicare contractors.

CMS worked with the Medicare Administrative Contractor (MAC) for Jurisdiction 1, Palmetto GBA, to develop a plan for reducing the backlog of provider enrollment applications identified immediately following the Jurisdiction 1 implementation. Palmetto was able to rapidly resolve the issues encountered and is meeting CMS requirements for timely processing of claims and has been successful in reducing provider enrollment application inventories to workable levels within the timeframes established in the plan. We continue to work closely with our Medicare contractors, the medical associations, and other stakeholders to resolve any issues impacting provider payment as quickly as possible.

NEW BUSINESS

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

William Rogers, M.D., Director of PRIT, summarized some of the active issues his staff is addressing, including working with States to ensure Medicare claims cross over to Medicaid programs automatically, updating the online provider enrollment form to include the specialty code for pain medicine, and clarifying Medicare Advantage physicians' eligibility for the e-prescribing bonus payment (Presentation 1).

Agenda Item E — Value-Based Purchasing

Thomas Valuck, M.D., J.D., CMM Medical Officer and Senior Advisor, emphasized that value-based purchasing includes attention to both quality of clinical care and cost considerations (Presentation 2). He summarized the 2008 *Issues Paper* that describes the transition to a Medicare value-based purchasing program and the input from stakeholders at a December 2008 Listening Session.

In general, stakeholders agreed with the direction of CMS' plans and advocated for new payment approaches that cut across settings and align Medicare Part A and Part B payment incentives. Regarding performance measures, stakeholders stressed the need to employ valid, reliable, and nationally recognized measures. They also urged CMS to apply adequate risk adjustment to the measures and to address multiple levels of accountability. In terms of data and reporting, stakeholders requested that providers have an opportunity to review information before it's used for other purposes, such as public reporting. They cautioned that inaccurate information is worse than no information.

Council members' discussion centered around outcomes measures and patients' accountability for their own health. Dr. Valuck said CMS is exploring how to offer incentives that encourage providers to take on the added effort of caring for sicker patients. He added that most of the measures used come from AMA's Physician Consortium for Performance Improvement (PCPI). John Arradondo, M.D., suggested CMS gather more comprehensive data on the spectrum of patient care from various providers for a given condition (e.g., for diabetes, including health education) to get a

better understanding of all the facets and costs of treating patients with chronic health conditions.

Recommendations

67-E-1: PPAC recommends that in CMS' future planning for value-based purchasing programs, the following be included:

- Measurement of physician participation in quality-enhancement processes
- Recognition that a patient population's socioeconomic factors have an impact on achieving ideal patient outcome goals
- Recognition that a patient population's comorbidity has an impact on achieving ideal patient outcome goals
- Continuation of the use of recognized, reasonable consensus guidelines. The best source at present is the AMA's PCPI.
- Initiation of a discussion on enhancing patient education, activation, and motivation for participation in care

67-E-2: PPAC recommends that in CMS' value-based purchasing programs, PCPI be recognized as the leading developer of physician-level measures of quality.

67-E-3: PPAC recommends that in CMS' value-based purchasing programs, incentive payments be funded with new money and that payments not be made on a budget-neutral basis within the Medicare physician payment system.

67-E-4: PPAC recommends to CMS that physicians and other providers involved in the treatment of a patient must have an opportunity for prior review and comment and the right to appeal with regard to any data that are part of the public review process. Any such comments should also be included with any publicly reported data.

Agenda Item G —9th Scope of Work

Jean Moody-Williams, Director of the Quality Improvement Group in the Office of Clinical Standards and Quality, described several areas of focus being assessed by the Quality Improvement Organizations under the Statement of Work effective August 1, 2008 (Presentation 3). She said CMS is moving toward review of the overall effectiveness of services. She described the goals of some of the projects underway:

- Evaluate the effect on patient care of transitions (e.g., hospital discharge, moving to a skilled nursing facility)
- Use EHRs as a tool in preventive health efforts
- Prevent the progress of chronic kidney disease to end-stage renal disease through earlier intervention
- Address health disparities
- Improve patient safety

Dr. Arradondo suggested the chronic kidney disease project seek opportunities for even earlier intervention by looking at laboratory measures (e.g., glomerular filtration rate) that identify stages 1 and 2 chronic kidney disease.

Agenda Item H — RAC Update

Amy Reese, Health Insurance Specialist in the Division of Recovery Audit Operations, Financial Services Group, gave some background on the RAC program and outlined the RAC audit process (Presentation 4). LT Terrence Lew, also a Health Insurance Specialist in the same office, described CMS' efforts to minimize the burden of RAC audits on providers, ensure accuracy, and maximize transparency. For example, CMS has limited the number of medical records that a RAC can request per provider and is working on a mechanism to allow providers to transmit medical records electronically.

In response to questions by several Council members, CDR Marie Casey, R.N., Nurse Consultant for the RAC program, said she is confident that RACs will not risk wasting their resources on seeking repayment for minor discrepancies that may represent differences in individual judgment, such as one-level evaluation and management coding differences. She added that in seeking repayment from providers, RACs must give CMS and providers detailed, specific reasons why a claim should have been denied. The general language used in RAC letters to providers will be reviewed by a CMS panel. LT Lew said new data collection efforts might yield more detailed information on the types of providers and claims audited, and he offered to present such information at later PPAC meetings as available. Karen Williams, M.D., raised concern that when a RAC denies a physician payment because the service provided was deemed medically unnecessary, the specialists and consultants who provided their services at the request of the primary physician may also be denied payment.

Recommendations

67-H-1: Whenever a particular procedure or service has been questioned as unnecessary by a RAC after service has been delivered, all downstream medical services, including consultant services, have been called into question. Requests for repayment during the period of investigation have been made of consulting physicians (such as pathologists, radiologists, and anesthesiologists). These hospital-based specialists rendered their services in good faith in response to a request from another physician and have no way of determining at the time they are asked to participate in the care of a patient whether the underlying procedure or service may be questioned or determined to be medically unnecessary by a RAC at some time in the future. Therefore, PPAC recommends that the RAC

process be modified to exclude extending demands for repayment to subsequent consulting physicians for an index case for a particular surgery, procedure, or consultation.

67-H-2: PPAC recommends that the RACs only be allowed to request and review three records per physician per 45 days, regardless of whether the physician is a solo practitioner or part of a group of any size.

67-H-3: PPAC recommends that the RACs be required to reimburse providers for the cost of copies of requested medical records prior to commencement of a RAC audit.

67-H-4: PPAC recommends that CMS clarify for the RACs, in writing, that the 30-day deadline for filing an appeal should be flexible if there are extenuating circumstances and that such information should be included in the RACs' letter to the provider.

Agenda Item I — Local Coverage Determination Process

Paula Bonino, M.D., M.P.E., F.A.C.P., Contractor Medical Director for Highmark Medicare Services, described how local coverage determinations (LCDs) are made by MACs (Presentation 5). She emphasized that Federal statute mandates that Medicare use both LCDs and national coverage determinations (NCDs) and that the intent of LCDs is to take into account regional variations in service. Dr. Bonino added that her MAC reviewed the 959 LCDs in effect for the States in its jurisdiction and has reduced that number to 57.

Agenda Item J — NCD Process

Tamara Syrek Jensen, J.D., Deputy Director for the Coverage and Analysis Group in the Office of Clinical Standards and Quality, pointed out that there are over 5,000 LCDs and fewer than 1,000 NCDs (Presentation 6). Most NCDs are made at the request of drug and device manufacturers seeking coverage of their products. Ms. Jensen explained the process CMS uses for making determinations and the relatively new concept of “coverage with evidence development,” in which CMS agrees to pay for a product or service under certain circumstances that are intended to gather more information about the product or service.

Council discussion about LCDs and NCDs brought out the tension between the need for standards that promote consistent care across the country and the need to allow some flexibility to test new technology or innovative approaches to care in smaller settings. Ms. Jensen pointed out that when an NCD denies coverage (i.e., a national “no”), the issue will not be addressed again for some time.

Agenda Item M — Medicare Appeals Process

Arrah Tabe-Bedward, Director of the Division of Appeals Policy for the Medicare Enrollment and Appeals Group, Drug and Health Plan Choice, walked Council members

through the appeals process for Medicare claims denials, which is the same process by which providers appeal RAC repayment determinations (Presentation 7). She emphasized that Congress mandated and CMS established methods for early, quick reconsideration of denials, which are intended to address minor errors or omissions. Ms. Tabe-Bedward said that contractor staff members who make initial determinations are not the same contractor staff members who address provider appeals.

Agenda Item N — Testimony

The Council reviewed the written testimony of the AMA on value-based purchasing and RACs (Presentation 8).

Agenda Item O — Wrap Up and Recommendations

Dr. Bufalino asked for additional recommendations from the Council. The Council members reviewed the day's recommendations and revised them as needed. Recommendations of the Council are listed in Appendix C.

Recommendations

67-O-1: PPAC recommends to CMS that physicians and licensed health care providers not be subject to costly and burdensome durable medical equipment, prosthetics, orthotics, and supplies accreditation requirements, as they are already licensed and trained to provide durable medical equipment supplies to patients.

67-O-2: PPAC recommends that CMS provide data to determine whether there is a decrease in care to Medicare beneficiaries as a result of a "brown-out" (i.e., providers seeing fewer beneficiaries as opposed to opting out of Medicare).

Dr. Bufalino noted that the next PPAC meeting is June 1, 2009, and adjourned the meeting.

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

PPAC Members at the March 9, 2009, Meeting

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

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

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

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

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

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

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

M. LeRoy Sprang, M.D.
Obstetrician-Gynecologist
Evanston, Illinois

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

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

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

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

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

CMS Staff Present

Liz Richter, Acting Director
Center for Medicare Management

Steward Streimer, Acting Deputy
Director
Center for Medicare Management

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

Presenters

Paula Bonino, M.D., Contractor Medical
Director

Highmark Medicare Services

CDR Marie Casey, R.N., Nurse
Consultant
Division of Recovery Audit Operations
Financial Services Group

Tamara Syrek Jensen, J.D., Deputy
Director
Coverage and Analysis Group
Office of Clinical Standards and Quality

LT Terrence Lew, Health Insurance
Specialist
Division of Recovery Audit Operations
Financial Services Group

Amy Reese, Health Insurance Specialist
Division of Recovery Audit Operations
Financial Services Group

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

Arrah Tabe-Bedward, Director
Division of Appeals Policy
Medicare Enrollment and Appeals
Group
Drug and Health Plan Choice

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

Jean Moody-Williams, Director
Quality Improvement Group
Office of Clinical Standards and Quality

Dana Trevas, Rapporteur
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APPENDICES

Appendix A: Meeting agenda

Appendix B: Number of ICD-9-CM Diagnosis Codes per Electronic Claim by Medicare Payment System

Appendix C: Recommendations from the March 9, 2009, meeting

The following documents were presented at the PPAC meeting on March 9, 2009:

Presentation 1: PRIT Update

Presentation 2: Value-Based Purchasing

Presentation 3: 9th Scope of Work

Presentation 4: RAC Update

Presentation 5: Local Coverage Determination Process

Presentation 6: National Coverage Determination Process

Presentation 7: Medicare Appeals Process

Presentation 8: Statement of the American Medical Association

Appendix A

**Practicing Physicians Advisory Council
Hubert H. Humphrey Building
Room 705A
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201**

March 9, 2009

08:30-08:40	A. Opening Meeting	Vincent J. Bufalino, M.D., Chairman, Practicing Physicians Advisory Council
08:40-08:50	B. Welcome	Liz Richter, Acting Director, Center for Medicare Management Stewart H. Streimer, Acting 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
09:30-10:15	E. Value-based Purchasing	Thomas Valuck, M.D., J.D., Medical Officer and Senior Advisor, Center for Medicare Management
10:15-10:30	F. Break	
10:30-11:15	G. 9TH Scope of Work	Jean Moody-Williams, Director, Quality Improvement Group, Office of Clinical Standards and Quality

11:15-12:00	H. RAC Update	<p>Lt. Terrence Lew, Health Insurance Specialist, Division of Recovery Audit Operations, Financial Services Group</p> <p>Commander Marie Casey, R.N., Nurse Consultant, Division of Recovery Audit Operations, Financial Services Group</p> <p>Amy Reese, Health Insurance Specialist, Division of Recovery Audit Operations, Financial Services Group</p>
12:00-1:00	I. Lunch	
1:00-1:45	J. Local Coverage Determination Process	Paula Bonino, M.D., MPE, FACP, Contractor Medical Director, Highmark Medicare Services
1:45-2:30	K. National Coverage Determination Process	Tamara Syrek Jensen, J.D., Deputy Director, Coverage and Analysis Group, Office of Clinical Standards and Quality
2:30- 2:45	L. Break	
2:45- 3:30	M. Medicare Appeals Process	Arrah Tabe-Bedward, Director Division of Appeals Policy, Medicare Enrollment and Appeals Group, Drug and Health Plan Choice
3:30-3:45	N. Testimony	
3:45-4:00	O. Wrap Up/Recommendations	

Appendix B

Medicare Payment System	Number of ICD-9-CM Diagnosis Codes/Electronic Claim
Physician Fee Schedule	1 claim principal diagnosis code + 7 additional claim diagnosis codes
Inpatient Hospital PPS	1 claim principal diagnosis code + 1 claim diagnosis E code + 1 claim admitting diagnosis code + 8 additional claim diagnosis codes
Home Health PPS	1 claim principal diagnosis code + 1 claim diagnosis E code + 8 additional claim diagnosis codes
Inpatient Rehabilitation Facility PPS	1 claim principal diagnosis code + 1 claim diagnosis E code + 1 claim admitting diagnosis code + 8 additional claim diagnosis codes
Outpatient Hospital PPS	1 claim principal diagnosis code + 1 claim diagnosis E code + 8 additional claim diagnosis codes
Ambulatory Surgical Center PPS	1 claim principal diagnosis code + 7 additional claim diagnosis codes

Medicare Payment System	Number of ICD-9-CM Diagnosis Codes/Electronic Claim
Durable Medical Equipment Fee Schedule	1 claim principal diagnosis code + 3 additional claim diagnosis codes NOTE: CMS is in the process of updating its claims processing systems to accommodate 1 claim principal diagnosis code + 7 additional claim diagnosis codes on the electronic claim format; this change will be implemented October 1, 2009
Ambulance Fee Schedule	1 claim principal diagnosis code + 7 additional claim diagnosis codes
Clinical Laboratory Services Fee Schedule	1 claim principal diagnosis code + 7 additional claim diagnosis codes
ESRD Facility Services PPS	1 claim principal diagnosis code + 1 claim diagnosis E code + 8 additional claim diagnosis codes
Hospice PPS	1 claim principal diagnosis code + 1 claim diagnosis E code + 8 claim diagnosis codes
Inpatient Psychiatric Facility PPS	1 claim principal diagnosis code + 1 claim diagnosis E code + 1 claim admitting diagnosis code + 8 additional claim diagnosis codes
Skilled Nursing Facility PPS	1 claim principal diagnosis code + 1 claim diagnosis E code + 1 claim admitting diagnosis code + 8 additional claim diagnosis codes

Appendix C

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC) RECOMMENDATIONS March 9, 2009

Agenda Item E— Value-Based Purchasing

67-E-1: PPAC recommends that in CMS' future planning for value-based purchasing programs, the following be included:

- Measurement of physician participation in quality-enhancement processes
- Recognition that a patient population's socioeconomic factors have an impact on achieving ideal patient outcome goals
- Recognition that a patient population's comorbidity has an impact on achieving ideal patient outcome goals
- Continuation of the use of recognized, reasonable consensus guidelines. The best source at present is the American Medical Association's Physician Consortium for Performance Improvement (PCPI).
- Initiation of a discussion on enhancing patient education, activation, and motivation for participation in care

67-E-2: PPAC recommends that in CMS' value-based purchasing programs, PCPI be recognized as the leading developer of physician-level measures of quality.

67-E-3: PPAC recommends that in CMS' value-based purchasing programs, incentive payments be funded with new money and that payments not be made on a budget-neutral basis within the Medicare physician payment system.

67-E-4: PPAC recommends to CMS that physicians and other providers involved in the treatment of a patient must have an opportunity for prior review and comment and the right to appeal with regard to any data that are part of the public review process. Any such comments should also be included with any publicly reported data.

Agenda Item H — Recovery Audit Contractor (RAC) Update

Whenever a particular procedure or service has been questioned as unnecessary by a RAC after service has been delivered, all downstream medical services, including consultant services, have been called into question. Requests for repayment during the period of investigation have been made of consulting physicians (such as pathologists, radiologists, and anesthesiologists). These hospital-based specialists rendered their services in good faith in response to a request from another physician and have no way of determining at the time they are asked to participate in the care of a patient whether the underlying procedure or service may be questioned or determined to be medically unnecessary by a RAC at some time in the future.

67-H-1: PPAC recommends that the RAC process be modified to exclude extending demands for repayment to subsequent consulting physicians for an index case for a particular surgery, procedure, or consultation.

67-H-2: PPAC recommends that the RACs only be allowed to request and review three records per physician per 45 days, regardless of whether the physician is a solo practitioner or part of a group of any size.

67-H-3: PPAC recommends that the RACs be required to reimburse providers for the cost of copies of requested medical records prior to commencement of a RAC audit.

67-H-4: PPAC recommends that CMS clarify for the RACs, in writing, that the 30-day deadline for filing an appeal should be flexible if there are extenuating circumstances and that such information should be included in the RACs' letter to the provider.

Agenda Item O — Wrap Up

67-O-1: PPAC recommends to CMS that physicians and licensed health care providers not be subject to costly and burdensome durable medical equipment, prosthetics, orthotics, and supplies accreditation requirements, as they are already licensed and trained to provide durable medical equipment supplies to patients.

67-O-2: PPAC recommends that CMS provide data to determine whether there is a decrease in care to Medicare beneficiaries as a result of a "brown-out" (i.e., providers seeing fewer beneficiaries as opposed to opting out of Medicare).