

REPORT 6 OF THE COUNCIL ON MEDICAL SERVICE (I-03)
Status Report on Medicare Review Activities
(Reference Committee J)
(December 2003)

EXECUTIVE SUMMARY

Since 1997, the Council on Medical Service has presented an annual report to the House of Delegates on the status of Medicare review activities. Council on Medical Service Report 6 (I-03) details proposed rules on the Medicare claim appeals process, and on establishing and maintaining Medicare billing privileges; summarizes recent judicial action on the status of the Medicare beneficiary complaint process; describes the results of a recent study of Medicare Quality Improvement Organization (QIO) national projects; and summarizes pending Medicare regulatory relief legislation.

Over the years, the AMA has established extensive policy on Medicare review and appeals procedures. Accordingly, the Council is pleased with many of the changes that the Center for Medicare and Medicaid Services (CMS) has proposed to the Medicare claim appeals process, such as requiring Medicare carriers to complete requested redeterminations more quickly, and providing easier access to reconsiderations by QICs and to ALJ hearings due to a lowering of the respective monetary thresholds. Reflective of the AMA comments submitted earlier this year, however, the Council believes that there remain several areas where the Association needs to keep working with CMS prior to the issuance of a final rule.

Given the progress the Administration has made in its regulatory relief efforts to date, the Council believes that it would be a major mistake for CMS to implement the new and burdensome requirements contained in its proposed rule on establishing and maintaining Medicare billing privileges. The Council continues to have serious concerns about the potential impact on physicians the proposed new requirements, as well as the secondary impact the rule will have on the patients who depend on them for medical care. The Council strongly opposes these new requirements and believes that the AMA should continue to advocate for CMS to simplify and reduce the burden that could potentially be associated with any new enrollment requirements.

Similarly, the Council continues to have serious concerns that the June 2003 decision of the U.S. Court of Appeals for the D.C. Circuit, to affirm the lower court's ruling regarding the Medicare beneficiary complaint process, could compromise both the current quality focus of the Medicare QIO program and the improved relationship that has developed between patients, physicians, and QIOs. Without the protection of a medical review privilege, the Council remains concerned that many physicians may become unwilling to participate in meaningful peer review under the QIO program. As a result, the Council believes that the AMA will need to monitor issuance of notices of final dispositions by QIOs within the Medicare beneficiary complaint process and, as needed, work with CMS to provide further guidance to QIOs.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6 - I-03
(December 2003)

Subject: Status Report on Medicare Review Activities

Presented by: Ardis D. Hoven, MD, Chair

Referred to: Reference Committee J
(Steven C. Arendt, MD, Chair)

1 Since 1997, the Council on Medical Service has presented an annual report to the House of
2 Delegates on the status of Medicare review activities. The following report details proposed rules
3 on the Medicare claim appeals process, and on establishing and maintaining Medicare billing
4 privileges; summarizes recent judicial action on the status of the Medicare beneficiary complaint
5 process; describes the results of a recent study of Medicare Quality Improvement Organization
6 (QIO) national projects; and summarizes pending Medicare regulatory relief legislation.

7
8 MEDICARE CLAIM APPEALS PROCEDURES

9
10 In the November 15, 2002, *Federal Register* (67 Fed. Reg. 69311), the Center for Medicare and
11 Medicaid Services (CMS) issued a proposed rule implementing changes to the Medicare claim
12 appeals process mandated under Section 521 of the Medicare, Medicaid, and SCHIP Benefits
13 Improvement and Protection Act of 2000 (BIPA), P.L. 106-554. The Act called for a series of
14 structural and procedural changes to the existing appeals process, including the establishment of a
15 uniform process for handling all Medicare Part A and Part B appeals; revised time limits for filing
16 appeals; reduced decision-making timeframes throughout all levels of the Medicare administrative
17 appeals system; and the introduction of new entities known as “qualified independent contractors”
18 to conduct reconsiderations of the initial determinations or redeterminations made by Medicare
19 carriers.

20
21 Under BIPA, Medicare carriers are required to issue initial determinations on “clean claims” within
22 30 days, and within 45 days on all other claims. Upon request for redetermination of a claim,
23 carriers are required to issue a decision with 30 days of receiving the request. Previously, carriers
24 had to process 95% of such requests within 45 days. However, CMS has proposed an automatic
25 14-day extension of the redetermination decision timeframe when an appellant submits evidence
26 after the request. In addition, the timeframe in which a physician may request a redetermination
27 has decreased. In the past, a physician had six months (i.e., 180 days) to file a request for
28 redetermination with the Medicare carrier, and now will have only 120 days.

29
30 Under the previous system, a Medicare carrier redetermination of a claim could be appealed if the
31 amount in controversy was at least \$100. The second level of appeal involved a “fair hearing”
32 before a hearing officer at the carrier. Physicians had six months to file a request for a fair hearing,
33 and the carrier had to handle 90% of such hearings within 120 days. Under the new system, new
34 entities called qualified independent contractors (QICs) will process “reconsiderations” of carrier
35 initial determinations and redeterminations. Appellants will have easier access to this second level

1 of appeal because the \$100 threshold for the amount in controversy has been removed. Physicians
2 also can expect a quicker turnaround on these second-level appeals, since QICs must process their
3 reconsiderations within 30 days. Physicians still have six months to file a second-level appeal.
4

5 Under both the previous and new appeals systems, the third level of appeal is an administrative law
6 judge (ALJ) hearing, and physicians have 60 days to file an appeal with an ALJ. The major
7 changes in the process at this stage concern the amount in controversy that is necessary to qualify
8 for an ALJ hearing, and the time limit for ALJs to make their decisions. Under the previous
9 system, the minimum amount in controversy for physician claims was \$500, and there was no time
10 limit on ALJs for issuing a decision. Under the new system, the minimum amount in controversy
11 for an ALJ hearing has been decreased to \$100, and ALJs have 90 days in which to make a
12 decision. The levels of appeal beyond the ALJ are the Departmental Appeals Board and Federal
13 District Court. Appeals of physician claims rarely reach either of these levels. There have been no
14 major changes in the process at either of these stages, except that there is now a 90-day time limit
15 on decisions at the Departmental Appeals Board level; previously, there was no time limit for
16 reaching these decisions.
17

18 In a January 14, 2003, letter to CMS Administrator Thomas Scully, the AMA submitted detailed
19 comments on the proposed rule, which included the following key points:
20

- 21 • Stronger enforcement efforts may be necessary to ensure that Medicare contractors meet the
22 BIPA-specified time frames for issuing determination decisions.
23
- 24 • There is concern with respect to the established timeframe for contractor decisions on a request
25 for redetermination (i.e., proposing an automatic 14-day extension when an appellant submits
26 evidence after the request).
27
- 28 • There appear to be unequal rights for participating and non-participating physicians vis-à-vis
29 the right to appeal Medicare initial determinations.
30
- 31 • There is concern with waiving the established timeframe on ALJ decisions if an appellant
32 “escalates” an appeal to the ALJ before the QIC issues its decision.
33
- 34 • There is concern with modifying the reconsideration process by QICs. Although BIPA
35 requires QICs to “consider” local coverage determinations (LCDs) in issuing reconsideration
36 decisions, CMS has proposed that QICs “give deference” to LCDs, local medical review
37 policies, and program guidance.
38
- 39 • With regard to services furnished by physicians, there may be a need to ensure that
40 reconsiderations are made only by actively practicing physicians familiar with the medical
41 condition or treatment in question, of the same specialty, and licensed and actively practicing
42 in the same state where the physician practices.
43

44 At the time this report was written, the final rule on changes to the Medicare claims appeal
45 procedures had not been issued.

1 ESTABLISHING AND MAINTAINING MEDICARE BILLING PRIVILEGES

2
3 Council on Medical Service Report 15 (I-99) discussed the proposed new enrollment process for
4 Medicare providers and suppliers. In that report, the Council reviewed the Provider/Supplier
5 Enrollment Application (855 form); discussed proposed mandatory denial or revocation of
6 enrollment, as well as permissive denial or revocation; and offered suggestions for streamlining the
7 existing process. On the basis of its study, the Council concluded that:

8
9 The pending proposal to mandate a new method of enrollment in the Medicare
10 program would be an enormous new regulatory burden for physicians, who are
11 still trying to understand and cope with other confusing Medicare regulations.
12 This proposal would require many hours of physicians' time, and would subject
13 them to possible discretionary punitive measures such as revocation or denial of
14 their provider number. The Council believes that CMS must adhere to its narrow
15 statutory authority and must refrain from subjecting physicians to additional
16 regulatory hassles and from creating new harmful consequences for those who
17 fail to abide by these new burdensome requirements.

18
19 Policy H-330.911 (AMA Policy Database), established by Council Report 15 (I-99), calls for the
20 AMA to: (1) insist that CMS not exceed its statutory authority in the development of proposals
21 relating to Form 855 and physicians' enrollment in the Medicare program, and consider pursuing
22 litigation should CMS do so; (2) insist that CMS refrain from subjecting physicians to additional
23 administrative burdens in the Medicare enrollment process; (3) strongly urge CMS to create an
24 option during the Medicare enrollment process that will allow physicians to apply for and set up
25 electronic billing and payment; and (4) strongly urge CMS to institute temporary provider numbers
26 for physicians during the Medicare enrollment application period. More recently, Resolution 131
27 (A-03) directed the AMA to work to simplify and reduce the difficulty and burden of the CMS'
28 proposed Medicare provider enrollment policy.

29
30 In the April 25, 2003, *Federal Register* (68 Fed. Reg. 22064), CMS issued a formal notice of
31 proposed rulemaking on the Medicare enrollment process. If finalized as proposed, the more than
32 300,000 physicians who obtained their Medicare billing numbers before 1996, and hence were not
33 previously required to complete an 855 enrollment form, would be required to do so just to
34 maintain the Medicare billing privileges they currently have. Failure to complete the process could
35 lead to revocation of the physician's Medicare number. The new rule also proposed that the billing
36 numbers of any enrolled physicians that do not bill the program for two consecutive quarters be
37 deactivated and that they would need to re-enroll once they wish to again begin submitting claims.
38 Finally, physicians would be required to re-certify the accuracy of their enrollment information
39 every three years unless they had already notified CMS of changes in their billing information.

40
41 Consistent with Policy H-330.911 and Resolution 131 (A-03), the AMA submitted detailed
42 comments on the proposed rule in a letter to CMS Administrator Thomas Scully, on June 24, 2003.
43 Reminiscent of the conclusion reached by the Council four years earlier, the AMA stated that:

44
45 If finalized, the rule would require all physicians who provide care to patients in
46 the Medicare program and who have not previously submitted an 855 enrollment
47 form to do so, to report changes to the information on the form on an ongoing
48 basis as they occur, and to revalidate their enrollment information every three

1 years. Such an enormous new regulatory burden would undermine much of the
2 progress made to date on regulatory reform. The AMA strongly opposes these
3 new requirements and urges that the proposed rule be withdrawn.
4

5 In November 2001, CMS revised the 855 form to ease the enrollment of qualified providers into
6 Medicare. The application is now a set of four individualized forms, each geared toward a specific
7 provider or supplier type based on the applicant. These forms were published concurrently with
8 the 2003 proposed rule to allow review and comment on the complete enrollment process.

9 Although the 855 form revisions improved the application process in several respects, the process
10 has continued to present numerous challenges. As the AMA stated in its June 2003 comments,
11 these shortcomings were demonstrated by the results of a CMS customer service survey presented
12 to the Practicing Physicians Advisory Council in December 2002, which identified 17 customer
13 service objectives for the enrollment process. Key among the objectives that were identified by
14 respondents as needing improvement were the following:
15

- 16 • appropriate number of hours spent on process and effort required to complete the 855 form;
- 17
- 18 • information requested by the 855 form in a user-friendly manner;
- 19
- 20 • helpfulness of the CMS regional office and consistent answers received to questions;
- 21
- 22 • ease in finding out the status of the 855 form;
- 23
- 24 • carrier minimized number of times the 855 form was returned for corrections; and
- 25
- 26 • prompt notification by the carrier of the provider number.
27

28 However, just four months after identifying these numerous deficiencies in the enrollment process
29 for physicians who are new to Medicare, CMS proposed a major expansion of the process to all
30 physicians and that the enrollment information be revalidated every three years.
31

32 As the AMA stated further in its comments on the proposed rule, CMS has not provided
33 justification as to why the massive administrative undertaking associated with the proposed
34 periodic revalidation is needed, nor has it explained how the validation should occur. The current
35 855 form encompasses 27 pages and most physicians would need to complete multiple 855 forms,
36 most likely the 855I for individual practitioners, the 855B for practices that submit bills to
37 Medicare carriers, and the 855R to reassign benefits. The proposed requirements that all
38 physicians complete the necessary forms initially, submit changes on the various forms every time
39 any of the data on the form changes, then revalidate the information every three years will be
40 extremely burdensome. The revalidation requirement seems excessively redundant given the
41 requirement to report changes as they occur. Compounding the hassle factor is the proposal to
42 deactivate the Medicare numbers of those physicians who fail to promptly report changes to the
43 information submitted on the form.

44 The AMA also pointed out in its comments that CMS has failed to provide any details regarding
45 how carriers or other contractors will manage to process the vast number of enrollment applications
46 that would be required, what deadlines physicians and carriers would face associated with the
47 process, and how carriers will be able to process these forms using their existing resources.

1 Although CMS has indicated that this undertaking would be accomplished without jeopardizing the
2 60-day deadline by which carriers are supposed to issue Medicare identification numbers, it is
3 difficult to see how this would be possible, given that many carriers are currently missing this
4 deadline.

5
6 Consistent with Resolution 131 (A-03), the AMA has continued to meet with CMS officials to
7 underscore the points made in its comment letter. The AMA and several national medical specialty
8 societies have particularly emphasized the need for CMS to drop its proposal that physicians who
9 obtained their Medicare numbers before 1996 now be required to complete the 855 form process.
10 Even if CMS proceeds to finalize such a requirement for suppliers of durable medical equipment,
11 hospitals and other providers, the AMA has stressed the need to exempt physicians. Otherwise, the
12 Medicare program runs a serious risk of antagonizing the hundreds of thousands of physicians who
13 have been caring for Medicare patients for many years.

14
15 Based on these meetings, it appears that Medicare officials are rethinking the approach described in
16 the proposed rule and attempting to ensure that any new requirements will be as simple and
17 efficient for physician practices as possible and not impose new paperwork burdens. Before the
18 new rules are finalized, for example, the agency is making an effort to get a comprehensive
19 enrollment database up and running that would allow physicians to view online the information
20 that Medicare already has for them and validate its accuracy and completeness, instead of needing
21 to fill out a lengthy paper form.

22 23 MEDICARE BENEFICIARY COMPLAINT PROCESS

24
25 In Council on Medical Service Report 6 (I-02), the Council reported on the status of a lawsuit that
26 was filed by consumer advocacy group Public Citizen on behalf of a consumer who wished to learn
27 the complete results of a Medicare QIO (previously known as peer review organization)
28 investigation into a beneficiary complaint (*Public Citizen, Inc. v. Department of Health and Human*
29 *Services, 151 F. Supp. 2d-64*). In July 2001, the U.S. District Court for the District of Columbia
30 (DC) ruled that the findings of such investigations could be open to Medicare patients and their
31 families. Medicare officials were ordered to disclose the results of all cases in which a patient or
32 family member has complained of medical mistakes or poor care. CMS appealed the court's ruling
33 and was successful in obtaining a stay in September 2001.

34
35 In May 2002, the AMA, the American Hospital Association, and the Federation of American
36 Hospitals filed a friend-of-court brief in this case. In the brief, it was argued that the court's
37 decision "would effectively eviscerate the institution of peer review in the Medicare context,
38 because without the guarantee of confidentiality, physicians will decline to participate in the peer
39 review process." The U.S. Court of Appeals for the D.C. Circuit heard arguments on the lower
40 court's ruling on October 4, 2002.

41
42 In a June 20, 2003, opinion, the U.S. Court of Appeals for the D.C. Circuit affirmed the judgment
43 of the U.S. District Court. In its opinion, the appellate court concluded that to "inform" a Medicare
44 beneficiary of the organization's "final disposition" of the complaint as required by
45 § 1320c-3(a)(14), a PRO must notify the complainant of the results of its review. At a minimum,
46 this means that the PRO must disclose its determination as to whether the quality of the services that
47 the recipient received met "professionally recognized standards of health care." The district court's

1 judgement, which held that the provisions of the PRO Manual prohibiting disclosure of the results
2 of § 1320c-3(a)(14) investigations were invalid as contrary to law, was affirmed.

3
4 To comply with the court's decision, CMS instructed QIOs on August 11, 2003, to "inform
5 complainants (i.e., beneficiaries or their designated representatives) of the final disposition of a
6 beneficiary complaint." CMS further directed QIOs to "communicate in your final notice to the
7 beneficiary, or his or her representative, whether or not care met applicable professionally
8 recognized standards of care." Although CMS provided QIOs with model letters to use as guides
9 in developing notices of final dispositions, it had not provided, at the time this report was written,
10 uniform guidance as to how QIOs are to determine or define "professionally recognized standards
11 of care."

12
13 Long-standing AMA policy calls for PROs to be required to receive affirmative physician consent
14 before patients are notified of PRO review determinations (Policy H-340.901) and urges
15 implementation of a Medicare beneficiary complaint process that maintains confidentiality of
16 review findings (Policy H-340.900). In addition, Policy H-375.972 supports the enactment of
17 federal legislation to prohibit discovery of records, information, and documents obtained during the
18 course of professional review proceedings.

19
20 The AMA has aggressively advocated physician concerns on this critical issue, and has been in
21 regular contact with CMS officials regarding the complaint process and recent instructions to the
22 QIOs. In addition, the AMA has met with the American Health Quality Association, the national
23 membership association for the QIOs, regarding the appellate court decision and recent disclosure
24 instructions. These advocacy and outreach efforts remain ongoing to ensure the highest level of
25 confidentiality and integrity of the Medicare professional review process. The AMA will closely
26 monitor the implementation of the beneficiary complaint process and we will look for opportunities
27 with both the Congress and Administration to improve the situation.

28 29 QIO NATIONAL QUALITY IMPROVEMENT PROJECTS

30
31 In previous reports to the House (Council on Medical Service Reports 9, I-00, and 16, I-98), the
32 Council reported extensively on the national quality improvement projects undertaken by Medicare
33 QIOs. A January 2003 study published in the *Journal of the American Medical Association*
34 (*JAMA*) concluded that medical care for beneficiaries under the Medicare fee-for-service program
35 improved substantially between 1998-99 and 2000-01 (Jencks, et. al., *JAMA*, January 2003).

36
37 Conducted by CMS and the QIOs, the study concentrated on 22 quality indicators that previously
38 have been shown to help prevent or treat breast cancer, diabetes, acute myocardial infarction, heart
39 failure, pneumonia, and stroke. Examples of such indicators include administration of aspirin
40 within 24 hours of admission for acute myocardial infarction; recommendation of a mammogram at
41 least once every two years for women aged 52 to 89 years; and an eye examination at least every
42 two years for diabetic patients.

1 Abstractions from state-wide random samples of medical records for inpatient care and from
2 beneficiary surveys or claims for outpatient care revealed that the median state's performance
3 improved from baseline (1998-99) to follow-up (2000-01) on 20 of the 22 indicators. In the
4 median state, the study concluded that the percentage of patients receiving appropriate care on the
5 median indicator increased from 69.5% to 73.4%, a 12.8% relative improvement. According to the
6 authors of the study, the improvement "is consistent with the goals of the Medicare QIO program,
7 which has performance-based contracts with QIOs to achieve precisely these kinds of
8 improvements." Furthermore, while the authors acknowledge that a larger opportunity remains for
9 further improvement, they conclude that the study is the first to demonstrate improvement in
10 quality of care over multiple settings for both Medicare inpatient and outpatient care.

11 MEDICARE REGULATORY RELIEF LEGISLATION

12
13
14 During 2003, there was considerable congressional action regarding Medicare regulatory relief
15 legislation. In April 2003, both the House Ways and Means Committee and the House Energy and
16 Commerce Committee favorably reported the Medicare Regulatory and Contracting Act of 2003
17 (H.R. 810). The Act would amend title XVIII of the Social Security Act to provide regulatory
18 relief and contracting flexibility under the Medicare program.

19
20 More recently, the Medicare Prescription Drug and Modernization Act of 2003, passed by both the
21 House (H.R. 1) and the Senate (S. 1) in June 2003, contained many of the same or similar
22 regulatory relief provisions. At the time that this report was written, the tentative agreement
23 reached by House and Senate conferees would:

- 24
- 25 • Limit the use of extrapolation to only those cases where there is a sustained or high payment
26 error rate or documented education efforts have failed.
 - 27
 - 28 • Eliminate penalties and interest for physicians faced with alleged overpayments who have
29 relied on written guidance from Medicare.
 - 30
 - 31 • Educate physicians about incorrect billing practices and allow an opportunity to correct errors
32 before repayment demands are made.
 - 33
 - 34 • Delay repayment demands until after physician appeals have been considered.
 - 35
 - 36 • Offer physicians installment plans for repayment instead of withholding payment of their
37 claims.
 - 38
 - 39 • Ensure that any new documentation guidelines for evaluation and management codes are
40 thoroughly pilot tested before they can be implemented as national policy.
 - 41
 - 42 • Prohibit retroactive application of Medicare rules.
 - 43
 - 44 • Require carriers to provide physicians with clear, concise, and accurate answers to their billing
45 questions.

- 1 • Ensure that prepayment reviews are terminated in a timely manner instead of continuing
2 endlessly.
- 3
- 4 • Give physicians the right to appeal if their application for a Medicare billing number is denied.
5
- 6 • Ensure that services furnished under the prudent layperson standard and according to
7 EMTALA requirements are covered by Medicare.
8

9 DISCUSSION

10
11 Over the years, the AMA has established extensive policy on Medicare review and appeals
12 procedures. Accordingly, the Council is pleased with many of the changes that CMS has proposed
13 to the Medicare claim appeals process, such as requiring Medicare carriers to complete requested
14 redeterminations more quickly, and providing easier access to reconsiderations by QICs and to ALJ
15 hearings due to a lowering of the respective monetary thresholds. Reflective of the AMA
16 comments submitted earlier this year, however, the Council believes that there remain several areas
17 where the Association needs to keep working with CMS prior to the issuance of a final rule.
18

19 Given the progress the Administration has made in its regulatory relief efforts to date, the Council
20 believes that it would be a major mistake for CMS to implement the new and burdensome
21 requirements contained in its proposed rule on establishing and maintaining Medicare billing
22 privileges. The Council is extremely disappointed that many of the suggestions for improving and
23 streamlining the Medicare enrollment process that it raised four years ago (Council on Medical
24 Service Report 15, I-99) appear to have been largely ignored by CMS in its proposed rule. The
25 Council continues to have serious concerns about the potential impact of the proposed new
26 requirements on physicians, as well as the secondary impact the rule will have on the patients who
27 depend on them for medical care. The Council strongly opposes these new requirements and
28 believes that the AMA should continue to advocate for CMS to simplify and reduce the burden that
29 could potentially be associated with any new enrollment and validation requirements.
30

31 Similarly, the Council continues to have serious concerns that the June 2003 decision of the U.S.
32 Court of Appeals for the D.C. Circuit, to affirm the lower court's ruling regarding the Medicare
33 beneficiary complaint process, could compromise both the current quality focus of the Medicare
34 QIO program and the improved relationship that has developed between patients, physicians, and
35 QIOs. Without the protection of a medical review privilege, the Council remains concerned that
36 many physicians may become unwilling to participate in meaningful peer review under the QIO
37 program. Accordingly, the Council believes that the AMA will need to monitor issuance of notices
38 of final dispositions by QIOs within the Medicare beneficiary complaint process and, as needed,
39 work with CMS to provide further guidance to QIOs.
40

41 The Council is pleased with the Administration's continued support for the ongoing quality of care
42 focus of the Medicare QIO program. The results of the January 2003 *JAMA* study referenced in
43 this report demonstrate the benefit that the redirection of the QIO program has had on the quality of
44 care provided to Medicare beneficiaries. It is the Council's hope that future quality improvement
45 projects under the QIO program will not be diminished by the recent appellate court ruling on the
46 Medicare beneficiary complaint process.

1 Finally, the Council continues its strong support of AMA advocacy efforts toward passage of
2 Medicare regulatory relief legislation for physicians that would provide limits on extrapolation,
3 implement stronger due process rights, and require carriers to provide physicians with clear,
4 concise, and accurate answers to their billing questions. Passage of such regulatory relief
5 legislation should continue to be one of the legislative priorities for the Association.

6

7 RECOMMENDATIONS

8

9 The Council on Medical Service recommends that the following be adopted and the remainder of
10 the report be filed:

11

12 1. That the American Medical Association (AMA) continue to advocate that the Centers for
13 Medicare and Medicaid Services (CMS) simplify and reduce the burden that could
14 potentially be associated with any new Medicare enrollment and validation requirements
15 for physicians. (Directive to Take Action)

16

17 2. That the AMA monitor issuance of notices of final dispositions by Medicare Quality
18 Improvement Organizations (QIOs) within the Medicare beneficiary complaint process
19 and, as needed, work with CMS to provide further guidance to QIOs.
20 (Directive to Take Action)

21

Fiscal Note: Continue to monitor and advocate to CMS at estimated total staff cost of \$1,362.