REPORT NUMBER FORTY-THREE

to the

Secretary

U.S. Department of Health and Human Services

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(Re: Physicians Regulatory Issues Team, Sustainable Growth Rate, Physician Fee Schedule, and other matters)

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From the

Practicing Physicians Advisory Council

(PPAC)

Central Office Headquarters

Baltimore, MD

February 10, 2003

SUMMARY OF THE FEBRUARY 10, 2003, MEETING

Introduction and Overview

The Practicing Physicians Advisory Council (PPAC) met at the CMS Headquarters in Baltimore, MD, on Monday, February 10, 2003. The chair, Dr. Michael T. Rapp, said the Council scheduled its meeting earlier in the year than usual to allow more time for comment on the proposed physician fee schedule. He emphasized that the Council's advice should stem specifically from its members' experience in clinical practice. Dr. Rapp announced that Drs. Richard Bronfman, Stephen Imbeau, Dale Lervick, and Victor Vela had completed their terms on the Council and thanked them for their work. Four new physicians will join the Council in June: Dr. Carlos Hamilton, Endocrinologist, of Houston, TX; Dr. Dennis Iglar, Family Practitioner, of Oconomowoc, WI; Dr. Laura Powers, Neurologist, of Knoxville, TN; and Dr. Robert Urata, Family Practitioner, of Juneau, AK. Drs. Hamilton and Iglar sat in on the meeting to observe.

Dr. Rapp referred to a conference call meeting in which Council members discussed the agenda for this meeting. Dr. Rothammer asked that in the future, members who are unable to take part in a Council conference call be provided with a summary report of the call.

Dr. Rapp noted that PPAC had received written testimony and requests to present oral testimony from several organizations. Those presenting oral testimony were asked to confine their comments to the issue at hand as the Council progressed through the agenda. In making its recommendations, the Council considered both the oral and written testimony provided.

Mr. Tom Grissom, director of the Center for Medicare Management, thanked the departing members of the Council and welcomed the new members. He expressed gratitude to Dr. Rapp for working with CMS staff on the agenda and minutes from previous meetings, as well as organizing the conference call. He hoped these efforts, in addition to detailed information provided to Council members in advance of the meeting, would help facilitate the communication process and result in timely resolution of concerns.

Old Business

Agenda Item C — Status and Update on PPAC Recommendations from December 2002

Dr. Paul Rudolf, executive director for PPAC, presented the responses from CMS and DHHS to PPAC recommendations made at the December 2002 meeting (Report Number 42):

(***Key:*** *Numeric and alpha organization refer to the following: 42 refers to the meeting number; A, B, etc. refers to agenda item; and 1, 2, etc. refers to number of recommendation under each agenda item.)*

42-C: Federal Register Notice

42-C-1: PPAC recommends that the Old Business list from the PPAC minutes be included in the agenda published in the *Federal Register* for the purpose of discussion at future meetings.

NOT ADOPTED on the basis that the recommendation would lead to repeated discussion of the same issues at each meeting.

42-C: Carrier Medical Directors

42-C-2: PPAC recommends that CMS instruct carriers to ensure that carrier medical directors be available through current toll-free telephone lines.

NOT ADOPTED on the basis that the toll-free telephone contact system is currently overwhelmed and that transferring calls can result in a toll charge.

42-E: Physician Fees

42-E-1: For its future meetings, PPAC recommends the agenda include, under new business items, the outcomes of research on the costs of reestablishing practices that were lost (i.e., no longer participating in Medicare) due to decreases in the physician fee schedule.

NOT ADOPTED on the basis that CMS is not aware of any existing research on the costs of reestablishing practices that were lost and does not know how such research could be conducted. Further, CMS does not believe that decreased Medicare physician fee payments are solely responsible for the closing of physician practices.

42-E-2: PPAC recommends that it get updates from the appropriate entity on the assumption that physicians can accommodate an annual 30% increase in productivity ad infinitum.

NOT ADOPTED on the basis that the recommendation does not accurately portray CMS' assumption. The agency does not believe that physicians must increase their work per unit of time by 30% annually in order to maintain their fees; rather, 30% of fees are offset by changes in practice, such as selecting less expensive procedures. The agency's assumptions are based on a 1998 report from the Office of the Actuary, "Physician Volume and Intensity Response," which can be found on the Internet at www.cms.hhs.gov/statistics/actuary/physicianresponse/.

42-F: Doctors Office Quality (DOQ) Project

42-F-1: PPAC recommends that the DOQ project take steps to minimize the paperwork and time required by participating physicians in order to avoid creating a financial

disincentive to participation.

TO BE CONSIDERED at the June 2003 meeting.

42-F-2: PPAC recommends that CMS explore future demonstration projects on the use of financial incentives to achieve quality improvement goals.

TO BE CONSIDERED at the June 2003 meeting.

42-F-3: PPAC recommends that CMS use the American Medical Association's (AMA's) Physician Consortium for Performance Improvement's evidence-based performance measures and any resulting data for quality improvement purposes only.

TO BE CONSIDERED at the June 2003 meeting.

42-F-4: PPAC recommends that CMS continue to work with the AMA and the Consortium to ensure the appropriate development and implementation of evidence-based clinical performance measures that enhance the quality of patient care and advance the science of clinical performance measurement and improvement.

TO BE CONSIDERED at the June 2003 meeting.

42-F-5: PPAC recommends that CMS use information gleaned from implementing the measures in the pilot tests of the DOQ project to further refine the measures, if necessary, in collaboration with the Consortium, and the Consortium should be involved in future implementation efforts.

TO BE CONSIDERED at the June 2003 meeting.

42-F-6: PPAC recommends that CMS recognize the state-of-the-art of physician performance measurement, which supports the use of measurement to promote continuous quality improvement; existing methodologies do not warrant the use of measures for purposes of individual accountability, comparison, or choice.

TO BE CONSIDERED at the June 2003 meeting.

42-F-7: PPAC recommends that CMS acknowledge the serious limitations in using performance measurement to assess physician competence and to work with the AMA and the Consortium to ensure that data from the DOQ project are used to improve the overall quality of patient care and not to assess individual physician performance.

TO BE CONSIDERED at the June 2003 meeting.

42-F-8: PPAC recommends that CMS consider the burden of data collection; consider the use of electronic medical systems to collect and process data; and agree to collect data for the DOQ project prospectively only.

TO BE CONSIDERED at the June 2003 meeting.

42-F-9: PPAC recommends that CMS involve the national medical specialty societies and boards in addressing what constitutes the appropriate specialty-specific variance in clinical practice.

TO BE CONSIDERED at the June 2003 meeting.

42-F-10: PPAC recommends that CMS indicate physician participation only as the sole criterion for public recognition by the DOQ project.

TO BE CONSIDERED at the June 2003 meeting.

42-F-11: PPAC recommends that the DOQ project measure physician productivity within the context of the current study.

TO BE CONSIDERED at the June 2003 meeting.

42-F-12: PPAC recommends that specialist physicians be included in the DOQ project.

TO BE CONSIDERED at the June 2003 meeting.

42-G: Immunoassay Fecal Occult Blood Testing

42-G: PPAC recommends that the existing rule related to coverage of guaiac-based fecal occult blood tests for screening for colorectal cancer be changed to allow other types of fecal occult blood tests to be considered for coverage.

ADOPTED. The change will be published in the 2003 physician fee schedule.

42-H: Customer Service Survey

42-H-1: PPAC recommends that when a comparative billing report on an individual is requested, the request does not trigger an investigation of the individual.

NOT ADOPTED on the basis that although a request generally does not trigger an automatic review, CMS will not preclude carriers from taking necessary steps to ensure appropriate billing.

42-H-2: PPAC recommends that CMS publish the results of the Program Integrity Customer Service Initiative survey and the resulting workplan and that CMS use those vehicles available through specialty and other medical societies to widely distribute the survey results and workplan.

ADOPTED. The steps recommended are underway.

42-H-3: PPAC commends the Program Integrity Customer Service Initiative for efforts to make the project more understandable.

ACKNOWLEDGED. CMS thanks the Council for its positive feedback.

42-H-4: PPAC recommends that Program Integrity Staff continue efforts to have contractors make their articles on coverage and coding policies and frequently asked questions available for the Medicare coverage database and searchable.

ADOPTED. The agency is working to build article data entry tools for contractors and is providing funding to include more articles in the database.

New Business

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

Dr. William Rogers, MD, medical advisor in the Office of the Administrator, updated the Council on the work of the PRIT (see Appendix 1). He reported that PRIT has made progress on a number of issues; the status of the Team's efforts are described on its web site (www.cms.hhs.gov/physicians/prit). The group will next focus on concerns identified by the Secretary's Regulatory Reform Committee and clinicians' concerns about the provision of translation services for patients with limited English proficiency. The Council praised Dr. Rogers on his progress and suggested PRIT take up the issue of physicians having difficulty contacting carrier medical directors. Dr. Wood suggested that the Council review at its next meeting a 2002 report from the General Accounting Office, "Medicare: Communications with Physicians Can Be Improved" (GAO-02-249, available on the Internet at www.gao.gov).

D-1: PPAC recommends physician communication issues with carrier medical directors (e.g., ease of contact and response time) be referred to the PRIT for consideration.

Agenda Item E — Sustainable Growth Rate (SGR) Issues for 2003 and 2004

Terry Kay, director of the Division of Practitioner Services, said he and others from his staff were on hand to answer questions from the Council about the SGR. Adjustments published in the final rule will be made as soon as possible. Marc Hartstein, Health Insurance Specialist in the Division of Practitioner Services, said CMS adopted a proposal to adjust the SGR for drug prices, because drug prices are increasing faster than the other components of the Medicare Economic Index (MEI). (Drugs included in the MEI are those administered by physicians in an office setting, such as chemotherapy drugs, and are often referred to as "incident to" drugs).

Council members said the goal of controlling spending by including drugs in the calculation has not been realized. John Shatto from the Office of the Actuary stated that removing drug costs from the SGR calculation may have a positive effect on the physician fee schedule in future years, but, had they been removed in earlier years, the outcomes would have been the same (i.e., the physician fee update would still have been negative for 2002 and 2003). Members further noted that regulatory requirements and recommendations that affect clinical practice (e.g., increased office visits for preventive care for patients with diabetes) are not adequately reflected in the SGR. Mr. Kay added that the agency recognizes the flaws in the SGR but believes they can only be fixed by Congressional changes to the federal statute.

Dr. Duane Cady, representing the AMA, said the cuts to the physician fee schedule are affecting Medicare beneficiaries' access to physicians (see Appendix 2). He supported removing drug costs from the SGR and added that projected changes in utilization and spending that result from national coverage decisions should be reflected in the SGR. Dr. William Jessee, representing the Medical Group Management Association, also supported removing drug costs from the SGR and asked that Medicare use industry-

specific measures of overhead costs and accurate measures of the costs of regulatory compliance in its calculations (see Appendix 3).

Dr. Tom Weida, representing the American Academy of Family Physicians (AAFP), echoed the concerns raised by the AMA and the Medical Group Management Association (see Appendix 4), as did Dr. Hugh Trout, representing the American College of Surgeons (ACS) (see Appendix 5).

The Council expressed grave concern that the cuts to the physician fee schedule would potentially decrease beneficiaries' access to a wide pool of qualified and well-trained physicians.

E-1: PPAC recommends CMS remove drug expenditures from the definition of physician services in the calculation of the SGR.

E-2: PPAC recommends CMS calculate the cost of regulations and sub-regulatory actions by the agency (e.g., quality initiatives) that impact physician practice costs and use the results to increase Medicare payment rates each year to account for these costs.

E-3: PPAC recommends CMS consult with organizations representing physicians concerning the methodology for calculating regulation impact costs.

E-4: PPAC recommends CMS invite public comment in the proposed rule on changes to the SGR formula.

E-5: PPAC recommends that CMS work with stakeholders to develop new methods of calculating the true costs associated with providing care to Medicare beneficiaries.

E-6: PPAC recommends that CMS use accurate estimates of proposed expenditures for national coverage decisions in utilization to adjust the sustainable growth rate targets.

Agenda Item F — 2003 Physician Fee Schedule: Open Comment Period to Address Specific G Codes Issues, Anesthesia Issues, Delay in 2003 Fee Schedule, and Other Issues

Dr. Lloyd Smith, representing the American Podiatric Medical Association, said the agency had established two new G codes for podiatric procedures that are already sufficiently covered by Current Procedural Terminology (CPT) codes (see Appendix 6). He said CMS should continue transitioning existing G codes to the more widely used CPT codes, that new G codes should only be developed in the face of a compelling need, and that the development of new G codes should include opportunities for input from interested parties. Dr. Smith complained that the current approach violates the

Administrative Procedure Act.

Dr. Julia Pillsbury, representing the American Academy of Pediatrics, noted similar concerns about G codes as the American Podiatric Medical Association (see Appendix 7). She pointed out that administering vaccines to children requires more counseling time than adult vaccination and asked that CMS acknowledge this by incorporating the corresponding work values recommended by the Relative Value Scale Update Committee (RUC) in the 2004 final rule.

Dr. Alexander Hannenberg, representing the American Society of Anesthesiologists, explained that Medicare uses a unique calculation system to determine the reimbursement for anesthesia services (see Appendix 8). He claimed Medicare reimbursement rates are two to three times lower than private insurance rates and also lower than other public assistance reimbursement rates. A recent study by the RUC identified the underpayment of anesthesia services, but CMS made only a very small adjustment in response. He asked that CMS evaluate the anesthesia conversion factor and incorporate adequate anesthesia reimbursement rates in the 2004 physician fee schedule. Dr. Rapp noted that if the RUC or other advisory committees made recommendations on the matter, PPAC would like to review the recommendations.

In its written testimony, the AMA asked that clinicians be given ample time to consider changes to the fee schedule before making decisions about continued Medicare participation (see Appendix 2).

F-1: PPAC recommends CMS continue its efforts to transition G codes to CPT codes, as appropriate, at least annually.

F-2: PPAC recommends that if new coding and payment decisions are made by CMS, the decisions should be addressed in the proposed rule whenever possible so that interested parties have sufficient opportunity to provide comment on suggested changes.

F-3: PPAC recommends CMS adhere to the Administrative Procedure Act.

F-4: PPAC recommends CMS continue efforts to achieve coding standardization, accuracy, and clarity.

F-5: PPAC recommends CMS *not* introduce new G codes without a compelling need. If a new G code is developed to accommodate changes in legislation, regulation, coverage, and payment policy, its transition to a CPT code should occur as soon as possible.

F-6: PPAC recommends that new G codes not duplicate existing CPT codes.

F-7: PPAC recommends that CMS modify the G code development process to allow organized medicine to play an integral role.

F-8: PPAC recommends that CMS reevaluate its decision *not* to recognize physician work in the administration of vaccines.

F-9: PPAC recommends that CMS continue to study the anesthesia conversion factor to determine adequate reimbursement for physician work.

F-10: PPAC recommends that CMS ensure that the duration of Medicare participation agreements is consistent with the duration of the Medicare fee schedule payment period.

Agenda Item G — Proposed Rule for 2004 Physician Fee Schedule: Open Comment Period to Address Liability Insurance Issues, Radiology Issues, Practice Expense Issues (Including Issues Regarding Unfunded Mandates and Regulatory Burden), Physical and Occupational Therapy Issues, and Other Issues

Mr. Kay said CMS collects data on professional liability insurance rates, which are used to calculate relative value units (RVUs) and are reflected in the SGR. However, the data are somewhat outdated. The agency has contracted to begin collecting more current data. Stephen Heffler of the Office of the Actuary explained that data for the MEI are collected from large commercial insurance carriers; because the approach is more limited in scope than that for the Geographic Practice Cost Index (GPCI) or RVU's, it yields data more quickly.

Dr. Cady of the AMA said the agency's current approach does not adequately address all the factors that affect what physicians must pay for professional liability coverage (see Appendix 2). Dr. Trout of the ACS asked that the agency provide more detailed information about how it estimates coverage rates and how premiums at the specialty level are assessed (see Appendix 5). He pointed out that revisions to the RVUs regarding professional liability insurance costs can and should be made more frequently than every 5 years.

Dr. Albert Bothe, representing the Association of American Medical Colleges, said the high costs of professional liability coverage result in more Medicare beneficiaries seeking care in academic medical centers (see Appendix 9). He supported the recommendations of the AMA and ACS to enable CMS to assess professional liability coverage rates in a more timely and realistic manner.

Gail Lee, representing the American Physical Therapy Association, asked that CMS repeal the annual $1,500 cap on non-hospital outpatient occupational, speech, and physical therapy services (see Appendix 10). She also described a CMS program manual requirement that an individual receiving outpatient physical or occupational therapy see a physician at least every 30 days, regardless of whether the physician deems it necessary

to see the patient within 30 days of therapy. The "30-day visit" is not specified by Medicare regulations and is unrelated to the requirement for recertification every 30 days.

Dr. Bibb Allen, representing the American College of Radiology, expressed concern that CMS is considering allowing non-physician health care providers to supervise diagnostic imaging examinations (see Appendix 11). He said supervising imaging examinations requires medical knowledge well beyond the training of non-physician providers. Mr. Kay noted that states individually determine the scope of practice of certified registered nurses, nurse practitioners, and physician assistants (PAs). Dr. Allen further requested that CMS maintain separate coding and reimbursement for low osmolar contrast media.

Ina Cushman, representing the American Academy of Physician Assistants, stated that supervision of diagnostic tests can be appropriately delegated by a physician to a PA (see Appendix 12). She said in rural areas and other situations, a physician is not always available on site. She suggested the individual physician should determine whether PAs can adequately supervise other personnel performing diagnostic tests. Dr. Weida of the AAFP supported Ms. Cushman's proposal, calling it reasonable and consistent with AAFP policy.

Dr. Weida of the AAFP said Medicare reimburses physicians who coordinate and manage care for home health and hospice patients (see Appendix 4). He asked that CMS reimburse primary care physicians for coordination of care in other settings as well. Mr. Kay said coordination of care was already considered part of the physician's work when evaluating services provided.

Barbara Morone, representing the American College of Emergency Physicians, expressed concern about PPAC's recommendation to evaluate reimbursement for anesthesia services. She felt almost every specialty could justifiably complain about underpayment by Medicare.

G-1: PPAC recommends that CMS's proposed rule address the refinement of the professional liability coverage relative value units.

G-2: PPAC recommends that CMS's proposed rule include a more detailed description of the methodology proposed by the neurosurgeons and the other alternatives CMS is considering for professional liability coverage relative value units.

G-3: PPAC recommends that CMS make available current professional liability premium data at the specialty level immediately.

G-4: PPAC recommends that CMS make an explicit request for comments on the appropriateness of refining the professional liability coverage relative value

units in 2004 rather than 2005.

G-5: PPAC recommends that CMS include a statistically significant sample of all professional liability insurance carriers—rather than only commercial carriers—when collecting liability premium data for the Medicare Economic Index.

G-6: PPAC recommends that CMS eliminate the 30-day physician visit requirement for outpatient therapy services.

G-7: PPAC recommends that CMS make available more specific data used to determine the increasing costs of medical liability insurance, as reflected in the Medicare Economic Index.

G-8: PPAC recommends that if CMS proposes changes to the supervision requirements for radiology services, PPAC should be given an opportunity to comment.

Report from the Administrator

Tom Scully, CMS Administrator, said he is optimistic about current Congressional efforts to address the legislative error that has resulted in decreased Medicare physician reimbursement rates. He asked for input from PPAC on how to add a prescription drug coverage benefit to Medicare. The costs of drug coverage and adjusting physician fees would come from newly allotted funds and not the existing budget, he said.

Mr. Scully suggested the Council can best assist the agency by focusing on a few issues of concern and reaching consensus on recommendations for the agency. In response to concerns raised about physician shortages in some specialties, Mr. Scully countered that both shortages and gluts tend to self-correct over time. He emphasized that the agency remains deeply concerned about beneficiaries' access to medical care. He also noted that the agency recognizes the need to update its adjustments for professional liability coverage.

Agenda Item H — Wrap-Up and Recommendations

The Council requested that PPAC staff forward to members the Office of the Actuary's 1998 report "Physician Volume and Intensity Response" and include it on the agenda for the next meeting.

After a review of all the motions adopted, Dr. Rapp adjourned the meeting.

Report Prepared and Submitted By
Dana Trevas, Rapporteur

PPAC Members at the February 10, 2003, Meeting

Michael T. Rapp, MD, JD, *Chair*
Emergency Room Physician
Arlington, Virginia

James R. (Ronnie) Bergeron, MD
Dermatologist
Shreveport, Louisiana

Richard Bronfman, DPM
Podiatrist
Little Rock, Arkansas

Ronald Castellanos, MD
Urologist
Cape Coral, Florida

Rebecca Gaughan, MD
Otolaryngologist
Olathe, Kansas

Joseph Heyman, MD
Obstetrician/Gynecologist
West Newbury, Massachusetts

Stephen A. Imbeau, MD
Internal Medicine/Allergist
Florence, South Carolina

Joe W. Johnson, DC
Doctor of Chiropractic
Paxton, Florida

Christopher Leggett, MD — Absent
Cardiologist
Atlanta, Georgia

Dale Lervick, OD
Optometrist
Lakewood, Colorado

Barbara L. McAneny, MD
Clinical Oncologist
Albuquerque, New Mexico

Angelyn L. Moultrie-Lizana, DO
Family Practitioner
Bellflower, California

Amilu Rothhammer, MD
General Surgeon
Colorado Springs, Colorado

Victor Vela, MD — Absent
Family Practice
San Antonio, Texas

Douglas Wood, MD
Cardiologist
Rochester, Minnesota

CMS Staff Present:

Tom Scully
CMS Administrator

Tom Grissom, Director
Center for Medicare Management, CMS

William Rogers, MD
Medical Advisor
Office of the Administrator

Centers for Medicare and Medicaid Services

Paul Rudolf, MD, JD
Executive Director, PPAC
Center for Medicare Management

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

Terry Kay, Director
Division of Practitioner Services
Centers for Medicare and Medicaid Services

John Shatto, Actuary
Office of the Actuary
Centers for Medicare and Medicaid Services

Marc Hartstein, Health Insurance Specialist
Division of Practitioner Services
Centers for Medicare and Medicaid Services

Stephen Heffler
Office of the Actuary
Centers for Medicare and Medicaid Services

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Dana Trevas, Rapporteur

Public Witnesses:

Dr. Bibb Allen, Jr., FACR, American College of Radiology
Dr. Albert Bothe, Association of American Medical Colleges
Dr. Duane M. Cady, American Medical Association, Board of Trustees
Ina S. Cushman, PA-C, American Academy of Physician Assistants
Dr. Alexander A. Hannenberg , American Society of Anesthesiologists
Dr. William F. Jessee, CMPE, Medical Group Management Association
Gail Lee, American Physical Therapy Association
Barbara Morone, American College of Emergency Physicians
Dr. Julia Pillsbury, FAAP, American Academy of Pediatrics
Dr. Lloyd Smith, American Podiatric Medical Association
Dr. Hugh H. Trout III, FACS, American College of Surgeons
Dr. Tom Weida, American Academy of Family Physicians, Board of Directors

APPENDICES

Appendix A: Meeting agenda
Appendix B: Recommendations from the February 2003 meeting

The following documents were presented at the PPAC meeting on February 10, 2003, and are appended here for the record:

Appendix 1: Update on Provider Outreach, Physicians Regulatory Issues Team
Appendix 2: Statement of the American Medical Association
Appendix 3: Statement of the Medical Group Management Association
Appendix 4: Statement of the American Academy of Family Physicians
Appendix 5: Statement of the American College of Surgeons
Appendix 6: Statement of the American Podiatric Medical Association
Appendix 7: Statement of the American Academy of Pediatrics
Appendix 8: Statement of the American Society of Anesthesiologists
Appendix 9: Statement of the Association of American Medical Colleges
Appendix 10: Statement of the American Physical Therapy Association
Appendix 11: Statement of the American College of Radiology
Appendix 12: Statement of the American Academy of Physician Assistants

The following documents were submitted to PPAC for consideration at its February 10, 2003, meeting and are appended here for the record:

Appendix 13: Statement of the Alliance of Specialty Medicine
Appendix 14: Statement of the American Academy of Otolaryngology — Head and Neck Surgery
Appendix 15: Statement of the American College of Obstetricians and Gynecologists
Appendix 16: Statement of the American Occupational Therapy Association
Appendix 17: Statement of the American Osteopathic Association
Appendix 18: Statement of the American Society of Cataract and Refractive Surgery/American Society of Ophthalmic Administrators
Appendix 19: Statement of the American Speech-Language Hearing Association
Appendix 20: Statement of the College of American Pathologists
Appendix 21: Statement of the Medical Society of the State of New York

Appendix A

Practicing Physicians Advisory Council

Central Office Headquarters
Centers for Medicare & Medicaid Services
Multipurpose Room
7500 Security Boulevard
Baltimore, Maryland 21244-1850

February 10, 2003 - Agenda

8:30 –8:45 a.m. A. Open Meeting		**Michael Rapp, M.D. - Chairman** Practicing Physicians Advisory Council
8:45 – 9:00 a.m. B. Welcome		**Tom Grissom - Director** Center for Medicare Management Centers for Medicare & Medicaid Services
9:00 – 9:30 a.m. C. Status and Update		**Paul Rudolf, M.D. - Executive Director** Practicing Physicians Advisory Council Centers for Medicare & Medicaid Services
9:30 – 10:00 a.m.	**D. Physicians Regulatory Issues Team (PRIT) Update**	**William Rogers, M.D. - Medical Advisor** **Office of the Administrator** Centers for Medicare & Medicaid Services
10:00	**Remarks from Administrator Thomas A. Scully**	
****10:15 – 10:45 a.m.**	**E. SGR Issues 2003 & 2004**	**John Shatto - Actuary** Office of the Actuary **Terry Kay – Director** **Marc Hartstein - Health Insurance Specialist** Division of Practitioner Services Centers for Medicare & Medicare Services

Break at Chair Discretion

****10:45 – 12 noon**	**F. 2003 Physician Fee Schedule – Open Comment Period** **1. Specific G Codes Issues** **2. Anesthesia Issues** **3. Delay in 2003 Fee Schedule** **4. Other**	**Terry Kay - Director** Division of Practitioner Services Centers for Medicare & Medicare Services **Stewart Streimer – Director** Provider Billing Group **Susan Myers – Director** Division of Practitioner Claims Processing Centers for Medicare & Medicaid Services
12:00 - 1:00 p.m.	**Lunch**	
****1:00 – 4:00 p.m.**	**G. Proposed Rule for 2004 Physician Fee Schedule** **1. Liability Insurance Issues** **2. Radiology Issues**	**Terry Kay – Director** Division of Practitioner Services Centers for Medicare & Medicare Services

	3. Practice Expense Issues –Including issues regarding unfunded mandates and regulatory burden	
	4. PT and OT Issues	**Laurie Feinberg, MD – Medical Officer**
	5. Other	Center for Medicare Management
		Dorothy Shannon, PhD – Health Insurance Specialist
		Center for Medicare Management
		Pamela West – – Health Insurance Specialist
		Center for Medicare Management
4:00 – 5:00 p.m.	**H. Wrap Up and Recommendations**	**Michael Rapp, M.D. - Chairman**
		Practicing Physicians Advisory Council
		Tom Grissom - Director
		Center for Medicare Management
		Centers for Medicare & Medicaid Services

**Association testimony to be provided during the meeting to coincide with the agenda topics:

I. Oral testimony provided by (in alphabetical order):

+**American Academy of Family Physicians**	Dr. Tom Weida, AAFP Board of Directors
+**American Academy of Pediatrics**	Dr. Julia Pillsbury, FAAP
+**American College of Radiology**	Dr. William T. Thorwarth, Jr.
+**American College of Surgeons**	Dr. Hugh H. Trout III, FACS
+**American Medical Association**	Dr. Duane M. Cady - AMA Bd. of Trustees
+**American Podiatric Medical Association**	Dr. Lloyd Smith
+**American Society of Anesthesiologists**	Dr. Alexander A. Hannenberg
+**Association of American Medical College**	Dr. Albert Bothe
+**Medical Group Management Association**	Dr. William F. Jessee, CMPE

J. Written testimony provided by (in alphabetical order):

+Alliance of Specialty Medicine
+American Academy of Otolaryngologists
+American Occupational Therapy Association
+American Osteopathic Association
+American Physical Therapy Association
+American Society of Cataract and Refractive Surgery/American Society of Ophthalmic Administrators (ASCRS/ASOA)
+American Speech-Language Hearing Association (ASHA)
+College of American Pathologists
+Medical Society of the Sate of New York

Appendix B

Practicing Physicians Advisory Council
RECOMMENDATIONS
February 10, 2003

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G-6: PPAC recommends that CMS eliminate the 30-day physician visit requirement for outpatient therapy services.

G-7: PPAC recommends that CMS make available more specific data used to determine the increasing costs of medical liability insurance, as reflected in the Medicare Economic Index.

G-8: PPAC recommends that if CMS proposes changes to the supervision requirements for radiology services, PPAC should be given an opportunity to comment.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Practicing Physicians Advisory Council

March 14, 2003

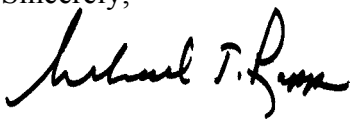
Hon. Tommy Thompson
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Secretary:

Enclosed is the Report of the 43rd meeting of the Practicing Physicians Advisory Council, a meeting that was concerned not exclusively but mainly with the processes by which the government sets the annual practicing physician fee schedule. Discouraged and confused by recent reductions in that schedule and pressed by the rising costs of independent medical practice, many of our colleagues are declining to renew their assignments as Medicare providers. Members of the Council regard this as a matter of grave concern not only for our profession, but also certainly for the continued health and well being of America's elderly.

We believe you and CMS Administrator Scully share our deep concerns on this matter and appreciate the effort you and your staffs are expending on this issue, but an equitable resolution still seems out of reach. Please be assured that the Council remains ready to work with you in any appropriate way to insure not only fairness in the physician fee-setting process but also the continued provision of quality medical care to our most vulnerable citizens.

Sincerely,



Michael T. Rapp, MD
Chair, PPAC

Enclosed: 43rd Report of the Practicing Physicians Advisory Council

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