REPORT NUMBER SEVENTY-ONE

to the

Secretary

U.S. Department of Health and Human Services

(Re: Physicians Regulatory Issues Team; Provider Enrollment, Chain, and Ownership System; Electronic Health Records; Fraud and Abuse; Recovery Audit Contractors; and other matters)

From the

Practicing Physicians Advisory Council

(PPAC)

Centers for Medicare & Medicaid Services

7500 Security Boulevard, Auditorium

Baltimore, MD

March 8, 2010

SUMMARY OF THE MARCH 8, 2009, MEETING

Agenda Item A — Introduction

The Practicing Physicians Advisory Council (PPAC) met at the headquarters of the Centers for Medicare & Medicaid Services (CMS) in Baltimore, MD, on Monday, March 8, 2010 (see Appendix A). Vincent Bufalino, M.D., chair, welcomed the Council members and speakers.

Agenda Item B — Welcome

Jonathan Blum, Director of the Center for Medicare Management (CMM), welcomed the Council members. He offered special thanks to four members who are completing their terms: Tye J. Ouzounian, M.D.; Jeffrey A. Ross, D.P.M., M.D.; Karen S. Williams, M.D.; and particularly Dr. Bufalino for his leadership as chair. Mr. Blum said that Congress is on the verge of passing health care reform legislation, which will give CMS new authority and direction to promote value and quality in its payment systems. Thus, the Council's advice will be even more critical to CMS in the future.

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 7, 2009, meeting (Report Number 70).

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

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

CMS Response: Since the publication of CMS-6002-F (Requirements for Establishing and Maintaining Medicare Billing Privileges) in the *Federal Register* on April 21, 2006, CMS encouraged physicians and other suppliers to update and maintain their enrollment record with the Medicare program. Physicians may enroll or update their Medicare enrollment record by completing and submitting the applicable Medicare enrollment application(s) (e.g., CMS-855I, CMS-855R) or by completing an enrollment application via Internet-based PECOS. In either case, a physician's application would be processed by a Medicare contractor using PECOS.

We will thoroughly address this recommendation during the PECOS presentation at the March 8, 2010, PPAC meeting.

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

CMS Response: Since the inception of the Medicare enrollment application in April 1996, CMS has issued several revisions to improve its usefulness and usability. In making these revisions, CMS solicited public comments via the *Federal Register* and obtained the Office of Management and Budget's approval before implementing changes to the application.

Prior to developing and finalizing the April 2006 revision, CMS contracted with the Pacific Consulting Group to review and revise the application format and instructions to make them more appealing and user-friendly. In addition to incorporating revisions mandated by changes in the Social Security Act or Medicare policy, the goal of revising the Medicare enrollment application has been to make it easier to complete and to make the instructions more concise. In fact, the April 2006 version of the Medicare enrollment application reflected a number of user-friendly revisions, including a reduction in the number of pages associated with completing the CMS-855B form (i.e., the enrollment application used by clinics and group practices) by 18 pages.

CMS announced the release of the revised Medicare enrollment application and outlined the significant revisions in *MLN Matters* article SE0632, http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0632.pdf, posted on the CMS website. Many of these revisions were based on comments received from representatives of the health care industry such as the American Medical Association (AMA), the Medical Group Management Association (MGMA), Medicare contractors, and providers and suppliers required to complete the form.

While we are considering revising the Medicare enrollment applications in calendar year (CY) 2010 to ease the burden and facilitate the enrollment process, it is important to note that the Internet-based PECOS enrollment process reduced the time necessary to complete a Medicare enrollment action (e.g., initial application, change in information) by a physician, provider, or supplier. It is also important to note that since Internet-based PECOS is based on content units and is scenario-driven, applicants are only required to complete questions based on their provider or supplier type. Accordingly, a physician would not see or complete questions related to a non-physician practitioner. The use of Internet-based PECOS reduces the application submission errors and facilitates the Medicare contractor's review and adjudication process.

We will thoroughly address this recommendation during the PECOS presentation at the March 8, 2010, PPAC meeting.

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

CMS Response: CMS originally released change request (CR) 6375 to address questions that have come to us from stakeholders on how to use place-of-service codes and bill date of service on the Medicare claim. As a result of concerns that

were raised to us by the physician and hospital community, CR 6375 was rescinded and will be replaced with another CR in the future pending further policy clarification on date-of-service and place-of-service reporting for the interpretation of diagnostic tests that consistently addresses the full spectrum of clinical scenarios.

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.

CMS Response: Section 1862(a)(11) of the Social Security Act ("the Act") prohibits Medicare payment under Part A or Part B for items or services "…where such expenses constitute charges imposed by immediate relatives of such individual or members of his household." The purpose of section 1862(a)(11) of the Act is to bar Medicare payment for items and services that would ordinarily be furnished for free because of the relationship between the physician and the beneficiary and to bar Medicare payment for medically unnecessary services that are ordered because of an immediate relative relationship. As explained in *Federal Register* volume 54, number 195, October 11, 1989, page 41723, "Congress recognized that, in family situations, it is difficult to differentiate between medically necessary services and those that are furnished because of affection or concern. Thus, the exclusion was also intended to guard against potential program abuse." Since the intent of section 1862(a)(11) of the Act is to bar Medicare payment for medically unnecessary services, CMS issued regulations at 42 CFR 411.12(c)(1)(ii) in order to implement those provisions by prohibiting Medicare payment when a physician who orders or supervises "incident-to" services has an excluded relationship with the beneficiary. Further, under 42 CFR 411.12(c)(2), services other than physicians' services are not covered by Medicare when they are provided by a group practice or partnership where one of the owners or partners has an excluded relationship.

Medicare may only pay for covered services and any changes to the current policy regarding physician payment for the treatment of family members would need to be consistent with the statute and adopted through notice and comment rulemaking. While CMS appreciates the recommendation of PPAC, the agency continues to believe that the current application of the payment exclusion is fully consistent with the statutory prohibition of Medicare payment for charges by immediate relatives of a beneficiary or members of his or her household and appropriately takes into consideration the unique challenges of assessing medical necessity in the context of family relationships by limiting the potential for program abuse in this area. Yet if PPAC is concerned about a particular aspect of this policy and its impact on beneficiaries, CMS will evaluate any additional information or evidence provided.

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.

CMS Response: The Secretary is required by statute to select clinical conditions that are subject to the hospital-acquired conditions (HACs) provision "that could reasonably have been prevented through the application of evidence-based guidelines." CMS, working with public health and infectious disease experts from the Centers for Disease Control and Prevention, identified clinical conditions that are "reasonably" preventable overall and not in each specific instance.

CMS will continue to carefully monitor and identify the clinical conditions selected as part of the HACs provision with the Inpatient Prospective Payment System. We will continue to review our policy regarding reimbursement when HACs occur annually through notice and comment in the *Federal Register*. That evaluation process will provide valuable information for future policy making aimed at preventing HACs. This work involves a multiyear contract that will examine the following: evidence-based guidelines, State tracking of HACs, and accuracy of coding, as well as other issues such as readmissions due to a HAC. CMS will share information from this contract as part of future rulemaking.

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 (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 and so that the other 80 percent of the cost should be attributed to the attending physicians and surgeons involved in the beneficiary's care.

CMS Response: CMS is carefully analyzing attribution rules for phase II of the RUR program. In phase I of the project, we created confidential reports using two different attribution rules — plurality-minimum, which attributes the entire cost of a beneficiary to one physician, and multiple-proportional, which attributes portions of a beneficiary's costs to multiple physicians based on each physician's contribution to the total cost. Both rules require physicians to bill for a minimum threshold amount of E&M services before being considered eligible for attribution of beneficiaries. The minimum threshold selected for phase I was 10 percent for both rules. We selected a lower threshold in phase I in order to be able to provide reports to more physicians; raising the threshold results in more unattributed beneficiaries, resulting in fewer reports. Attribution rules are applied to both per capita cost measures and costs of episodes of care. CMS is reviewing the attribution rules and minimum thresholds for phase II.

As part of our review of attribution methods, we will further consider PPAC's recommendation to cap attribution so that no more than 20 percent of the cost of a

beneficiary's hospitalization is attributed to physicians who provide E&M services to a beneficiary before or after a hospitalization. However, we are concerned that such an approach may not support the goal of improving accountability and coordination of care for beneficiaries when that care is related to the hospitalization. Identifying beneficiaries with a hospitalization and treating the costs associated with that hospitalization differently from costs not associated with that hospitalization would require some method of episode grouping. Proposed health care reform legislation would require CMS to build its own public domain episode grouper that combines separate but clinically related items and services into an episode of care for a beneficiary. Building this grouper to perform the type of analysis PPAC suggests would be a goal of that technology.

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.

CMS Response: CMS recognizes that statistical validity of RUR measurement information is important to providers. The RUR team in CMM is actively consulting with colleagues in the Office of Research, Development, and Information on the topic of statistical validity and the importance of being able to accurately distinguish physicians from each other when measuring resource use. We are considering data presentation alternatives for phase II, such as ranges and point estimates. CMS is still in the early stages of the program, and we plan to consider additional approaches to this issue through our collaborations with internal and external stakeholders.

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.

CMS Response: CMS considers risk adjustment among the most important factors to consider when measuring resource use. In phase I, the reports took into consideration several factors that affect the cost of patient care, such as the number of physicians per capita in the county and the median income of the physician's practice location ZIP code. The measurements also included demographic factors such as age, sex, and Medicaid status. CMS is carefully considering these and other risk-adjustment factors for phase II of the program. One possible source of risk-adjustment information is the Hierarchical Condition Categories (HCC) model used by Medicare Advantage. CMS is consulting with HCC experts about the applicability of this model to resource use measurement in fee-for-service Medicare.

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 (PQRI) reporting in 2011.

CMS Response: CMS has no current authority to pay incentives for PQRI reporting for 2011. The authority to pay a PQRI incentive and the scope of that authority would depend on Congressional action.

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.

CMS Response: CMS is actively considering a number of options for further continued physician education, including direct mailings and revalidations, to educate those physicians who have not updated their Medicare enrollment status in more than six years.

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.

CMS Response: As we adopted the consultation policy through notice and comment rulemaking effective January 1, delaying implementation of the policy would require us to issue new rulemaking. We are educating physicians about the change in policy in three main ways. First, CMS held Open Door Forums (free national conference calls available to any member of the public) on November 17, 2009; December 15, 2009; and February 2, 2010; where we answered a multitude of questions from the physician community. Second, CMS released operational instructions to its Medicare contractors on December 14, 2009, and provided information about this policy change to the provider community through a Medicare Learning Network article issued on December 15, 2009, and communications with the AMA and the medical specialty societies. CMS is also instructing its Medicare contractors to educate providers through various mechanisms, including their websites and listservs. Third, based upon suggestions from the AMA, we will be taking more steps to educate physicians, including posting questions and answers to respond to frequently asked questions. We believe the educational materials we have provided to our contractors and the physician community resolve many of the questions we have received since the final rule. See *MLN Matters* article SE1010, "Questions and Answers on Reporting Physician Consultation Services" (http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf), and revised article MM6740, "Revisions to Consultation Services Payment Policy" (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf).

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.

CMS Response: The President signed and CMS implemented the Department of Defense Appropriations Act of 2010. This Act provides a two-month, zero-percent update to the 2010 Medicare physician fee schedule effective for dates of service January 1, 2010, through February 28, 2010.

The President signed into law H.R. 4691, the Temporary Extension Act of 2010, on March 2, 2010. This law extends the expiration deadline for COBRA health care subsidies for one month. (This program was set to expire on February 28, 2010.) The new law also temporarily prevents the 21-percent cut in physician payments that are scheduled to take place under the sustainable growth rate and extends the Medicare physical therapy service caps exceptions process. (Both are extended through March 31, 2010.)

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

CMS Response: In the Medicare physician fee schedule final rule, CMS decided to finalize its proposal to no longer make payment for consultation codes and instruct physicians to bill for their services using other visit codes. In deciding to finalize this policy, CMS considered all of the public comments, including those that were opposed to the policy, but also ones from physician specialties and the MedPAC in support of the policy. In light of recent reductions in the documentation requirements for consultation services, CMS found that the resources involved in furnishing an inpatient or office consultation are not sufficiently different from the resources required for an inpatient or office visit to justify the existing differences in payment levels. The policy change for consultation codes had the effect of increasing payments for the office visit codes that are billed by most physicians, and, most commonly, by primary care physicians. See *MLN Matters* article SE1010, "Questions and Answers on Reporting Physician Consultation Services" (http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf), and revised article MM6740, "Revisions to Consultation Services Payment Policy" (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf).

Agenda Item O — Wrap Up and Recommendations
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.

CMS Response: Medicare will no longer recognize the CPT consultation codes for purposes of determining Medicare secondary payer payments. In Medicare secondary payer cases, providers must bill an appropriate E&M code for the services previously reported and paid using the CPT consultation codes. If the

primary payer for the service continues to recognize CPT consultation codes for payment, providers billing for these services may either:

- ☐ bill the primary payer an E&M code that is appropriate for the service, and report to Medicare the amount actually paid by the primary payer, along with the same E&M code, for determination of whether a payment is due; or

- ☐ bill the primary payer using a CPT consultation code that is appropriate for the service, and report to Medicare the amount actually paid by the primary payer, along with an E&M code that is appropriate for the service, for determination of whether a payment is due.

Corrected Response from the August 31, 2009, PPAC Meeting
Agenda Item O — Wrap Up and 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 (DMEPOS) accreditation requirements as they are already licensed and trained to provide durable medical equipment supplies to patients.

CMS Response: CMS acknowledges that most non-physician practitioners, e.g., podiatrists and optometrists, are exempt from the bond requirements as outlined in Medicare regulations. Section 1861(r) of the Social Security Act includes podiatrists and optometrists within its definition of "physician." We are clarifying our previous response that podiatrists and optometrists are considered physicians. The reference in the previous response that podiatrists and optometrists are non-physician practitioners, rather than physicians, was in error and was retracted from the response.

Arthur D. Snow, M.D., said CMS' refusal to accept CPT consultation codes poses an undue burden on physicians treating beneficiaries for whom Medicare is the secondary payer.

Recommendation
71-C-1: PPAC recommends that CMS reconsider its deletion of CPT consultation codes because doing so causes problems when billing Medicare as a secondary carrier.

Fredrica Smith, M.D., said CMS' rules against paying for care of family members could limit access for beneficiaries who seek care from very large group practices or affiliated practices in rural areas.

Recommendation

71-C-2: PPAC recommends that CMS clarify the definition of a group practice or partnership where one of the owners or partners has an excluded relationship to ensure it does not apply to very large groups or entities or to widely scattered groups or partnerships.

Dr. Fredrica Smith pointed out that county borders and median physician incomes are not good surrogates for service areas.

Recommendation
71-C-3: In considering risk-adjustment measures, PPAC recommends that instead of looking at the number of practitioners and their median income, CMS determine the areas that practitioners or medical groups serve.

Dr. Ross said that the deadline for health care providers to apply for or renew participation in Medicare should fall after the physician fee schedule for the year has been finalized.

Recommendations
71-C-4: PPAC again strongly 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.

71-C-5: PPAC recommends that CMS set the deadline for indicating participation in Medicare to two weeks following the finalization of the physician fee update.

NEW BUSINESS

Agenda Item D — PRIT Update

William Rogers, M.D., Director of PRIT, said CMS will likely remove the requirement for mandatory training about Medicare fraud and abuse because it is too burdensome and may be redundant (Presentation 1). As PPAC recommended, CMS tabled its proposal to modify the billing for date and place of service. Also, CMS extended the deadline for enrolling in PECOS. Dr. Rogers said a policy will go out soon that addresses illegible provider signatures. Finally, 49 State Medicaid programs now have the ability to accept Medicare crossover claims; South Carolina recently received funds to implement such a system.

Agenda Item E — PECOS

James Bossenmeyer, Director of Provider/Supplier Enrollment in the Program Integrity Group, explained that the Internet-based PECOS is available to all providers except DMEPOS suppliers, who should be able to use the system later this year (Presentation 2). Mr. Bossenmeyer described some of the mechanisms in place to facilitate use of PECOS. He emphasized that the processing time for online enrollment is faster than submitting paper forms. Mr. Bossenmeyer said once the contractor receives the signed certification

statement, processing takes less than 30 days. Providers and suppliers can verify their enrollment status by checking the PECOS database, which is updated every four to six weeks.

Dr. Snow said the enrollment forms are confusing, and revalidating his enrollment resulted in denial of claims as a result of the transition between systems. He also said he will no longer see patients who are transferred to nursing homes if he has not already included the specific nursing home on his Medicare information, because it's too complicated to add new locations. Dr. Fredrica Smith and Roger L. Jordan, O.D., both noted that providers are not aware of the requirement to enroll in PECOS.

> *Recommendation*
> **71-E-1**: PPAC recommends that CMS undertake significant outreach to the physician community about the extension of the deadline for PECOS enrollment to January 3, 2011.

Agenda Item G — Electronic Health Records (EHR) Update

Tony Trenkle, Director of E-Health Standards and Services, explained that the proposed rules for the EHR Incentive program define meaningful use of EHRs and identify who is a hospital-based eligible professional, among other things (Presentation 3a). The criteria for meaningful use of EHRs include quality reporting, electronic prescribing, and information exchange; the definition of meaningful use will be implemented in three stages from 2011 through 2015. Mr. Trenkle outlined the requirements for eligible professionals and hospitals to report clinical quality measures as a function of meaningful use. Mr. Trenkle noted that most of the recommendations of the Health Information Technology Policy Committee, a multidisciplinary Federal advisory body, are reflected in the proposed rules.

David Hunt, M.D., Medical Officer in the Office of the National Coordinator for Health Information Technology (ONCHIT), described the philosophy behind the promotion of health information technology (HIT) as a tool for improving quality and efficiency and reducing costs and disparities in health care (Presentation 3b). He acknowledged the key barriers to adoption of EHR, primarily the cost and complexity of implementing the systems. The EHR Incentive program seeks to mitigate financial barriers. In addition, Federal grants to support State-based HIT regional extension centers and national workforce training will help practitioners identify the best EHR systems for their practices and implement those systems smoothly. Extension centers will provide technical assistance and disseminate best practices, especially in rural and other underserved areas. Dr. Hunt added that successful information exchange also requires a framework of standards and certification as well as guidelines for privacy and security.

Richard E. Smith, M.D., said his practice is part of a regional effort that uses HIT to improve efficiency in providing care. He said CMS should ensure that its efforts do not create barriers to beneficiary access to care. Chiledum A. Ahaghotu, M.D., echoed the point, saying that providers can only absorb so many costly and time-consuming Federal requirements. Dr. Ross suggested ONCHIT wage a public relations campaign promoting

the cost- and time-saving potential of EHRs. Joseph Giaimo, D.O., said the current meaningful use criteria require practitioners to collect data by hand to demonstrate use of EHRs.

Recommendations

71-G-1: PPAC believes that the proposed stage-1 criteria for meaningful use are too aggressive and will deter adoption and participation in the program. For example, the use of numerator and denominator data to determine meaningful use requires significant work by the individual provider, and no automated method exists to collect such data. Therefore, PPAC recommends that CMS remove the requirement to obtain numerator and denominator data as an objective measure to meet the meaningful use criteria until those data are readily available using EHR systems.

71-G-2: PPAC recommends that CMS develop an effective feedback mechanism so that practitioners can determine early on whether they are meeting the criteria for meaningful use.

71-G-3: PPAC recommends to CMS that the quality measures included in the definition of meaningful use incorporate measures developed by consensus organizations (e.g., the AMA's Physician Consortium for Performance Improvement, the Ambulatory Quality Alliance, and the Surgical Quality Alliance) to facilitate the use of evidence-based medicine and to more fully reflect quality-of-care parameters in quality measurement.

Dr. Williams said that CMS categorizes anesthesiologists as hospital-based eligible professionals, but many practice in other settings and are thus not eligible for the EHR Incentive program. Jonathan E. Siff, M.D., asked that CMS provide guidance on navigating privacy regulations to share health information electronically.

71-G-4: Given CMS's proposal to use prior year claims data to determine professionals' eligibility for incentive payments for meaningful use of EHR, PPAC recommends that CMS a) inform professionals of their eligibility status before the start of each year in which incentive payments or penalties are determined and b) make publicly available in a de-identified, summarized form the number of professionals deemed hospital-based and the number deemed eligible professionals by specialty designation.

71-G-5: As part of the meaningful use objectives and measures for eligible hospitals, PPAC recommends that CMS include requirements that will encourage investment in EHR technology in all clinical areas of the hospital, including inpatient and outpatient operating rooms, ambulatory surgical centers, and emergency departments in which the hospital has a financial stake. Such investment would allow hospital-based physicians and other eligible professionals who frequently practice in the hospital (e.g., surgeons) to use hospital EHRs in a meaningful way that pertains to their patients.

71-G-6: PPAC recommends that CMS clarify and disseminate how organizations can share EHR information without violating the Health Insurance Portability and Accountability Act or other compliance regulations.

71-G-7: PPAC recommends that CMS modify the meaningful use criteria to allow traditionally hospital-based professionals the opportunity to receive incentive payments (or avoid the penalties set to begin in 2015) if they demonstrate that they have purchased and are meaningfully using a certified EHR system in their primary practice location.

Christopher Standaert, M.D., said EHRs may be cost-beneficial to the practice (or institution) as a whole but time-consuming and thus costly to the individual provider. He added that the current financial incentives for using EHRs work against the goal of sharing information across systems. Dr. Hunt noted that the extension centers will also support research to identify improvements in systems and software. Dr. Bufalino asked for more clarification of who will be eligible for incentives. Terry Kay, Senior Technical Advisor for CMM, explained some of the proposed guidelines but said eligibility would be determined according to the place of service on the claims data submitted.

Agenda Item I — Fraud and Abuse Update

George Mills, Director of the Provider Compliance Group, explained the roles of the various divisions of his group (Presentation 4a). Among the projects under the purview of the Provider Compliance Group are:

- ☐ implementation of an audit process for incentive payments under the Health Information Technology for Economic and Clinical Health Act,
- ☐ ensuring CMS can receive EHRs,
- ☐ developing automatic edits to prevent some of the coding discrepancies found by recovery audit contractors (RACs) on automated review, and
- ☐ creating a comparative billing report for hospitals.

Mr. Mills described some common errors and sources of concern that his office addresses, such as failure to document medical necessity when prescribing DMEPOS. Latesha Walker, Director of the Division of Medical Review and Education, noted that some CMS decisions are overturned by administrative law judges who are not bound by CMS regulations, manuals, and local coverage decisions, resulting in a disconnect between the policies applied by contractors and the findings of administrative law judges on appeals.

Dr. Fredrica Smith said outreach efforts on fraud and abuse and correcting errors have not been apparent in New Mexico. Dr. Bufalino suggested CMS work with medical specialty societies to get the message out.

Kim Brandt, Director of the Program Integrity Group in the Office of Financial Management, described the most common types of fraud and the States where the most

Medicare fraud occurs (Presentation 4b). While it's difficult to provide accurate data on the role of physicians in fraud and abuse, said Ms. Brandt, a recent crackdown on suspicious DMEPOS claims and indictments brought by the Health Care Fraud Prevention and Enforcement Action Team identified very few physicians involved in Medicare fraud. Ms. Brandt said CMS is working with AMA, MGMA, and others on improving education and messaging about fraud and abuse.

Recommendations

71-I-1: PPAC recommends that CMS direct the Program Integrity Group to inform the general public and Congress that physicians are an extreme minority of those committing fraud and abuse in the Medicare system.

71-I-2: PPAC recommends that CMS direct the Program Integrity group auditors to consider matters of fraud and abuse without a punitive philosophy regarding physician reviews.

Agenda Item J — RAC Update

Connie Leonard, Director of the Division of Recovery Audit Operations, said all the RAC websites allow practitioners to check on the status of a claim under review, which is helpful to those concerned that they may not have received communication from the RAC about a case (Presentation 5). CMS is working with the AMA to devise a policy on the number of records a RAC can request for review; until a policy is finalized, RACs will not conduct complex medical reviews (i.e., reviews requiring analysis of medical records). CDR Marie Casey, R.N., Deputy Director of the Division of Recovery Audit Operations, said that only three of the four regions have identified issues for review (approved by CMS), and all of those issues center around miscoding of the number of units involved in care.

Dr. Williams said that one RAC has wrongly identified anesthesiologists as billing incorrectly and continues to send out notification letters despite acknowledging the billing is correct. The same RAC has delayed notification letters, postmarking them as much as three weeks after the date of the letter, which eliminates the recipient's two-week rebuttal period. Dr. Fredrica Smith said mail delivery in rural New Mexico has become very slow, so the two-week rebuttal period is easily missed.

Dr. Ouzounian said CMS should identify coding errors, not the RACs. Dr. Standaert pointed out that the RACs are not penalized for their mistakes and so have no disincentive that would prevent them from wrongly sending out notification letters.

For the limitations on documentation that practitioners must provide, Ms. Leonard said CMS leans toward requiring a set percentage of the practitioner's Medicare claims. Dr. Standaert said that if CMS uses that method, CMS — not the RACs — should calculate that percentage for the practitioner.

Recommendations

71-J-1: PPAC recommends that CMS investigate the methodology that RACs intend to use for potential target areas such that implementation appropriately captures miscoding.

71-J-2: PPAC recommends that CMS direct the RACs to send notification letters in a manner that is consistent with reasonable and timely reply expectations for providers.

71-J-3: PPAC recommends that CMS change the time allotted for rebuttal for both RAC and Medicare Administrative Contractor requests from 15 days to 45 days before recoupment is initiated in order to reflect the realities of mail delivery and physician schedules.

Agenda Item O — Wrap Up and Recommendations

Liz Richter, CMM Deputy Director, thanked the outgoing members of the Council. Dr. Bufalino asked for additional recommendations from the Council.

Recommendations

71-O-1: PPAC recommends that CMS review the list of recognized denominators used in the PQRI, particularly the physical examination codes used in the preventive care panel.

71-O-2: PPAC recommends that CMS revise the rules regarding physician supervision of outpatient services at critical access hospitals and report the outcomes of the March 9, 2010, rural health Open Door Forum.

71-O-3: PPAC recommends that CMS revise its implementation of the PECOS revalidation system to furnish providers a date certain (e.g., six weeks from revalidation) when the new application information will become effective in order to stop disruption of cash flow as a result of revalidation.

71-O-4: PPAC recommends that CMS limit its payment restriction for services to immediate relatives to only those physicians with an excluded relationship.

71-O-5: PPAC recommends that CMS add two representatives to the Health Information Technology Policy Committee: a physician representing a rural practice and a physician representing a small practice (i.e., fewer than five providers).

Recommendations of the Council are listed in Appendix B. Dr. Bufalino adjourned the meeting.

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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

Jonathan Blum, Director
Center for Medicare Management

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

Presenters

James Bossenmeyer, Director
Division of Provider/Supplier Enrollment
Program Integrity Group
Office of Financial Management

Kim Brandt, Director
Program Integrity Group
Office of Financial Management

CDR Marie Casey, R.N., Deputy Director
Division of Recovery Audit Operations
Provider Compliance Group
Office of Financial Management

David Hunt, M.D., Medical Officer
Office of the National Coordinator of Health Information Technology
Department of Health and Human Services

Connie Leonard, Director
Division of Recovery Audit Operations
Provider Compliance Group
Office of Financial Management

George Mills, Director
Provider Compliance Group
Office of Financial Management

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

Tony Trenkle, Director
E-Health Standards and Services
Centers for Medicare & Medicaid Services

Latesha Walker, Director
Division of Medical Review and Education
Provider Compliance Group
Office of Financial Management

Dana Trevas, Rapporteur
Magnificent Publications, Inc.

John O'Leary, Sound Engineer
Magnificent Publications, Inc.

APPENDICES

Appendix A: Meeting agenda
Appendix B: Recommendations from the March 8, 2010, meeting

The following documents were presented at the PPAC meeting on March 8, 2010:

Presentation 1: PRIT Update
Presentation 2: Provider Enrollment, Chain, and Ownership System
Presentation 3a: Electronic Health Records (EHR) Update
Presentation 3b: Provider Support for EHR Adoption, Implementation, and Meaningful Use
Presentation 4a: Medical Review
Presentation 4b: Fraud and Abuse Update
Presentation 5: Recovery Audit Contract Update

Appendix A

Practicing Physicians Advisory Council
Centers for Medicare & Medicaid Services
The Multipurpose Room
Central Office Single Site Campus
7500 Security Boulevard
Baltimore, Maryland 21244
03-08-2010

08:30 - 08:40	**A. Opening Remarks**	**Vincent J. Bufalino, M.D., Chairman, Practicing Physicians Advisory Council**
08:40 - 08:50	**B. Welcome**	**Jonathan D. Blum, Director, Center for Medicare Management, and Acting Director, Center for Drug and Health Plan Choice**
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. Provider Enrollment and Chain, Ownership System (PECOS)**	**James Bossenmeyer, Director, Division of Provider/Supplier Enrollment, Program Integrity Group, Office of Financial Management**
10:15 - 10:30	**F. Break** (*Chair Discretion)*	
10:30 - 12:00	**G. Electronic Health Records (EHR) Update**	**Tony Trenkle, Director, E-Health Standards & Services Centers for Medicare & Medicaid Services**

	--Provider Support for EHR Adoption, Implementation, and Meaningful Use	**David R. Hunt, M.D., Medical Officer, Office of the National Coordinator for Health IT**
12:00 - 01:00	**H. Lunch**	
01:00 - 02:00	**I. Fraud & Abuse Update**	**Kim Brandt, Director, Program Integrity Group, Office of Financial Management**
	--Medical Review	**George Mills, Director, Provider Compliance Group, Office of Financial Management** **Latesha Walker, Director, Division of Medical Review & Education, Provider Compliance Group, Office of Financial Management**
02:00 - 02:45	**J. RAC Update**	**Commander Marie Casey, R.N., Deputy Director, Division of Recovery Audit Operations, Provider Compliance Group, Office of Financial Management** **Connie Leonard, Director, Division of Recovery Audit Operations, Provider Compliance Group, Office of Financial Management**
02:45 - 03:00	**K. Break** *(Chair Discretion)*	
03:00 – 03:30	**L. Wrap Up and Recommendations**	

Appendix B

PRACTICING PHYSICIANS ADVISORY COUNCIL (PPAC)
RECOMMENDATIONS
Report Number Seventy-One
March 8, 2010

Agenda Item C — PPAC Update

71-C-1: PPAC recommends that CMS reconsider its deletion of Current Procedural Terminology (CPT) consultation codes because doing so causes problems when billing Medicare as a secondary carrier.

71-C-2: PPAC recommends that CMS clarify the definition of a group practice or partnership where one of the owners or partners has an excluded relationship to ensure it does not apply to very large groups or entities or to widely scattered groups or partnerships.

71-C-3: In considering risk-adjustment measures, PPAC recommends that instead of looking at the number of practitioners and their median income, CMS determine the areas that practitioners or medical groups serve.

71-C-4: PPAC again strongly recommends that CMS recommend to Congress to avoid the 21-percent cut to the physician fee schedule 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.

71-C-5: PPAC recommends that CMS set the deadline for indicating participation in Medicare to two weeks following the finalization of the physician fee update.

Agenda Item E — Provider Enrollment, Chain, and Ownership System (PECOS)

71-E-1: PPAC recommends that CMS undertake significant outreach to the physician community about the extension of the deadline for PECOS enrollment to January 3, 2011.

Agenda Item G — Electronic Health Records (EHR) Update

71-G-1: PPAC believes that the proposed stage-1 criteria for meaningful use are too aggressive and will deter adoption and participation in the program. For example, the use of numerator and denominator data to determine meaningful use requires significant work by the individual provider, and no automated method exists to collect such data. Therefore, PPAC recommends that CMS remove the requirement to obtain numerator and denominator data as an objective measure to meet the meaningful use criteria until those data are readily available using EHR systems.

71-G-2: PPAC recommends that CMS develop an effective feedback mechanism so that practitioners can determine early on whether they are meeting the criteria for meaningful use.

71-G-3: PPAC recommends to CMS that the quality measures included in the definition of meaningful use incorporate measures developed by consensus organizations (e.g., the American

Medical Association's Physician Consortium for Performance Improvement, the Ambulatory Quality Alliance, and the Surgical Quality Alliance) to facilitate the use of evidence-based medicine and to more fully reflect quality-of-care parameters in quality measurement.

71-G-4: Given CMS's proposal to use prior year claims data to determine professionals' eligibility for incentive payments for meaningful use of EHR, PPAC recommends that CMS a) inform professionals of their eligibility status before the start of each year in which incentive payments or penalties are determined and b) make publicly available in a de-identified, summarized form the number of professionals deemed hospital-based and the number deemed eligible professionals by specialty designation.

71-G-5: As part of the meaningful use objectives and measures for eligible hospitals, PPAC recommends that CMS include requirements that will encourage investment in EHR technology in all clinical areas of the hospital, including inpatient and outpatient operating rooms, ambulatory surgical centers, and emergency departments in which the hospital has a financial stake. Such investment would allow hospital-based physicians and other eligible professionals who frequently practice in the hospital (e.g., surgeons) to use hospital EHRs in a meaningful way that pertains to their patients.

71-G-6: PPAC recommends that CMS clarify and disseminate how organizations can share EHR information without violating the Health Insurance Portability and Accountability Act or other compliance regulations.

71-G-7: PPAC recommends that CMS modify the meaningful use criteria to allow traditionally hospital-based professionals the opportunity to receive incentive payments (or avoid the penalties set to begin in 2015) if they demonstrate that they have purchased and are meaningfully using a certified EHR system in their primary practice location.

Agenda Item I — Fraud and Abuse Update

71-I-1: PPAC recommends that CMS direct the Program Integrity Group to inform the general public and Congress that physicians are an extreme minority of those committing fraud and abuse in the Medicare system.

71-I-2: PPAC recommends that CMS direct the Program Integrity group auditors to consider matters of fraud and abuse without a punitive philosophy regarding physician reviews.

Agenda Item J — Recovery Audit Contractor (RAC) Update

71-J-1: PPAC recommends that CMS investigate the methodology that RACs intend to use for potential target areas such that implementation appropriately captures miscoding.

71-J-2: PPAC recommends that CMS direct the RACs to send notification letters in a manner that is consistent with reasonable and timely reply expectations for providers.

71-J-3: PPAC recommends that CMS change the time allotted for rebuttal for both RAC and Medicare Administrative Contractor requests from 15 days to 45 days before recoupment is initiated in order to reflect the realities of mail delivery and physician schedules.

Agenda Item O — Wrap Up and Recommendations

71-O-1: PPAC recommends that CMS review the list of recognized denominators used in the Physician Quality Reporting Initiative, particularly the physical examination codes used in the preventive care panel.

71-O-2: PPAC recommends that CMS revise the rules regarding physician supervision of outpatient services at critical access hospitals and report the outcomes of the March 9, 2010, rural health Open Door Forum.

71-O-3: PPAC recommends that CMS revise its implementation of the PECOS revalidation system to furnish providers a date certain (e.g., six weeks from revalidation) when the new application information will become effective in order to stop disruption of cash flow as a result of revalidation.

71-O-4: PPAC recommends that CMS limit its payment restriction for services to immediate relatives to only those physicians with an excluded relationship.

71-O-5: PPAC recommends that CMS add two representatives to the Health Information Technology Policy Committee: a physician representing a rural practice and a physician representing a small practice (i.e., fewer than five providers).