REPORT NUMBER THIRTY-SEVEN
To
Secretary
U.S. Department of Health and Human Services

(Re: Evaluation & Management Documentation Guidelines,
Medical Review Forms, PRIT, Advanced Beneficiary Notices,
Physician Participation in Pilot Studies,
and other matters)

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From the

Practicing Physicians Advisory Council

(PPAC)

For June 25, 2001

Attendees at the June 25, 2001, Meeting

Members of the Council:

Derrick L. Latos, MD, *Acting Chair**
Nephrologist
Wheeling, West Virginia

Jerrold M. Aronson, MD
Pediatrician
Narberth, Pennsylvania

Richard A. Bronfman, DPM
Podiatric Physician
Little Rock, Arkansas

Joseph Heyman, MD
Obstetrician/Gynecologist
West Newbury, Massachusetts

Sandral Hullett, MD
Family Practitioner
Eutaw, Alabama

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

Jerilynn S. Kaibel, DC
Chiropractor
San Bernardino, CA

Dale Lervick, OD
Optometrist
Lakewood, Colorado

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

Sandra B. Reed, MD
Obstetrician/Gynecologist
Thomasville, Georgia

Amilu S. Rothammer, MD
General Surgery
Colorado Springs, Colorado

Maisie Tam, MD*
Dermatologist
Burlington, Massachusetts

Victor Vela, MD
Family Practice
San Antonio, Texas

Kenneth M. Viste, Jr., MD
Neurologist
Oshkosh, Wisconsin

Douglas L. Wood, MD
Cardiologist
Rochester, Minnesota

*** Absent**

DHHS and CMS Staff Present at the June 25, 2001, Meeting

Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services (CMS)

Paul Rudolf, MD, JD,
Executive Director
Practicing Physicians Advisory Council
Center for Medicare Management

Raymond Boyd
Health Insurance Specialist
Division of Consumer Protection
Center for Beneficiary Choices

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

Thomas Grissom
Director
Center for Medicare Management, CMS

Tim Hill
Director
Program Integrity Group
Office of Financial Management

Ruben José King-Shaw, Jr.
Chief Operating Officer
Centers for Medicare & Medicaid Services (CMS)

Barbara Paul, MD
Director
Physicians Regulatory Issues Team (PRIT)
Center for Medicare Management

Cindy Read
Acting, Associate Deputy Director
for Contractor Management
Center for Medicare Management

Kit Scally, RN
Health Insurance Specialist
Center for Medicare Management

Latesha Walker, RN
Health Insurance Specialist
Center for Medicare Management

Dana Trevas, Consultant Writer-Editor

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Public Witnesses:

Michelle Freed, Federal Affairs Director, American College of Emergency Physicians
Barbara Marone, American Hospital Association

Statement Submitted:

American Medical Association

The June 25th Meeting: Morning Agenda

The 37th meeting of the Practicing Physicians Advisory Council was held at the Hubert H. Humphrey Building in Washington, D.C. In the absence of Derrick L. Latos, MD, Acting Chair, the meeting was opened at 8:40 a.m. and thereafter chaired pro tem by Paul Rudolf, MD, JD, Executive Director of PPAC. Dr. Rudolph reported that new appointments to the Council have been delayed. He briefly described the reorganization of HCFA into the newly named Centers for Medicare and Medicaid Services (CMS), which encompasses three major centers:

- the Center for Beneficiary Choices to oversee managed care,
- the Center for Medicare Management to oversee traditional fee-for-service care, and
- the Center for Medicaid and State Operations.

Dr. Rudolf then outlined the day's agenda for the meeting, which would focus on the status of the Evaluation and Management Documentation Guidelines and the proposed Medical Review Form, as well as other aspects related to the eventual institution of the new guidelines.

Concerns About Clinical Examples for the Revised E&M Guidelines

Update on the clinical examples: Latesha Walker, RN, Health Insurance Specialist, told of CMS's cooperation with Aspen Systems to develop clinical examples for the revised Documentation Guidelines. These examples are based on actual medical records, as well as a standardized carrier medical review protocol and the medical review form. Ms. Walker reported that the clinical examples were sent to specialty societies and six Medicare carriers for comment. Aspen Systems plans to compile all of the results for a second round of review in August. "The end product will be used only in the pilot studies," Ms. Walker said, "and we'll continue to report updates to the CPT [Current Procedural Terminology] editorial panel meetings."

General unhappiness with the examples: Council Members generally dismissed the current clinical examples as unhelpful, observing that they, as practicing physicians, "can't figure it out," nor apparently can the coding experts working on the program itself. Observing that the proposed clinical examples would become integral to the government's "payment methodology and a methodology to compare different specialties," as such, Council Members judged it was "inherently flawed" and "should be stopped." Members also reported that the House of Delegates of the American Medical Association has registered its official opposition to the examples and suggested that the process for developing clinical examples be extended for another six months. Council Members generally felt the same way.

Questions raised about "downcoding": The Council reported that "there is a tremendous amount of confusion in the practicing physician's office as to exactly how to code." They went on to note that the medical records used as the basis for the clinical examples were undercoded or downcoded, observing that "as much as 20 to 25 percent of the claims are undercoded." Many physicians at the House of Delegates meeting also admitted to intentionally undercoding their own patient records because they "do not have time to sit down and document everything." The Council strongly suggested that CMS solicit the advice of coding experts in each of the specialty societies in order to produce "clinical examples relevant to their practices" and reflective of "what is accepted in our field."

Recommendation: Members recommended to the Secretary of HHS that "the documentation guideline project timeline [for phase two] be delayed until PPAC has had time to review [Aspen's] methodology and all specialty society comments" at its September 17 meeting and "to develop a method for [understanding and] evaluating the reasons for undercoding [or downcoding] that appear to be present." The Council also recommended that PPAC review data showing coding level trends up or down over the past 5 years. Dr. Rudolf cautioned that parts of the recommendation that went counter to contractual arrangements (CMS v. Aspen) might not prevail. However, he also agreed to provide the coding trend data for the next meeting.

Critique of the Medical Review Form

Draft form presented, "categorization" questioned: Kit Scally, RN, CMS Health Insurance Specialist, presented the most recent draft of the Medical Review Form, to be used by carriers when reviewing physicians' medical records and documentation. Ms. Scally acknowledged that both minor and major changes in format and wording were still needed. The form was "designed for audit purposes," she said, "but it can also be used as an educational tool for physicians." Ms. Scally said CMS needed a form that "would coincide obviously with the physician's reporting and ... documentation." "Ms. Scally indicated that CMS reviewers look at both the current versions of the guidelines (the 1995 and 1997 versions) and determine which is the most advantageous for the physician in regard to review." Although the current draft of the instructions includes many more clinical examples than are anticipated for the final version, she said they may be categorized by specialty. Members were skeptical, however, suggesting that categorization would "put an excess burden on physicians who practice in more than one area."

Forms and the role of the carriers: The Council wondered whether individual physicians would see this form and know how their charts were being reviewed by carrier medical directors (CMDs). Ms. Scally replied the agency would develop and make widely available the proposed medical review form, something that was not done in previous years. As in earlier discussions, Council Members wondered how the form might be used by the CMDs. Ms. Scally said the new guidelines will require CMS to thoroughly educate CMDs and physicians, which was not the case with the 1997 guidelines and previous forms.

The continuing search for objectivity: During the colloquy on medical decision-making, Ms. Scally and the Council agreed that "a major problem ... we never have been able to correct" is "getting away from subjectivity" and attempting to be totally objective in physician documentation. Other Members noted that a physician's "dictating style [e.g., "to dictate with hand-wringing that this was the toughest case we've ever seen"] can make a big difference in a reviewer's opinion whether [a case is] low-, medium-, or high-complexity." Members mentioned that physicians commonly disagree among themselves about the severity of a patient's condition; also, physicians who perform many diagnostic tests are reimbursed better than those who can diagnose and treat without extensive or unnecessary testing, a situation that "penalizes the more informed physician."

Recommendations: The Members made the following recommendations/suggestions regarding the proposed Medical Review Form:

- a separate medical review form may be needed for evaluating a single system;
- there ought to be some way to document the expenditure of the great amount of time needed to review past medical records of new patients;
- the new form should indicate on the first page whether a visit was strictly for counseling or coordination of care, to avoid having the reviewer seek additional, irrelevant information on the form (e.g., results of a physical exam, etc.);
- the proposed review form should be able to account for the emotional as well as intellectual intensity of the physician-patient relationship in certain complex counseling presentations (e.g., as in a miscarriage);
- part of the counseling section should also show whether informed consent was or was not obtained;
- that the instructions for responding to the cells in the form be made much clearer and certain other errors be corrected
- that "extensive provider education" with regard to the form be mounted by CMS;
- PPAC should be able to review the specialty societies' comments on this form, also;
- remove the third bullet (re: counseling, etc.).

The revised form will be presented to the Council again at its September meeting.

What is the overall purpose?: As the E&MDG discussions wound down, several Members again questioned CMS as to the ultimate purpose of the proposed forms and guidelines. They agreed, however, that it is as "important for us to ... measure *what* we're trying to achieve" as it is to know *why* we're trying to achieve it, whether "*it*" is "cost containment, better documentation, or improved quality of care." Dr. Rudolph suggested the Council review the goals statement for the Documentation Guidelines that is posted on the Web. He then called for a mid-morning break.

Progress of the Physician Regulatory Issues Team (PRIT)

Progress report on seven priority issues: After the break, Barbara Paul, MD, PRIT Director, summarized her group's efforts on 25 issues regarding specific Medicare requirements that affect the daily practice of physicians. Of the 25, ten had solutions underway. Of the remaining 15, Dr. Paul described efforts to address a priority cluster of seven:

- Advance Beneficiary Notices (ABNs)
- Coverage and payment for preoperative evaluations
- Coverage and payment for follow-up visits for cancer patients
- Certificates of Medical Necessity
- Diabetic glucose monitoring supplies
- Physician supervision of medical residents
- Laboratory services

The Council noted that payment claims have been denied for follow-up care for chronic conditions other than cancer, such as hypertension, diabetes, and heart disease. Dr. Rudolf responded that specific examples of such coverage denials should be reported to CMS so that staff could identify the problem and seek a resolution.

Report of Subcommittee for the Sentinel Clinician Program: Dr. Bronfman, reporting on behalf of the new Subcommittee for the Sentinel Clinician Program, said its task was to help "decrease the administrative burden of Medicare on physicians and improve CMS responsiveness to clinical concerns..." Dr. Bronfman said the program provides CMS with a "standardized, ongoing, easy-to-use system to routinely obtain input from practicing physicians from different regions of the country and different specialties." He then presented the Subcommittee's 19 recommendations:

1. That PPAC endorse and continue to work with CMS on this program.
2. That it is important for organized medicine to provide its clinical concerns to CMS.
3. That PPAC communicate its support of this program to organized medicine.
4. That all information collected by this program be evaluated.
5. That if the information isn't worth the cost and the effort, the program should be discontinued.
6. That CMS should share with PPAC the evaluation process and timeframes prior to project implementation.
7. That this initiative be called a "program," since "projects" are finite while "programs" go on indefinitely.
8. That "Sentinel Clinician Program" is an inappropriate title; hence, the new name should be Clinical Environment Appraisal Program (CEAP).
9. That the program solicit information from focus groups, with participation by persons representing the appropriate specialty societies, as well as from individual physicians.
10. That demographic categories be included, starting with specialties.
11. That the "specialties" should be the ones listed by the American Board of Medical Specialists, with the addition of chiropractic medicine, optometry, and podiatric medicine.
12. That demographic data for the program should include practice location and Medicare carrier.
13. That CEAP materials should be sent to all clinicians in a practice.

14. That program records should be able to show physicians who are self-employed or employed by others, if the clinicians do their own billing or use a billing service.
15. That practice locations should be identified as rural or urban.
16. That care be taken to insure that clinicians in the program are active Medicare providers; hence, the statement "This system [CEAP] is for clinicians who actively treat Medicare beneficiaries" should be included prominently on the application, and the question "Do you care for Medicaid beneficiaries?" should be asked as well.
17. That a centrally generated recruitment letter for physician participants be made part of the Medicare newsletter sent to and through all carriers to all individual physicians.
18. That PPAC ask national clinician organizations to support and participate in the promotion of this system.
19. That the centrally generated recruitment letter be signed jointly by the CMS Administrator, the Chair of PPAC, and the heads of clinician organizations.

Surveys and pilot studies might be needed for a start: Dr. Bronfman said the program should be heavily promoted through specialty medical societies, but he was unsure how to target physicians who were not involved in Medicare. Some Members felt that CEAP surveys should include physicians who have opted out as Medicare providers, but the Council did not reach consensus on this point. Dr. Paul outlined a step-wise pilot project for CEAP: (1) identify a small number of participating physicians to establish the best method of communication, and (2) mount a pilot project to gather information and measure its value. Some Members also suggested that several small multiple pilot studies might be useful to assess the viability of the program.
Dr. Bronfman again stated the Council's need to establish goals and outcome measures before any pilot research is undertaken involving practicing physicians. Dr. Paul agreed with Members who urged that CEAP surveys ask respondents if they participate in the fee-for-service program, the managed care program, or both.

Writing regulations and getting feedback on their effects: In response to Council concerns about the length of time it takes to develop and implement a regulation and then find out how it affects physicians and beneficiaries, Dr. Paul said she envisions CEAP to be a tool for continuous quality improvement in regulatory development. Some Members stressed the need for feedback from beneficiaries about how they, too, are affected by regulations. Dr. Paul noted that CMS has several methods to address that concern. For example, in response to such feedback, the agency developed a brochure explaining limited Medicare coverage of a woman's health exam and another on the role of a "hospitalist."

Report accepted, PRIT goes on: The Council accepted the Subcommittee's interim report on the understanding that a final report, with more detail about the proposed pilot projects, would be provided at PPAC's September meeting. In an aside to Council Members who support her program, Dr. Paul indicated there was continued support for PRIT from the new administration, adding that she felt HHS Secretary Tommy Thompson might even be interested in expanding the role of PRIT.

Following Dr. Paul's presentation, Dr. Rudolph, chair pro tem, adjourned for lunch.

Lunch Break: 12:00 - 1:00 p.m.

Instructions for the ABN

New draft may address too many issues: After the lunch break, Raymond Boyd, Health Insurance Specialist for the Center for Beneficiary Choice, was invited to the podium to describe progress on instructions for implementing ABNs. The most recent draft, shared with PPAC, was long, detailed,

and included instructions related to the Emergency Medical Treatment and Labor Act (EMTALA). Mr. Boyd admitted the draft tries to address all the concerns, issues, and complaints raised during the review process so far and may be more specific than needed. Mr. Boyd added that the new ABN form could be used by physicians while the accompanying instructions are still being developed.

Something shorter and simpler is needed: Members criticized the draft, saying the language was difficult to follow and seemed to be directed to carriers. They asked for a simple, brief publication to be made available to physicians describing why an ABN may be necessary and what services or procedures may not be covered by Medicare. They further suggested the agency provide detailed information for carriers and physicians in a separate reference manual. A similar publication is needed for beneficiaries, the Council said, so they, too, will "understand that these are not decisions ... made by their provider or their physician." Mr. Boyd said a booklet for beneficiaries was in fact being developed.

"Common sense" doesn't always work with ABNs: Discussion centered on how and when to ask a patient to sign an ABN. Most Members complained that, with the instructions as currently written, "It's impossible for a physician to ever ... deliver a valid ABN to a patient with [an urgent] medical condition." At the same time, the instructions prohibit physicians from giving ABNs with blanket statements such as "Medicare may not pay for X." Mr. Boyd said the agency applies a "common-sense rule" on a case-by-case basis to determine whether an ABN was delivered with adequate time for the patient to consider the ramifications. Council members responded with several examples in which the CMS "common-sense" approach could or would not apply. (The Members also asked Mr. Boyd for a written definition of that term.) The Council further emphasized the need for a clearly defined appeals process for problematic situations.

When ignorance works: Members also noted that Question 13 says, "If the physician is found not liable on the basis that she or he did not know of the likelihood of Medicare denial, the claim may be paid under Section 1879 as if it were covered." Members paraphrased this to mean, "If you didn't know something you were supposed to know, it's okay." Members were skeptical of Section 1879 and asked CMS to provide concrete data as to how many cases had been successfully appealed under that Section. Other Members also asked for some form of feedback to indicate to the referring physician if a patient refused his or her recommended care. Currently, a physician may not know that a patient didn't get the recommended care.

National organizations speak out on ABNs and EMTALA: Michelle Freed, Director of Federal Affairs, American College of Emergency Physicians, testified to the "substantial confusion among emergency physicians and hospital registration staff and others about how the ABN should be used in the emergency department. Ms. Freed noted that the EMTALA statute itself prohibits hospitals from asking questions about an individual's method of payment or insurance status prior to giving a medical screening exam or stabilizing treatment, "and that's where the conflict between the ABN and EMTALA comes in." Ms Freed explained that EMTALA permits a "medical screening exam to be given to anybody who comes through the door in the emergency department requesting treatment in order to determine whether or not [that person] even has an emergency condition." On the other hand, she said, "An ABN cannot be given prior to a medical screening exam and stabilizing treatment." In a related presentation to the Council, Barbara Marone, American Hospital Association, said her group has asked CMS to exempt hospital emergency departments from local medical review policies (LMRPs), because it is impossible for a busy emergency department to keep track of everything that is and isn't covered by Medicare. The group is also asking for blanket exemption from use of ABNs for the same reason.

Pilot Testing the Proposed E&M Documentation Guidelines

Continued skepticism over pilot test participation: Tim Hill, Director of the Program Integrity Group in the Office of Financial Management, asked for PPAC's input for creating a pilot test to assess the usefulness and applicability of the new guidelines. The goals of the new guidelines, he

said, are to provide an effective means of accurately documenting the care provided and also decrease the current burden of documentation.

Put assurances in writing: Much of the discussion, however, focused on the potential negative consequences for physicians who participate in the pilot tests. Mr. Hill assured PPAC that participation would not trigger additional reviews: i.e., a physician's claims will have been thoroughly reviewed during the pilot testing, making it unlikely they would require further review at a later time. The goal of the test, he emphasized, was to determine whether physicians understood how to apply the new guidelines to their cases and not to punish them if they did not. Council Members suggested that Mr. Hill put these assurances in writing when soliciting physicians to participate. Mr. Hill agreed that PPAC should be involved in reviewing the various methods CMS may use to solicit physician participation in the pilot test.

How will overpayments and underpayments be handled?: Mr. Hill said that if, at a later time, it was determined that physicians had been overpaid or underpaid for claims reviewed during the pilot test, that issue would have to be rectified. However, he stressed again that the point of the pilot test is "not ... to be finding places that we've ... overpaid or underpaid," but to "determine [if the guidelines are] accurate and easy to use."

Coding, copying costs, and other issues: As for his opinion on the coding issue, Mr. Hill stressed that the pilot test could be designed to take into account many perspectives and opinions and not just follow the traditional model of a single medical reviewer determining the appropriate code. Members raised other issues, such as a participating physician's costs of photocopying additional documentation, etc. Mr. Hill said these details would be worked out by the time of the pilot. Speaking from the audience, Mr. Jack Emery of the AMA voiced his concern that claims in the pilot test might be reviewed by "non-carrier" individuals, but Mr. Hill said the use of "an entity different than a current carrier" in the pilot test might help inform both physicians and carriers on "best practices" regarding the use of the new guidelines. Dr. Rudolph closed this part of the meeting agenda by predicting that the pilot-test issue "will come back [to PPAC] in September or December, ... depending on where we are."

Contractor Oversight Issues

Units set up to watch over contractors: Cindy Read, Acting, Associate Deputy Director for Contractor Management, joined Mr. Tim Hill and spoke of HCFA's and now CMS's efforts to improve oversight of contractors. She reported that the agency's contractors serve "33 million beneficiaries; work with over a million physicians, practitioners, providers; process more than 918 million Medicare claims; [and] pay out more than $175 billion dollars for healthcare services" each year. Ms. Read also reported the establishment of an internal "Medicare Contractor Oversight Board, ... to develop current priorities and set future strategies" for managing the agency's contractors. CMS also has the year-old Consortium Contractor Management Organization (CCMO), which HCFA set up to improve the "accountability for contractor oversight functions" and strengthen "the reporting relationship on contractor management issues." The CCMO has staff ("basically the eyes and ears of the CMS") in each of four regional offices–Philadelphia, Chicago, Dallas, San Francisco–who look at the day-to-day management of given contractors.

National teams used for evaluations, too: "At the same time, the Contractor Performance Evaluation (CPE) program offers a more in-depth view of contractors' performance in specific business functions, such as medical review and customer service." Ms. Read explained how contractors are reviewed by the CPE through on-site assessments, the criteria by which they are evaluated, and the process for improvement when deficiencies are identified. She said the agency has "increased the use of national teams (which consist of staff from multiple regions and/or Central Office)... so that this year every single onsite review is being performed by a national team." The Council asked Ms. Read to "please explain how HMOs who are contractors of CMS under

Medicare+Choice will in fact receive oversight." She could not, and that question will be put on the PPAC agenda for September or December.

PPAC Members to attend CMD meeting: Council members voiced concerns about the wide state-to-state variations in local medical review policies (LMRPs) and the need to replace them with national policies whenever possible. Mr. Hill observed that it was difficult to find the right balance between making allowances for local conditions and narrowing the field for inconsistent carrier performance. Members also repeated their complaints of inconsistent performance by various contractors, and encouraged CMS to send staff to observe meetings of local carrier advisory committees (CACs). Members also expressed their frustration with the amount of time it takes (three months and more) for a physician to apply for and receive a Medicare provider number. Mr. Hill noted the initiation of a new application process, which had been outlined to PPAC at a previous meeting. Dr. Rudolph suggested that Mr. Robert Loyal report on the status of that new process at the next PPAC meeting.

PPAC subcommittee to meet with CMDs: Mr. Hill and Dr. Rudolph suggested and PPAC agreed that a subcommittee of the Council attend the August 14-17, 2001, meeting of carrier medical directors to discuss such issues. Arrangements were to be made immediately following the June meeting.

New Top Administrators Outline the Future of CMS

Ruben José King-Shaw, Deputy Administrator and Chief Operating Officer of CMS, explained his role as overseeing the day-to-day operations of the agency and making sure that policies and strategies are put into action. He spoke of his belief that the physician-patient relationship is "the cornerstone of healing and health in this nation," and that the agency's administrative, institutional, and financial mechanisms should support that relationship. Mr. King-Shaw expressed his desire to meet with PPAC members and other physicians to better understand their needs.

Tom Grissom, Director of the Center for Medicare Management (CMM), who has spent much of his career with provider organizations, said he hoped to "reduce the regulatory burden on the men and women and institutions and organizations that deliver health care." He indicated his Center would be responsible for educating provider groups and beneficiaries. He pointed to legislation being drafted in Congress to allow the agency more leeway in managing Medicare carriers.

More toll-free numbers and Internet access: By October, the CCM will have more toll-free phone numbers to better assist beneficiaries, physicians, and providers. Mr. Grissom also mentioned a proposed pilot project to allow "Internet access for physicians–directly from physician offices–for claims evaluation prior to submission." He also intends to meet with specialty societies to better understand their concerns and enhance the agency's responsiveness to physicians. Mr. Grissom noted he will be among those senior staff members who will act as "liaison to the major provider groups and to serve as an ultimate court of appeal [for] those provider groups who are not receiving the kinds of services ... from us that they wish."

Time to "change the culture" and tap into staff goodwill: Mr. Grissom indicated the agency has been seen as "a culture that did not encourage responsiveness to the providers and their organizations, to members of Congress, or to beneficiaries." However, "there is in my opinion a reservoir of goodwill that has not been tapped; there is a willingness to go the extra mile to make this program realize its potential and to be one that serves the needs of the beneficiaries first, the providers second, and at all times the interest of the taxpayers," he concluded.

Tom Scully, the new CMS Administrator, said he hoped to change the perception of his agency among doctors and hospital administrators as a confusing and frustrating place in which "you really can't figure out who is making the decision, you can't figure out where the substantive arguments come from." In response to a question about the collection and use of risk adjustment

information, Mr. Scully said it has been put on hold for a year and would be evaluated before going forward again.

A "healthy balance" in fraud and abuse enforcement: Asked if CMS would be moving away from its focus on fraud and abuse, Mr. Scully said, "I think 98 percent of providers are great people trying to do the right thing and they shouldn't be made to feel like they're intentional criminals. On the other hand, some of the things that happened in the last seven or eight years [in enforcement to prevent fraud and abuse] needed to happen and I hope we'll bring it into a healthy balance." While the agency would not retreat from its aggressive enforcement efforts, he nevertheless thought "the pendulum needs to swing back." He called for a "healthy tension" between government oversight and physicians' own sense of responsibility and accountability. The Council also suggested that certain lessons learned in improving Medicare could be applied to Medicaid and vice versa; Mr. King-Shaw assured Council Members that HCFA's reorganization into CMS would still allow communication of best practices between the two programs.

Time did not permit a wrap-up or summary of the agenda issues or PPAC recommendations. These would be included in this meeting report.

Prepared by Dana Trevas and Ted Cron
July 25, 2001

[HEADING]

The Honorable Tommy Thompson
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Thompson:

In the absence of the Acting Chair of the Practicing Physicians Advisory Council (PPAC), Derrick L. Latos, MD, I am pleased, as the Chair Pro Tempore, to submit to you the Council's Thirty-Seventh Report to the Secretary of HHS.

The meeting was fruitful and much progress was made in matters such as the revised Evaluation & Management Documentation Guidelines, Advance Beneficiary Notices, Program Integrity, and other issues. The Council hopes that its new Members may be chosen in time to be sworn in at its September 17 meeting.

Sincerely yours,

Paul Rudolph, MD
Chair Pro Tempore
Practicing Physicians Advisory Council

Enclosed: PPAC Report Number Thirty-Seven