REPORT NUMBER THIRTY-EIGHT
to the
Secretary
U.S. Department of Health and Human Services

(Re: PRIT Update, Decrease in Physician Fees, ABN Update,
Documentary Requirements for Supervising Physicians,
"Dear Doctor Update," PRO 7th Scope of Work,
HIPAA Electronic Transfer Standards, Role of the CMD,
E&M Documentation Guidelines Update,
and other matters)

From the

Practicing Physicians Advisory Council

(PPAC)

For December 10-11, 2001

Attendees at the December 10-11, 2001, Meeting

<u>Members of the Council:</u>

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

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

Richard A. Bronfman, MD
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

Joe W. Johnson, DC
Doctor of Chiropractic
Florida

Jerilynn S. Kaibel, DC
Doctor of Chiropractic
San Bernardino, CA

Dale Lervick, OD
Optometrist
Lakewood, Colorado

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

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

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

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 December 10-11, 2001, Meeting

Thomas A. Scully, Administrator
Centers for Medicare & Medicaid Services

Thomas Grissom, Director
Center for Medicare Management, CMS

Kevin Gerold, DO, JD
Acting Deputy Director
Center for Medicare Management

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

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

Brigid Davison, Technical Advisor
Program Integrity Group

George Greenberg
Office of the Assistant Secretary for
Financial Evaluation

Jeffrey Kang, MD, MPH
Chief Clinical Officer
Director of the Office of Clinical Standards
and Quality Centers.

Paul Kim, JD, MPH
Health Insurance Specialist
Division of Practitioner & Ambulatory Care
Purchasing Policy Group
Center for Medicare Management

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

Karen Trudel, Director
HIPAA Project Staff
Office of Operations Management

Ted Cron, Consultant Writer-Editor

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Public Witnesses:

D. Ted Lewers, MD, of the Board of Trustees of the American Medical Association (AMA)
James W. Thompson, MD, MPH, Director of Education for Minority National Programs of the American Psychiatric Association
Michael Beebe, Director of the CPT Editorial and Information Service of the AMA
Albert Bothe, Jr., MD, Chair of the Subcommittee on Legislative and Regulatory Issues of the American Association of Medical Colleges (AAMC)

December 10-11th Meeting: Morning Agenda of Day One

The 38th meeting of the Practicing Physicians Advisory Council was held at the Hubert H. Humphrey Building in Washington, D.C. The meeting was opened at 8:40 a.m. by Thomas A. Scully, Administrator of the Centers for Medicare & Medicaid Services (CMS). Mr. Scully noted that Health & Human Services Secretary Tommy Thompson was scheduled to appear, but was out of town and sends his regrets.

Words of thanks to retiring Members: On behalf of himself and Secretary Thompson, Mr. Scully said he "appreciated the commitment of the time and effort" made by Drs. Jerilynn S. Kaibel, Maisie Tam, and Derrick L. Latos, whose terms had expired, and Drs. Jerrold M. Aaronson, Sandra B. Reed, and Sandral Hullett, whose terms were to expire in February.

Wanted: a "more transparent" agency: In extended remarks to the Council and public guests, Mr. Scully touched on several concerns of his administration. He noted that HCFA had become a " kind of a black box operation" whose staff had tended to be reticent in the face of widespread criticisms. However, "I'm determined to ... break through that," he said, "and make the place much more transparent." To that end, Mr. Scully said he created 11 "open-door policy work groups" that would bring CMS staff together with non-government parties and interests in order "to fix a lot of small irritating problems early on." For the larger issues, Mr. Scully said he was "very interested in having a lot more input"from PPAC.

Fee schedule approach needs fixing: He paid special note to the current approach of updating physicians' fee schedules. Mr. Scully said he was proud to have been involved in the development of the relative value scale, adding that "it's been the most reliable payment system we've had in Medicare for the last ... 13 years. But it obviously needs updating ... and we need to fix it." Mr. Scully assured the Council that Members will "have a significant impact on policy" relating to such issues as peer review, nursing homes, patient/consumer information, marketing to seniors, and the conduct of the Medicaid program.

Award to John Lanigan, new Members sworn in: Mr. Scully then performed two administrative duties. He gave a special award of thanks (officially "the first CMS award") to Mr. John Lanigan, who has been "the staff person for PPAC since its inception" in 1992. Mr. Scully then swore in Drs. Bergeron, Rapp, and Johnson as Council Members. Mr. Scully ended his opening remarks with a special word of praise and thanks for Dr. Rapp, the Council's new chair, who then took charge of the proceedings.

Michael T. Rapp, MD, Becomes the Chair

Dr. Rapp thanked Administrator Scully and Secretary Thompson for their support and confidence. Dr. Rapp then expressed the hope that under his leadership "we can work actively together and try to give the best advice we can to CMS." Pursuing that collegial spirit, Dr. Rapp's first act as Chair was to ask if "we could just go around the table and introduce ourselves."

Scully responds to Members' questions: Following this round-robin of introductions, Mr. Scully agreed to take questions from Members. Their questions covered the following subjects:

- The issue of "disproportionate share" in Medicaid reimbursement schedules. Mr. Scully said that "basically the Medicaid matching system is broken," that there seemed to be a disconnect "between the statutory match rates and what's going on in the program," and that the program needed greater standardization across the states. He also admitted, however, that "we don't

necessarily believe in intervening with the states to tell them what to do with Medicaid."

- The loss of "dual eligibility" or "crossover billing." Council Members noted that in some states, if a beneficiary "has Medicare and Medicaid, we can only bill Medicare, we can't bill Medicaid." Mr. Scully agreed that there still were "a lot of crossover issues in the dual eligible population," but they were generally indicative of the range of "economic problems" facing the states.
- Firms withdrawing from Medicare+Choice. Mr. Scully said the main reason was "pure raw economics": popular urban plans have been limited to an annual growth rate of 2%, while rural plans have not attracted the broad patient base they need. He also noted that he had taken on an assistant with Wall Street experience to provide more insight into the business economics of Medicare+Choice.
- The need for a "more equitable [physician] payment rate nationwide." Mr. Scully observed that there are " a lot of historical reasons and political reasons for what goes into" the physician payments rates state by state, but suggested that this was "certainly something this Council and others should look at and make recommendations on."
- The shrinking of patient access, as a result of weakened physician reimbursement strategies. Mr. Scully said CMS is giving more waivers to states to develop ways to expand access, noting that there were "two million more people covered under Medicaid than ... when this Administration started."
- Because of "decreased reimbursement [and the] increased cost to practice medicine," physicians are losing the wherewithal "to take care of the uninsured and the private-pay patients." Mr. Scully recognized the dilemma and promised to try "to do as many things as we can to reduce the burden on physicians [and not] just the regulatory burden." He also reminded the Council that "Medicare is becoming a relatively good payer again," noting that "Medicare's inflation this year is ... a little over ten percent [and] Medicaid inflation is about 11 percent," the highest it's been in "six or seven years."
- The fact that patients are left in the dark, when their plans fold or withdraw from Medicare+Choice. Mr. Scully agreed that the patient/beneficiary needed help in dealing with changes in plans: "our total focus [must be] on the beneficiaries." Nevertheless, said Mr. Scully, "The government cannot require people to lose money as a business partner," and, therefore, Medicare+Choice plans will continue to come and go.

Mr. Scully concluded his visit by encouraging Council Members to "get involved in anything" that interests them. Should they come upon problems that adversely affect physicians and beneficiaries, he promised that his agency would "do everything we can within our existing statutory structure to fix them."

Nominations closing for new Members: After the departure of Administrator Scully, the Chair invited PPAC Executive Director Paul Rudolf, JD, MD, to brief the Council on housekeeping matters. Dr. Rudolf began by noting the presence at the table of Thomas Grissom, Director of the Center for Medicare Management, who was auditing this PPAC meeting for the first time. Dr.Rudolf also noted that the nominating period was closing as of the coming weekend and that four new Council Members may be seated at the March meeting; hence, he suggested postponing any major new-Member orientation until then. Dr. Rudolf reviewed the status of several issues since the last (June 25th) meeting, as well as the current meeting's agenda. He noted that "data on utilization of E&M services," promised to the Council for this meeting, had not yet been delivered but would be brought to the meeting for the Members to review and discuss. (It arrived a few minutes before adjournment.)

Update on PRIT

The Chair then welcomed Barbara Paul, MD, Director of the Physicians Regulatory Issues Team (PRIT) of the Center for Medicare Management. Dr. Paul quickly reviewed the PRIT program for the benefit of the Council's three new Members and gave an update on progress since last June in PRIT's efforts "to figure out new ways to make Medicare work for

physicians."

PRIT to implement "open-door"policy: Referring to Mr. Scully's announcement of the 11 open-door policy work groups, Dr. Paul noted that she was working closely with Ruben King-Shaw, chosen by Mr .Scully to head the "physician open-door initiative." She also spoke of HHS Secretary Tommy Thompson's regulatory reform efforts and said that PRIT would be "the implementing team that will help various components inside [CMS] to actually work on issues and chase them down." Dr. Paul observed that PPAC was expected to play an important role in "the open-door listening process"; hence, "a good chunk of the agenda" at the next (March) meeting would be devoted to PPAC Members having a dialogue with Dr. Paul and Ruben King-Shaw on a wide range of physicians' issues.

CEAP to be used for "reality check": Dr. Paul then briefed the Council on the Clinical Environment Appraisal Program (CEAP) and the physician issues project. She said the agency envisioned CEAP to be its "standardized, user-friendly system" for getting a "reality check" on physician practices and attitudes. PRIT will recruit physician participants for the program through letters in carrier bulletins and/or through professional associations.

New draft registration form reviewed: Dr. Paul then asked Dr. Bronfman, chair of the PPAC subcommittee on PRIT matters, to continue. Dr. Bronfman noted that the "registration form" was in draft and, providing the agency can quickly satisfy the requirements of the Paperwork Reduction Act, the program could go into its pilot phase in one or two states "probably in the mid-spring." If successful, the program could go national later in 2002. The Council's one suggestion was to shift Question 6 ("Do you provide care to Medicare beneficiaries?") from the back to the front of the registration form. Otherwise, the Council gave unanimous approval to (1) the subcommittee's report of progress thus far and (2) to the general concept and plan of the registration form thus far, with the proviso that the final draft will come back for Council review in March.

Report on PRIT's 25 issues: Dr. Paul then discussed her "Physician Issues Project November 21, 2001, Update." She offered the following review of the Teams's progress on the 25 issues on the Project's agenda:

- *Advance Beneficiary Notice (ABN):* The Council indicated there were still coding issues, even though CMS has taken steps to eliminate the confusion surrounding ICD-9 coding. The observation was also made that beneficiaries who, before they were eligible for Medicare "were perfectly able to understand what was covered and what wasn't covered"in an ordinary commercial health insurance policy, now needed "a program that requires 23 pages of instructions and a form to understand" what Medicare will and won't cover. Members also raised again the issue with regard to the locus of liability with regard to lab work.
- There was nothing new to report on *carrier bulletins*.
- "We have started a pilot ... to take a look at *CMNs* [Certificates of Medical Necessity]," said Dr. Paul, but she admitted that PRIT has not made "a whole lot of progress on CMNs this year."
- As for *claims resubmission*, Dr. Paul noted that CMS personnel "who work on this issue have been sensitized ... to have [automatic resubmission] be the default mode rather than the exception," thus relieving the physician of the burden. However, sometimes "the data doesn't exist anymore," and the claim file needs to be reconstructed by the physician. Council Members nevertheless were highly critical of a claims system that has such state-by-state and carrier-by-carrier variability regarding denials, to which Dr. Paul responded, "We would be very interested in your input on that, whether we should move to national coverage determinations completely or whether we should try to retain the local medical review policy variability." Dr. Rudolf added that the Council might have "an agenda item at the next meeting on claims processing issues where we can have one or two folks from the central office and maybe even have someone from the local carrier come in ... if the Council is agreeable." The Council was.
- (Following a mid-morning break) *Coverage/payment for follow-up visits for cancer patients*. "This was a fairly isolated issue," Dr. Paul said, but it is still a "work in progress."

- *Coverage/payment of pre-operative evaluations.* CMS issued instructions and is now tracking the effect. Dr. Paul told Members she hoped "you are now being paid for your appropriate pre-operative evaluations. [If not,] let us know."
- *Diabetic glucose monitoring supplies.* "We are very close to the final stages of a change." Dr. Paul indicated that "the renewal interval will be 12 months instead of six months and a simple physician prescription will suffice."
- *Eligibility determinations.* "We can check this one off as done ... for now." CMS recently instructed carriers to tell a physician over the phone whether a patient was in fee-for-service Medicare or Medicare+Choice and that such action would not violate patient confidentiality.
- *Home health issues.* Dr. Paul again admitted that PRIT had not done "a whole lot on home health issues."
- *Laboratory services.* Dr. Paul reported that CMS issued a "final negotiated rule on laboratory services [which] created a national coverage policy for 23 specific clinical laboratory tests," and she invited the Council's comments on this development.
- *Medicare summary notices.* Dr. Paul spoke of the "misunderstanding" as to who sees which notice. While a physician sees the much-disliked phrase, his or her patient does not: "They get lay language phrasing that says Medicare won't pay for this today under these circumstances," she noted. As for "Not reasonable and necessary," Dr. Paul referred to "an entity that determines what these notice phrases are that is not under the control of CMS."
- *Physician supervision of medical residents.* This matter was on the Council's agenda for discussion later in the day.
- *Prior hospitalization for skilled nursing facility placement.* Dr. Paul presented the agency's "underlying premise and reason for the three-day hospital stay requirement" and noted that Congress had "attached two strings" to the agency's authority to change the requirement (don't raise costs, don't change benefits), but "thus far [CMS] has not come up with a way to do that."
- *Seclusion and restraints.* CMS has issued "an interim final with comment [and has] the option, therefore, of issuing a final rule." Dr. Paul suggested the Council encourage CMS to issue a final rule and thus open up a new period of comment.
- *Verbal orders.* CMS staff issued "some clarifying guidance" (not a final rule) indicating that "it is acceptable for a covering physician to cosign the verbal order of an ordering physician who is off duty for the weekend or an extended period of time."
- *Medicare rules.* Dr. Paul reviewed "a variety of activities going on," such as Frequently Asked Questions on a new Website.
- *Understanding the practicing physician reality.* Dr. Paul reported that CMS now has "about 45 physicians on staff at the agency and about a third of those physicians ... continue to see patients." She also asked Council Members to inform her of any "county medical society and state medical society preceptorships" to which CMS personnel might apply.
- As for *communications*, Dr. Paul reported that "the special physician edition of *Medicare and You 2002* ... is in the mail."
- *Enrollment.* Although "it's still a bunch of pages," Dr. Paul said the enrollment had been improved, thanks to Council input. The agency has "written new instructions for our carriers and their intermediaries" to expedite form processing. Meanwhile, the applications are accessible on the Web; "sometime shortly after the first of the year," she said, "you will be able to go to the Web and then download the forms onto your hard drive [and] actually enter the information [onto] the form itself." The question was again raised whether or not "professional corporation" was listed as a physician's choice. Dr. Paul said she would check. She was also asked to see if carriers were indeed enrolling "at least 90 percent" of applicant physicians within 60 days, as CMS requires.

In the interests of time, Dr. Paul asked the Council to refer to her written report for the remaining issues T through Y.

Discussion of Scheduled 5.4% Drop in Fees

The Chair then opened the meeting to presentations by public witnesses, beginning with D. Ted Lewers, MD, a member of the Board of Trustees of the American Medical Association (AMA). Dr. Lewers began by noting "the AMA is strongly opposed to the 5.4 percent

Medicare physician payment cut that is to become effective on January the 1st, 2002." He said that "two-thirds of physicians' offices meet the definition of a small business." As such, he argued, they could not survive the scheduled reimbursement decrease. He also reminded the Council that a recent survey by the American Association of Family Physicians "found that nearly 30 percent – *30 percent* – of family physicians are not accepting new Medicare patients."

Four recommendations for PPAC: Dr. Lewers then urged PPAC...

1. "... to advise CMS in the development of a system for assessing Medicare access problems, including advising CMS on early warning signs of such access problems."

2. "... to recommend that CMS support H.R. 3351 and S-1707, the Medicare Physician Payment Fairness Act of 2001, which is currently pending before Congress. It would reduce physician payments in 2002 by a -0.9 percent and require MedPAC to make recommendations to Congress by March of 2002 concerning more appropriate methods for updating Medicare payments to physicians."

3. "... to put the Medicare payment issues on the Council's March 2002 agenda, which would be particularly timely, since we expect MedPAC to report to Congress in March concerning a new physician payment update system."

4. "... to recommend that CMS work with Congress to replace the current formula for updating Medicare payments to physicians with a new system that appropriately reflects physician practice cost increases." Dr. Lewers was especially critical of the use of the Medicare Economic Index (MEI) and the computation of the sustainable growth rate (SGR). "Each has serious flaws," he said and proceeded to describe them.

(The Council Chair, Dr. Rapp, later referred to the longer, formal AMA statement that phrased these recommendations in the following way: "We urge the Council to recommend that CMS take appropriate steps to ensure that Medicare beneficiaries do not suffer the same access problems that challenge Medicaid beneficiaries.

("We urge the Council to request that CMS develop a system for assessing Medicare beneficiary access problems that result in the event of a physician payment cut.

("We urge the Council to recommend that CMS work with Congress to prevent the 5.4 percent payment cut from becoming effective in 2002 and replace the fatally flawed Medicare payment update formula with a new system that appropriately reflects physician practice costs.")

A "disaster of access" ahead: The Council responded very positively to Dr. Lewers' testimony. Members noted that scheduled fee decreases would influence the fee schedules of other insurers as well, such as state-sponsored workers' compensation programs, which are "tied to what Medicare does, and this is going to have a tremendous effect all the way down, even for those [patients] that Medicare doesn't see." Agreeing with Dr. Lewers' assessment of physician wariness, Members warned that the country may be "running into a disaster of access."

Council focuses on data: Echoing another of Dr. Lewers' concerns, the Council also questioned CMS data collection strategies, which do not offer an accurate picture of patient access by region. Dr. Barbara Paul agreed, adding that CMS was "very concerned about tracking beneficiary access to care." She said the agency's Office of Strategic Planning has a project that may "identify new data points" regarding beneficiary access to care. On the matter of data, the Council was interested in looking at "all the components that go into the SGR in a rather comprehensive fashion."

The Council recommends: After further discussion, the Council unanimously

approved the following recommendation:

* "PPAC recommends that CMS work with Congress to prevent the 5.4 percent payment cut from becoming effective in 2002 and to replace the current approach for updating Medicare payments to physicians, which relies on a flawed system incorporating the Medicare Economic Index and the Sustainable Growth Rate, with a new, more comprehensive approach that appropriately reflects physician practice cost increases as well as changes in the larger economy.
  * "In this connection, PPAC specifically recommends that CMS support H.R. 3351 and S-1707, the Medicare Physician Payment Fairness Act of 2001, which is currently pending. This law would reduce physician payments in 2002 by a -0.9 percent (rather than the scheduled 5.4 percent) and require MedPAC to make recommendations to Congress by March of 2002 concerning more appropriate methods for updating Medicare payments to physicians.
* "PPAC further recommends that CMS develop a system for assessing Medicare beneficiary access problems, including advising CMS on early warning signs of such access problems."

The Chair then adjourned the Day One morning meeting for lunch.

The ABN Revisited

Following the lunch break, the Chair welcomed Denis Garrison, Director of Consumer Protection, and Valerie Hart, Director of Provider Education and Training, to the witness table to discuss progress in the re-drafting of the Advance Beneficiary Notice (ABN). Mr. Garrison explained that the new ABN form has not been changed, but that the agency has composed a full set of instructions to carriers regarding its use. The instructions "are written for the protection of physicians," he said. They tell the carriers about "the intricacies of these policies so that the carriers don't imagine answers when answers are not there."

"Lack of clarity" still a problem: Council Members noted that some terms and abbreviations used in the ABN are not defined or spelled out (e.g., assigned, unassigned, DME POS, ABN-G, ABN-X). The discussion continued to circle around what Dr. Paul Rudolf suggested was the "lack of clarity in the issue of statutory exclusion versus when something was just not medically necessary."

Educational campaign described: Ms. Hart described the Medicare Learning Network, which "takes a topic such as the ABNs and pulls together an appropriate educational campaign" for everyone affected by that topic. She invited Council Members to visit the Network's Website at www. hcfa.gov/medlearn. Ms. Hart also asked PPAC to review and comment on (via e-mail to mloane@cms.hhs.gov) two new ABN brochures for physicians: "What Doctors Need to Know About the ABN" and "The Physician Reference Guide to Advanced Beneficiary Notices."

The GZ modifier as protective coloration: Mr. Garrison and Ms. Hart discussed a number of aspects of the new Section 7310 proposed for the Medicare Carrier Manual and Sections 1834 and 1879 of Title XVIII of the Social Security Act, all related to the need for and the use of the ABN. Questions were raised regarding the GZ modifier, but Mr. Garrison explained it usefulness in this way: "That's what happens, ... when you get denials that you weren't expecting, and at that point your protection, if there is any for you, if you're

justified in not knowing that it wasn't going to be paid for, is under the other part of 1879 or the refund requirements, where, if you can show that you didn't know and couldn't be expected to know that Medicare was not going to pay, then you are allowed under the limitation of liability to be paid by the program and under the refund requirements you're allowed to collect from the beneficiary, even if the beneficiary was previously held not liable." The Council wondered if the Inspector General would become interested "if we're sending in a code where we think we should have known to put the GZ and [we] didn't put the GZ." "Well, that's exactly the point," said Mr. Garrison. "Some folks ... wanted the GZ modifier, to indicate that they were not trying to kid the government, that it was covered."

All ABNs are local: The Council wondered if the ABNs "apply equally to local medical review policies (LMRPs) and national coverage decisions." Mr. Garrison said they did because the criterion is the same everywhere: "medical necessity." Then technically, said the Council, an ABN may be required in Arkansas " where they don't require an ABN in Florida for the same service because their LMRPs are different." Mr. Garrison agreed: "That could happen," he said.

The Council recommends: After further discussion, the Council unanimously agreed on the following recommendations:

(1) That CMS clarify or explain the Exclusion and Technical Denials box in the 8 x 11 glossy brochure and clarify what the physician needs to do with regard to claim submission.
(2) That CMS clarify or explain in more detail the use of the GZ modifier.
(3) That CMS provide more information regarding the limitations of liability and refunds requirements noted in the first paragraph of page one of the pamphlet.
(4) That CMS either explain or get rid of the abbreviations and explain certain technical terms that physicians might not be expected to know.

Dr. Rudolf also agreed to gather together the comments of individual Council Members after the meeting and send them to Mr. Garrison and then back to all Members of the Council. However, since they will be circulated outside a formal public meeting, they cannot be considered official Council comments.

New Documentation Requirements for Medical Students

The Chair then welcomed to the witness table Paul Kim, Health Insurance Specialist in the Division of Practitioner & Ambulatory Care in the Purchasing Policy Group of the Center for Medicare Management. Mr. Kim spoke on the matter of documentation requirements for teaching physicians, an issue that concerns PRIT as well. Mr. Kim presented the Council with proposed language for revising Section 15016 of the Medicare Carrier Manual. He asked the Members specifically if the three sample clinical scenarios "reflect current medical practice involving teaching physicians and residents and, second, whether the documentation examples ... reflect current practice."

Psychiatry requests extension of exception: Following Mr. Kim's brief introduction of the topic, the Chair welcomed to the witness table the next public presenter, James W. Thompson, MD, MPH, Director of Education of Minority National Programs of the American Psychiatric Association (APA). Dr. Thompson asked PPAC to support the APA's request that CMS extend the "primary care exception" (for Levels 1, 2, and 3 of outpatient care) to psychiatric GME programs that provide outpatient psychiatric services.

Dr. Thompson thought the change would not require new rulemaking but rather “just a change in the [carrier] manual instructions .”

All patients are entitled: Council Members wondered “why there are even separate rules about residency supervision ... for primary care or specialists.” Weren’t all patients “entitled to the same sort of supervision ... whether they are primary care problems or specialty problems”? Dr. Rudolf and Mr. Kim gave the history of the exception, and Mr. George Greenberg, of the Office of the Assistant Secretary for Financial Evaluation, noted that the family practice, OB/GYN, internal medicine, and geriatric medicine communities successfully argued that “the whole purpose of our teaching program and [an] important part of it” is to help the resident “establish a primary care relationship” with the patient.

The Council recommends: Nevertheless, the Council unanimously recommended that CMS “open up the primary care exception to include all specialties in residency training programs that use Level 1, 2, and 3 E&M codes or equivalents.”

The Council endorses examples and scenarios: Albert Bothe, Jr., MD, of the American Association of Medical Colleges (AAMC) and Chair of the AAMC’s Subcommittee on Legislative and Regulatory Issues, then stepped to the witness table. His testimony narrowly turned on support of Mr. Kim’s efforts to use illustrations and scenarios to clarify the documentation issue, but Dr. Bothe had nothing to say with regard to the APA’s request for extension of the primary care exception to psychiatry. The Council, however, returned to Mr. Kim’s original questions and, recalling Dr. Bothe’s testimony, unanimously agreed that the scenarios and examples are helpful and that more of them would doubtless provide “further clarification of difficult situations.”

“Dear Doctor Update”

The Chair then welcomed Dr. Barbara Paul back to the witness table to discuss the “Dear Doctor Update,” which she described as the “phrase that we use internally for the [required] annual fall mailing to physicians.” The mailing, implemented through the carriers, has three parts: It invites physicians to participate in the program, it gives updated fee schedule information, and it provides a fact sheet. The Council was asked its opinion of the “2002 Fact Sheet,” which went into the mail last fall. The Members wondered if any physicians see it at all. If it has billing information in it, they said, the whole thing goes to the billing office or billing agency and never comes back. Also, if it comes in a carrier’s mailing envelope, it goes to other administrative staff. The comments were not encouraging.

The Council recommends: However, the Council did strongly urge Dr. Paul to consider using the *Journal of the American Medical Association (JAMA)* as a vehicle for this kind of information. The suggestion reminded Dr. Paul that the AMA had already offered CMS a full page every three months. Thereupon the Council recommended that CMS take advantage of the opportunity to use one page per quarter in *JAMA* or more, if they’re willing to provide it,” especially for materials such as the “2002 Fact Sheet,” now enclosed in the quarterly “Dear Doctor Letter.”

Good Response to PRO 7th Scope of Work

Following a short mid-afternoon break, the Chair welcomed Jeffrey Kang, MD, MPH, Chief Clinical Officer and Director of the Office of Clinical Standards and Quality Centers, to discuss the current draft of the PRO 7th Scope of Work. Dr. Kang noted that Medicare operates the PRO program through 43 contractors serving all 50 states and D.C. The new (7th) Scope of Work, now in draft, is planned to be in effect from October 2002 through

October 2005.

From "gotcha!" to quality improvement: The new draft "reflects a change in emphasis," said Dr. Kang, "... moving it out of case review, or what I call the regulatory 'gotcha!' approach, to more of a quality improvement approach ... to improve the care that Medicare beneficiaries receive." The new approach has three main areas: "protecting beneficiary safety and improving beneficiary health, ... participation in community-wide improvement efforts, ... and the dissemination and promotion of quality/performance measures by CMS."

CMS publishing clinical performance data: Dr. Kang said that CMS has already begun working in the third emphasis area: on medicare.gov, for example, the agency has published clinical performance data (e.g., standardized mortality rates, adequacy of dialysis, adequacy of anemia management) for the country's 3,000 dialysis facilities. Such information, available to consumers, should stimulate the kind of market competition "that will actually drive continual quality improvement efforts," he said. This new emphasis is, in effect, "changing the PRO program from peer review organizations to ... quality improvement organizations," or "QIOs."

Five-state pilot for nursing home data: Dr. Kang indicated that the next focus would be on nursing homes, because "we already actually have a standardized data collection [the minimum data set] for the quality of nursing home care that's delivered." As a result, CMS will begin a pilot project in five states in April, publishing performance measures based on the minimum data set and evaluating nursing homes in those states against those published measures. PROs in those states will work with the homes to make improvements, where indicated. If the pilot test is successful, CMS intends "to move nationwide sometime in the fall or winter of 2002 with regards to publishing measures for nursing home care." Dr. Kang said that the agency also has an "outcomes assessment instrument for home health care" called OASIS, and "we hope to be ... publishing the result of those performance measures" as well.

No performance measures yet for hospitals, physicians: But "hospitals [are] a different story," Dr. Kang pointed out, because there is not one but "some 30 different measurement systems which are certified by the Joint Commission." Performance measures of physicians' offices are elusive for yet other reasons, he said: first, there is no "electronic medical record ... and so there's a structural problem"; second, we can't yet define "what I would call the unit of accountability," something analogous to "an episode of care" in a hospital; and finally, which physician or physicians in an outpatient setting are actually accountable for performance? Dr. Kang indicated that there have been some collaborative efforts begun involving different payers; he told the Council that CMS is "trying to encourage ... all those payers of care [to] get together and do a one-time collection" of measurement-relevant performance data. The Council wondered if CMS would get around to publishing "standardized mortality rates" for physicians' offices. So far, CMS would not.

How do you know the data are good?: The Members also asked Dr. Kang how he knew he was getting good data in those reports from nursing homes and home health agencies. He responded that he thought the facilities understood it was in their own and their industry's best interest to report the truth. But, in any case, CMS has "random validation efforts going on ... with regard to nursing homes [and] home health agencies to look for ... systematic [and, hence, fraudulent] under- or over-reporting." He said that "those efforts will continue."

Confidentiality, consumer roles are discussed: Dr. Kang also reassured the

Council that the cloak of confidentiality would still protect the work of the PROs, even after they became QIOs and, secondly, that adding consumers to the QIO boards would be helpful, but he did not believe consumers would be involved as "peers" in reviewing medical records and medical decision-making.

Physician performance an "outstanding issue": To the Council's question as to the immediate effect of the 7th Scope of Work on physicians, Dr. Kang thought there would be none for most physicians "in the near future"; but physicians involved in nursing home care, home health, and dialysis ought to expect some pressure to perform better according to CMS's generally accepted minimum data sets. However, he did add that physician performance is "still an outstanding issue that the medical community and the various purchasers and payers of care need to ... think through."

Council supports "physician-friendly" Scope: In general the Council indicated its support of the "much more physician-friendly" draft 7th Scope of Work because of its emphasis on education rather than punishment. The Council also wished to be assured that the new approach maintained the PRO system of confidentiality, did not place consumers in the role of peer reviewers, and would not increase the reporting burden on physicians. On this and other matters, Dr. Kang was reassuring but said he would be happy to report back to the Council at its March meeting.

E&M Data Distributed, To Be Discussed Later

Minutes before the close of the day's meeting, Dr.Rudolf distributed printouts of Evaluation & Management data for CPT codes 99201-05, -11-15, -21-23, and -31-33, by number of services in millions and percentages of services for the years 1992 through 2000, organized by New Patient, Established Patients, Initial Hospital Care, and Subsequent Hospital Care. The Council had expressed interest in seeing such data. Dr. Rudolf suggested that discussion of the data might take place on the Day Two of this December meeting.

With that, Dr. Rapp adjourned Day One at 4:30 PM.

Morning Agenda of Day Two

The second day's meeting of the Practicing Physicians Advisory Council, held at the Hubert H. Humphrey Building in Washington, D.C., on December 11, was opened at 8:35 a.m. by the Council Chair, Michael T. Rapp,MD. Following the request to the Nation by President Bush, Dr. Rapp led the meeting in a recitation of the Pledge of Allegiance at 8:46 a.m., the time when the first plane struck the World Trade Center three months earlier. After the Pledge, the Council reiterated its support for the recommendations suggested in Day One by Dr. Lewers of the AMA. A memorandum was prepared to that effect.

NOTE: There are discrepancies between the Council's original recommendation of Day One and the memorandum prepared on Day Two, as shown below:

Day One Recommendation: "PPAC recommends that The Department of Health and Human Services work with Congress to prevent the 5.4 percent payment cut from becoming effective in 2002 and to replace the current approach for updating Medicare payments to physicians, which relies on a flawed system incorporating the Medicare Economic Index and the Sustainable Growth Rate, with a new, more comprehensive approach that

appropriately reflects physician practice cost increases as well as changes in the larger economy.

"In this connection, PPAC specifically recommends that HHS support H.R. 3351 and S-1707, the Medicare Physician Payment Fairness Act of 2001, which is currently pending. This law would reduce physician payments in 2002 by a -0.9 percent (rather than the scheduled 5.4 percent) and require MedPAC to make recommendations to Congress by March of 2002 concerning more appropriate methods for updating Medicare payments to physicians.

"PPAC further recommends that CMS develop a system for assessing Medicare beneficiary access problems, including advising CMS on early warning signs of such access problems."

Day Two Recommendation/Memorandum to the Secretary of HHS: "The Practicing Physicians Advisory Council recommends that the Department of Health and Human Services work with the Congress for the passage of the following legislation: S1707 and HR3351.

"The Council also recommends that the enters for Medicare & Medicaid Services evaluate the current physician update formula and consider, if possible, making appropriate administrative revisions to that formula."

Implementation of HIPAA Electronic Standards

The Chair welcomed Ms. Karen Trudel, Director of the new HIPAA project staff within the Office of Operations Management, who briefed the Council on the new transaction standards that go into effect to implement the Health Insurance Portability and Accountability Act (HIPAA).

One claim form for everybody: Under the HIPAA standards, said Ms. Trudel, the government would no longer accept paper claims; rather, the transaction standards "establish one format ... for the entire industry, whether it's Medicare or Blue Cross/Blue Shield, Medicaid, other private insurance... That means that the current Medicare formats ... will no longer be used and we will transition to the HIPAA formats which are very different, some are more complex." She said the new format was developed by a "standards developing organization called X12." HIPAA goes into effect February 16, 2002, but the deadline for implementing the HIPAA transaction standards is October 16, 2001. However, Congress may extend that one year to October 2003. The law does exempt "small businesses" from having to comply with the standards. A "small business," under law, has fewer than 10 full-time employees; a physician practice with fewer than 10 employees would therefore qualify and be exempt.

Paper or no paper?: Ms. Trudel said "over 80 percent of Medicare's Part B claims [and] well over 90 percent of our Part A claims are electronic, so [providers'] non-compliance or inability to comply" by the deadline would "significantly increase the submission of paper claims," which she admitted the agency could not handle. Pilot testing and physician and carrier education (Web-based training on MedLearn, etc.) are already underway. Ms. Trudel noted, "There isn't a requirement for providers to use any of these transactions if they don't want to. They can ... continue to use paper claims." However, since the "same claim formats and other transaction formats can be used for all payers," Ms. Trudel said the change will, "in the long run, make a [physician's] practice much more

efficient."

Yet another form on the way: Council discussion focused on a pending Congressional requirement of a form to be filed by providers who need a year's delay before complying with the new transaction standards. Since CMS would have to publish the form by March 31, 2002, the Members insisted that they be able to review the form while in draft, because "we've had problems ... in the past getting information or seeing things before [they're] actually printed" in the Federal Register.

The Council recommends: Opinion on the form was mixed: some Members thought it represented a learning opportunity for providers "to think through this process and ... develop a timeline for implementation," while others suggested that CMS will "get several hundred thousand forms," an impossible number of review, "so no one is ever going to look at these forms [anyway]." After further discussion, the Council recommended that, if the law passes and a form is drafted, that it be shared with the members of PPAC (by e-mail, if possible) before it is printed; but, in any case, that the form be on the agenda for discussion at the March meeting.

Privacy may be the bigger issue: Members then suggested that "the privacy part of HIPAA is going to be much more difficult for practicing physicians/providers to handle than electronic transfer" and considered it a major barrier to physician compliance. (Privacy issues in emergency departments were specifically mentioned.) Ms. Trudel responded that the Department's Office for Civil Rights (OCR) is "tasked for enforcing the privacy rule. They have established an outreach group and a technical group to develop educational materials, to answer questions, [and] to prepare additional guidance." The Council, however, did not think OCR has been very effective on this matter thus far. Since HIPAA's privacy rules don't go into effect until April 2003, the Council indicated it wanted privacy put on the PPAC agenda of its June meeting and asked that someone from OCR be at the March meeting to provide an update.

The Council recommends: The Council indicated that the physician community was hardly aware of the HIPAA situation. Therefore, it recommended that Ms. Trudel work with the state medical societies, national professional associations, malpractice insurers, and CMS regional offices to inform physicians of the new HIPAA requirements. They further recommended that any instructions or other educational materials "be put in lay language, that it be boiled down and [made] simple for the physicians to figure out what they have to do to comply." The Council also repeated its request that HHS "work with Congress to minimize burdensome forms that might come out of legislation."

Role of the CMD

The Chair then welcomed to the witness table Ms. Brigid Davison, Technical Advisor to the Program Integrity Group, to discuss "both the role of the CMD [carrier medical director] and the advisory process."

What does the CMD really do?: Ms. Davison reviewed the agency's recent efforts to get carriers to help "reduce the claims payment error rate," to make the policies of multi-state carriers consistent across all the states, and to improve their advisory process. The question arose as to the CMD's role in these matters. Ms. Davison admitted that "we actually saw their role in medical review as one of policy development mainly, with education and claims review ... secondary." However, in the course of its review, CMS learned that carrier medical directors get involved in a variety of tasks (medical review, claims review, payments, education, and arbitration as well as policy-making) and decided it

was time to get a better fix on what the CMD really does. To that end it established a CMD work group, which is now "in this information-gathering stage." The Council recalled that, at its March meeting, it had asked for CMD representatives to appear at a PPAC meeting to discuss their roles, but so far that had not been arranged; the hope was expressed that the request would not "get lost in the shuffle." The request was considered important because most physicians react to CMDs as if they were the government; thus, if CMDs are creating problems, then the government is perceived as "the bad guy."

Strong feelings pro and con: Members' feelings about CMDs ranged from positive ("it's very important ... to have that local input to know who we are going to discuss issues and problems with when they arise") to negative ("when we hear the local [CMD] is coming to our office, you'd think the Gestapo, the KGB, the CIA and everything else is coming in"). Members said, "It's almost like there're two different organizations out there. You find physicians who believe that their medical director... works with them [and] others that don't believe they do." At the request of the Chair, the Council unanimously supported the statement that "outreach and education is a proper role of the carrier medical director."

Local vs. national coverage policy: Members also wondered to what extent carriers could make coverage policy. For the benefit of new Members, Dr. Rudolf reviewed the difference: "If there's no national coverage decision [for a particular procedure], then local carriers have complete authority at this time to make coverage decisions, [but] they have to go through ... a notice and comment process, just [as] at the national level. Until recently the vast majority of coverage decisions were being made at a local level ... If you talk to physicians in different parts of the country, you'll see that for most procedures there's going to be some variation right now." Dr. Rudolf added, however, that there is currently more interest in making more national coverage decisions, "but it's a very long, complicated process. And there's been a lot of discussion about which is better: to have everything national, everything local, or some combination of the two."

A shift in focus from fraud to mistakes: In this connection, Kevin Gerold, DO, JD, Acting Deputy Director of the Center for Medicare Management, addressed the Council, noting that CMS is "attempting to balance constantly" between the physicians who say, "You're making too many rules" and those who say "You're not giving me enough instruction." But at the heart of the issue, he said, is the recent shift in focus. "In the past," said Dr. Gerold, "there was a huge emphasis on identifying and correcting fraud and abuse and we created incentives for the contractors to seek out bad players and they zealously did so." Maybe, he admitted, "we brought the pendulum too far to one side." Today, however, the focus is on paying claims correctly. Dr. Gerold said the agency recognizes that most providers are "good, honest providers attempting to bill Medicare correctly; the ones who are making mistakes are ... not doing that fraudulently, they're doing that erroneously." The solution, therefore, is to mount "broad-based educational activities" and also "to specifically target ... those we identify as erroneous billers." Therefore, as to CMDs, Dr. Gerold said, "Their role is to exercise leadership and demonstrate to [erroneous billers] what we think their behavior should be," maintaining the "focus on paying claims correctly, focusing on education." Ms. Davison also indicated that the agency was considering a "customer satisfaction survey" that would tell how physicians (as customers) view CMDs and CMS.

Local policies despite consolidation: The Council wondered if CMDs working for a multi-state carrier would want to "homogenize" their view of medical practices across the several states. Dr. Gerold admitted that was a problem. "We're seeing a consolidation of contractors nationally, which makes business sense, [but] the challenge for us is to facilitate

the efficiencies that come with that, [yet also] preserve local participation in healthcare policy development." He again stressed the importance of Carrier Advisory Committees for preserving local participation. Council Members agreed, but were nevertheless concerned about the spread of consolidations and the turmoil of change that doubtless occurs among local medical review policies. The bottom line, however, as Dr. Gerold indicated, was the mission of the Medicare program, which is "to provide access to healthcare to the people who need it."

The Council supports: At this juncture, the Council indicated its support for the CMS efforts to evaluate and investigate the broader role of the carrier medical director. The Council added that the carrier medical director should have a role in outreach and education, be responsive to the physician community, and be involved in the appeals process. In addition, the Council agreed that CMS ought to monitor the CMD's ever-changing role in light of carrier consolidations. The Council also supported the idea of "the customer service model" with regard to the role of the carrier medical director and, in that connection, a survey of physicians in their role as "customers."

E&M Work Group Update

The Chair then welcomed Mr. Michael Beebe, Director of CPT at the American Medical Association, to brief the Council on the CPT Editorial Panel E&M Work Group. The group was organized, he said, after the demise of the Aspen-"vignettes" project, in which PPAC, he observed, played "no small role."

Review could last until Feb 2003: The Work Group, said Mr. Beebe, wants to be sure that "the E&M codes reflect current clinical practice; that they describe indeed what physicians do in their offices." The 21-member Work Group will hold its first meeting on January 18, 2002, then set about to "look at E&M codes in a very broad way." PPAC Member, Dr. Joseph Heyman, is a member of the Work Group, and a former PPAC Member, Dr. Douglas Wood, is its chair. (Mention was made of the absence of an ER physician from the proposed Work Group roster, even though "there's a separate set of E&M codes for hospital emergency departments.") Mr. Beebe said the Work Group will submit recommendations to the CPT Advisory Committee (composed of "all the medical specialty societies in the AMA House of Delegates, as well as the Health Care Professionals Advisory Committee") by August 2002. The Advisory Committee will then look at the recommendations and report to the full CPT Editorial Panel, which will review the whole record in November 2002. However, said Mr. Beebe, "given the importance of E&M coding, I wouldn't be surprised if the panel's review dragged out until February of 2003."

Coding the un-codable: Members raised a number of questions for Mr. Beebe and his Work Group, such as "How do you capture how sick a patient is?," and how do you account for telephone calls, consultations, research, FedEx mailings, etc. Mr. Beebe replied that, first, "We need to look at a new paradigm: medical decision making. [It] gets away from the history and physical elements and looks at the decision-making process the physician goes through, [gathering and assessing] data and making clinical judgments based on that data." He also noted that "in the first five-year review of the ... relative values of the E&M codes, [the values] were increased and HCFA at that time accepted the increase," partly in recognition of the ancillary effort – phone calls, research, etc. – that is involved but cannot be precisely measured. Members also chafed at "modifier 25," which, they argued, did not adequately reflect the pre- and post-procedural work done within the same day by,

for example, a surgeon or a podiatrist. It was also noted that Medicare always pays for modifier 25, but some state Medicaid agencies never pay for it. Dr. Rudolf said he would try to bring an answer back to the Council, adding it "might be one way to get into a Medicaid issue at the next meeting."

Who needs the codes and guidelines anyway?: Mr. Beebe observed that "no one likes the '95 or the '97 guidelines" and physicians generally object to the burden they present. Asked if he thought the E&M documentation guidelines might eventually disappear, Mr. Beebe replied he thought not, but possibly "we can limit them to elements that are clinically appropriate for the care of the patient and not have them as a checklist." He added that it might even be possible to include "documentation principles or principles of clinical documentation in either the ... guidelines that would precede the actual CPT code or in the descriptor of the codes themselves." But the Council also noted that, over the past 10 years, "doctors weren't upcoding [before the '95 guidelines] and they didn't stop upcoding after the guidelines." The persistent use of codes and E&M guidelines was compared to the question, "When did you stop beating your wife?" Maybe, the Council mused, "the whole E&M guideline thing is unnecessary."

CMS will not develop its own codes: Turning back to Mr. Beebe, the Council asked, "What impact is [the work group] going to have" on CMS? Dr. Rudolf replied, "I don't think we can have a position at this time on something that hasn't happened." Mr. Tom Grissom, Director of the Center for Medicare Management, who had been auditing the discussion, observed that "the CPT codes are owned ... by the American Medical Association. The E&M guidelines are essentially policy and programming memoranda ... to make sure that a physician using a certain code gets reimbursed appropriately for it." Mr. Grissom said that, shortly after he became Center Director, he "looked at the distribution of the codes. It's an absolute bell curve, relatively unchanged over the last decade ... I said, 'Why are we spending so much time on this effort?' And so we stopped." (The end of the vignette idea occurred at the same time.) As to the CPT Work Group's recommendations, Mr. Grissom said, "There is no commitment at the front end that we're going to use them or that they are going to become law. [But] I will say this: CMS is not going to develop its own CPT codes." Asked if he might return to report the Work Group's progress to PPAC, Mr. Beebe said he would be "very happy to come back ... whenever you're willing to have me."

The Council recommends: After further discussion, the Council recommended that the Work Group query the specialties not represented among its members and "consider the nuances of their particular codes and their problems." They also asked that the Work Group, in its evaluation of the E&M codes, "consider the established patient" as well as the new patient and where the care is being delivered.

Closing Discussion

In his closing remarks to the Council, Mr. Grissom made the following observations:

- He and the Council were "doing the public's business."
- The Pentagon's largest procurement ever, "which will go for 30 years, costs less than we spend in Medicare in one year."
- "There are many constituencies on every side of every issue and there are very few clean wins and absolute losses."
- His staff would screen calls and adjust surveys in order to yield more data with regard to access.
- A GAO report published in September discussed the electronic information (IT) architecture and systems in the Medicare program. "I hope you will read it and study it and help us become advocates of a serious effort to overcome what I think is a major, major under-investment in resources."

- He placed in the Council Members' folders an analysis of physician payments by year, by specialty group, and ... what the changes have been over the last few years."
- He also added a copy of the new provider enrollment form for physicians. (Council comment: "It's spectacular!")
- "I have new management [that is] really trying to reach out to physicians" to answer their questions with more and better provider education and training.
- He directs the Center for Medicare Management, and "PPAC is on my organization chart ...The problem is, you all are concerned about Medicaid, too, and you're also concerned about Medicare+Choice. So there needs to be and there will be, I'm pledging to you, greater involvement by other centers within CMS in the work of PPAC."
- "I pledge to you that there will be greater follow-up and accountability for your work to make sure that what you are asking us to do and what you're recommending to us doesn't go into a black hole."
- "There are already efforts underway within the agency to change and improve the management of our contractors. And I pledge to you that we will."

Recommendations and Support Statements

The last piece of business was a recapitulation of the Council's several recommendations and support statements, which follow:

Recommendation I (Re: Physicians Fees):
PPAC recommends that The Department of Health and Human Services work with Congress to prevent the 5.4 percent payment cut from becoming effective in 2002 and to replace the current approach for updating Medicare payments to physicians, which relies on a flawed system incorporating the Medicare Economic Index and the Sustainable Growth Rate, with a new, more comprehensive approach that appropriately reflects physician practice cost increases as well as changes in the larger economy.

In this connection, PPAC specifically recommends that HHS support H.R. 3351 and S-1707, the Medicare Physician Payment Fairness Act of 2001, which is currently pending. This law would reduce physician payments in 2002 by a -0.9 percent (rather than the scheduled 5.4 percent) and require MedPAC to make recommendations to Congress by March of 2002 concerning more appropriate methods for updating Medicare payments to physicians.

PPAC further recommends that CMS develop a system for assessing Medicare beneficiary access problems, including advising CMS on early warning signs of such access problems.

Recommendation II (Re: ABN):
PPAC recommends...

(1) That CMS clarify or explain the Exclusion and Technical Denials box in the 8 x 11 glossy brochure and clarify what the physician needs to do with regard to claim submission.

(2) That CMS clarify or explain in more detail the use of the GZ modifier.

(3) That CMS provide more information regarding the limitations of liability and refund requirements noted in the first paragraph of page one of the pamphlet.

(4) That CMS either explain or get rid of the abbreviations and explain certain technical terms that physicians might not be expected to know.

Recommendation III (Re: Physician information):
The Council recommends that CMS take advantage of the opportunity to use one page per quarter in *JAMA*, or more if they're willing to provide it, for materials such as the "2002 Fact Sheet," now enclosed in the quarterly Dear Doctor Letter.

Recommendation IV (Re: Primary Care Exception):
The Council recommends that CMS open up the primary care exception to include all specialties in residency training programs that use Level 1, 2, and 3 E&M codes or equivalents.

Recommendation V (Re: HIPAA transaction standards):
The Council recommends that, if Congress requires a delay form and one is drafted, that it be shared with the members of PPAC (by e-mail, if possible) before it is printed; but, in any case, that the form be on the agenda for discussion at the March meeting. The Council also recommends that CMS work with the state medical societies, national professional associations, malpractice insurers, and its own regional offices to inform physicians of the new HIPAA transaction standards and requirements. It further recommends that any instructions or other educational materials be put in lay language, that it be boiled down and [made] simple for the physicians to figure out what they have to do to comply. The Council again requests that HHS work with Congress to minimize burdensome forms that might come out of legislation.

Recommendation VI (Re: CPT Work Group):
The Council recommends that the CPT Editorial Panel's Work Group query the specialties not represented among its members and consider the nuances of their particular codes and their problems. The Members also ask that the Work Group, in its evaluation of the E&M codes, consider the established patient (as well as the new patient) and where the care is being delivered.
....

Statement of Support I:
The Council approves (1) the progress report of its PRIT subcommittee and (2) supports the general concept and plan of the registration form thus far, with the proviso that the final draft will come back for Council review in March. The Council's one suggestion is to shift Question 6 ("Do you provide care to Medicare beneficiaries?") from the back to the front of the registration form..

Statement of Support II:
The Council finds the scenarios and examples in the documentation guidelines for supervising physicians in an academic setting to be helpful and that more of them would doubtless provide further clarification of difficult situations.
Statement of Support III:
The Council supports of the much more physician-friendly draft of the 7th Scope of Work because of its emphasis on education rather than punishment. The Council also wishes to be assured that the new approach maintained the PRO system of confidentiality, did not place consumers in the role of peer reviewers, and would not increase the reporting burden on physicians.

Statement of Support IV:
The Council unanimously supports the idea that a proper role of the carrier medical director should include outreach, education, responsiveness to the physician community, and involvement in the appeals process.

Statement of Support V:
The Council supports all CMS efforts to evaluate and investigate the broader role of the carrier medical director. The Council adds that the carrier medical director should have a role in outreach and education, be responsive to the physician community, and be involved in the appeals process. In addition, the Council agrees that CMS ought to monitor the CMD's ever-changing role in light of carrier consolidations. The Council also supports the idea of "the customer service model" with regard to the role of the carrier medical director and, in that connection, a survey of physicians in their role as "customers."

Prepared by Ted Cron
January 10, 2002

[HEADING]

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

Dear Secretary Thompson:

I am pleased to submit to you Report Number Thirty-Eight of the Practicing Physicians Advisory Council (PPAC). This Report summarizes the deliberations held on December 10-11, 2001, in Room 800 of the Humphrey Building. This was my first meeting as both a Member and as Chair of the Council, and I am pleased to report that the Council is made of very hard-working, tough-minded professionals who are dedicated not only to excellence in medical care but also to the highest ideals of public service. I must commend also the many members of the staff of the Centers for Medicare and Medicaid Services (CMS), beginning with Administrator Tom Scully, who provide the Council with support, information, and judgments based on their many years of experience in both the private and public sectors.

The deliberations covered in the December meeting covered a broad range of difficult policy matters, which were quite thoroughly discussed. The Council made certain recommendations and gave statements of support in most cases, and these may be found at the close of our Report.

Finally, it is my privilege and pleasure to invite you to take a few moments from your busy schedule, if you possibly can, to personally greet the Council at its March meeting, to swear in its new Members, and share with them your vision of the future of the Medicare and Medicaid programs. I believe you will find us to be strong allies in your pursuit of a more equitable, efficient, and cost-effective program of medical care for America's most vulnerable citizens.

Sincerely yours,

Michael T. Rapp, MD
Chair
Practicing Physicians Advisory Council

Enclosed: PPAC Report Number Thirty-Eight