

## *Serving on the Practicing Physicians Advisory Council*

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**I**n March 2000, I began a four-year term on the Practicing Physicians Advisory Council (PPAC), serving as the College's representative and the only Fellow on PPAC. I will become eligible for a second term in 2004. This article summarizes my experiences in this role and the functions of PPAC.

### ***What is PPAC?***

PPAC is an advisory group composed of physicians currently in practice throughout the country. It was formed by statute in 1990 to advise the Secretary of the Department of Health and Human Services (HHS) on Medicare and Medicaid policies that affect practicing physicians. Although technically PPAC advises the Secretary of HHS, its real job is to ensure that the administrator and staff of the Centers for Medicare & Medicaid Services (CMS) hear our views about the practicalities and potential impact of various policies and procedures.

PPAC has a diverse membership representing all areas of the country and practice settings. The statute requires that PPAC include both participating and nonparticipating Medicare physicians, as well as physicians practicing in rural and underserved urban areas. Most of the seats on PPAC are held by physicians, but up to four seats may go to those limited license practitioners who are designated as "physicians" under the Medicare statute (chiropractors, dentists, optometrists, and podiatrists). Currently 12 of the 15 seats are held by MDs and DOs.

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### **Members' functions**

As the College's representative, it has been my responsibility to ensure that the surgeon's voice is heard as the CMS considers changes in policy and procedures. Certainly, my experience as the Chair of the College's Board of Governors provided me with a unique perspective on the issues affecting surgeons and may have played a part in my appointment. I find it very important to have the input of many physicians so that we really know what is affecting them and ultimately their patients. Administrators need a surgeon's real world experience, no matter what his or her discipline, to be certain that good policies are crafted and reality tested.

I think we have a real impact on the Medicare program by concentrating on those policies that affect a physician's everyday activities. We have been able to accomplish a number of goals in the two years I have been on PPAC, including:

- We have made suggestions on a revised physician enrollment form that went into effect January 1, 2002. If the CMS follows through on their plans, physicians will need to re-enroll periodically so that eventually all physician offices will be expected to complete the new form.
- The CMS found that a few carriers were denying all preoperative testing on the grounds that it was a screening service. We pointed out how important it was that they write a directive to carriers making it clear that preoperative testing was covered.
- We reviewed the CMS's plans for documentation requirements for evaluation and management (E&M) services at important points in the process. This was prompted by the CMS's decision that it would be better to evaluate E&M services by using clinical examples rather than using the elaborate documentation requirements they had developed in 1995 and 1997. However, the development of the clinical examples became overwhelming, with a massive number of examples for each specialty. PPAC and other specialty societies recommended that the work on clinical examples stop and the CMS agreed. The *Current Procedural Terminology* (CPT) editorial panel now has a work group examining whether revisions can be made in CPT that would reduce the need for documentation guidelines.
- We have worked to simplify the revised ad-

vanced beneficiary notice and related instructions to physicians. My experience indicated that surgeons do not use this form very often, but signing the form shifts financial liability to the patient in the event Medicare chooses not to cover a procedure that is usually covered.

### **2002 fee schedule**

We also try to review all directives to physicians from Medicare to prevent misunderstandings from occurring. However, we were unable to review the letter that was sent to physicians regarding the changes in Medicare reimbursement for 2002 because our meeting in late September 2001 was canceled.

We do not generally provide advice on matters that will be settled in the political arena because other players, such as the President and Congress, take the lead. However, we did make an exception regarding the flawed update for physician services. Our meeting in December 2001 occurred two weeks after the CMS announced the negative update for physicians for 2002. Our meeting provided an early opportunity to speak about the issue. Although there are a number of problems with the update, the major error is using the gross domestic product in the calculation of the update. This number has nothing to do with the need for physician services.

We recommended that the Secretary not oppose a statutory "fix" for the problem. The President's budget for fiscal year 2003, which was announced in early February and begins October 1, 2002, calls for the development of a new "budget neutral" update factor. Having the problem of the flawed update factor mentioned in the budget was certainly a surprise, but the physician community will have to see what the phrase "budget neutral" means as events play out in the legislative arena.

### **Meeting procedures**

The agenda for our meetings is developed jointly by the CMS with input from PPAC. The CMS places some topics on the agenda because they want our input, while council members identify issues of concern to their constituency. For example, we plan to hold sessions on a number of topics including Medicare's oversight of carriers. Some items appear only once on our agenda, but others are on it more than once so we can review

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the issues at various points in their development. It looks as though we may become even more involved in CMS operations with the appointment of a new chair of PPAC. Tom Scully, the administrator of the CMS, has appointed Michael J. Rapp, MD, to serve as chair, because he is from the Washington, DC, area and can personally participate frequently in the work of the agency.

Typically we meet once each quarter for a day. Usually there are four to six items on the agenda, which is published in the *Federal Register* about a month before the meeting so that the medical societies are able to prepare written or oral testimony. Agenda materials, consisting of what the CMS has prepared and any public testimony, are delivered to our hotel the evening before the meeting.

At the meeting, we first hear from one or two CMS representatives who are working on a project identified in the agenda. They usually make a presentation about the program or process and answer any questions from the council members. Next, we hear any oral testimony and have a chance to ask questions of the presenter. We then discuss what we have heard and make our recommendations. A formal transcript of the meeting, containing all of the discussion and recommendations, is produced. At the end of each year, a report that captures our recommendations and the actions taken is prepared.

The atmosphere of these meetings is more informal and interesting than a dry recitation of briefing notes. Members of the council and some of the CMS staff have worked closely through the years and have developed collaborative relationships. There usually is an audience of about 20 to 30 people, including specialty society representatives and CMS employees. Sometimes these members present clarifying information or even ask questions. Finally, one or two top officials from the CMS are usually present during portions of the meeting to provide their views on items of current interest.

In many ways PPAC functions like the Medicare Carrier Advisory Committees (CACs), although the subject matter is different. The CACs' primary purpose is to provide clinical advice on proposed local medical review policies, whereas PPAC provides advice on a broad range

of issues that will be implemented nationwide.

### ***Expanding territory***

So far I have only discussed Medicare, but the committee also has responsibility for examining the Medicare+ Choice and Medicaid programs. We have not done a great deal with either program yet. There does not seem to be much interest in Medicare+ Choice, probably because network administration is left largely to the plans.

Although it has not been a part of the formal agenda, Medicaid has been addressed at each of the meetings. Some members of PPAC practice in economically disadvantaged areas, so they have a great deal of experience with Medicaid and can cite many areas in the program that could be improved. However, states have responsibility for administering the program as long as they meet some rather broad federal criteria. Nonetheless, we plan to receive an overview of the Medicaid program to see just what opportunities exist for PPAC to be of assistance. It certainly would do a lot to ease the pressures many physicians encounter if we could fix some of the problems.

Ultimately, I believe it is my responsibility to help the leadership and staff of the CMS understand the real-world implications of policies and processes that stand in the way or add unnecessary complications as physicians attempt to provide quality care for their patients. I think it is important that the College insist upon our continued representation on PPAC after my term is completed. Ω

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