

Provider Communication Advisory (PCOM) Group Minutes

March 27, 2003 - 8:30 A.M. – 12:00 P.M.

Agenda Item	• Discussion	Outcome/Action
<p>Welcome and Introduction</p>	<ul style="list-style-type: none"> • Roll Call Chairperson: Barbara Kahler bkahler@wpsic.com AIM Systems, Inc Department of Urology University of Illinois College of Medicine Dreyer Medical Clinic, S.C Edward Hospital First Care Ambulance Services Foot & Ankle Clinic of America Health One Midwest Illinois Chiropractic Society Illinois State Medical Society Little Company of Mary Hospital McKesson HBOC Medi-Data Services, LTD Midwest Heart Specialists Mount Sinai Hospital Northwestern Medical Faculty Foundation (NMFF) Professional Medical Business Systems Quest Diagnostics Senior Health Insurance Program (SHIP) The Centers for Medicare & Medicaid Services (CMS) University Of Chicago Hospitals & Physicians Group Wisconsin Physicians Service Wolcott, Wood & Taylor 	<p>Twenty-six PCOM Advisory Group members, four WPS staff and Greg Chesmore attended this meeting. Three members called to say they were unable to attend.</p> <p>A letter was distributed to committee members reporting CMS' changes regarding the purpose and focus of the PCOM Advisory Group as explained in Section 5107.A4 of the MCM, Transmittal 146 published January 24, 2003.</p>
<p>PCOM Advisory Group Guidelines</p>	<p>Transmittal 146 directs Medicare Part B contractors that they should:</p> <ul style="list-style-type: none"> • Maintain professional and geographic diversity within the PCOM Advisory Group members. • Include representatives of various provider/supplier specialties, including state and local associations, practicing provider/supplier or staff members and representatives of billing organizations. 	<p>Greg Chesmore, Health Policy Specialist, CMS Provider Outreach Advisory – PCOM Advisory Group Coordinator for Region V provided the same Power Point presentation for all WPS PCOM Advisory Group meetings, outlining their purpose and focus, that he discussed at the Chicagoland PCOM Advisory Group meeting. He said that the effective date of the requirements outlined in</p>

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	<ul style="list-style-type: none"> • Consider more than one PCOM Advisory Group when their geographic service areas are such that it would diminish the effectiveness of having a single PCOM Advisory Group. • Consider the suggestions and recommendations of the PCOM Advisory Group and implement them if reasonable and within budget constraints. • Hold PCOM Advisory Group meetings in-person or via teleconferencing. • Maintain a web site address for PCOM Advisory Group information that contains the minutes of the last meeting, a list of organizations/entities comprising the PCOM Advisory Group, and contact information. <p>Transmittal 146 states that CMS' priority is:</p> <ul style="list-style-type: none"> • Have claims paid correctly. • Provide clear guidance to contractors to ensure that providers receive the correct input and provide good customer service. • Have contractors meet CMS requirements, provide forum for Medicare providers to offer feedback and assist in creating effective education and outreach strategy. • Have Providers assist CMS and contractor community in developing a strategy that will result in provider satisfaction, reduced claims filling errors and reduced provider inquiries. <p>Greg Chesmore briefly discussed the Centers for Medicare & Medicaid Services (CMS) Open Door Policy. He said that within CMS, there are areas that deal with specific issues. CMS has 13 conference calls a month that deal with such issues. Providers can check the schedules and list of groups conducting the conference call. Callers can ask questions on national policy, on issues, clarifications or for guidance.</p>	<p>Section 5107.A4 of the MCM was February 1, 2003. He reviewed the purpose of the PCOM Advisory Group which are:</p> <ul style="list-style-type: none"> • Advise the contractor in the creation, development, implementation of effective provider/supplier education strategies and efforts by providing input and feedback on training topics, materials; • Assist contractor in its efforts to effectively reach the provider community with Medicare education and training <p>The Budget and Performance Requirements (BPRs) were briefly discussed. Greg explained that PCOM Advisory Group is a requirement of the BPRs. He said that PCOM Advisory Group is not:</p> <ul style="list-style-type: none"> • A forum for individual providers to discuss claims-specific issues and problems. • A provider education workshop. • Opportunities for select providers to receive individual attention from contractor staff. • A mere extension of existing advisory groups (e.g., Carrier Advisory Committees).

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<p>PCOM Advisory Group Letter/Survey, Mission Statement</p>	<p>Changes regarding the direction of the PCOM Advisory Group are:</p> <ul style="list-style-type: none"> • PCOM Advisory Group meeting minutes must be disseminated to the members and others who request them within 7 business days of the meeting, and must be posted on the web site, • The names of the member organization or entities comprising the PCOM Advisory Group will be posted on the web site. Individual member names will not be posted. Members were told concerns regarding names being posted on the web site will be taken to CMS. • Members were asked to fill out a survey in the distributed packet regarding training needs and preferred media of communication and submit it after the meeting. <p>J. David said Medicare Part B contractors need people who can communicate and be able to challenge them. Members of the PCOM Advisory Group are to share the material discussed at the meeting with their organization or association.</p> <p>J. David reviewed the PCOM Advisory Group Charter for Illinois.</p> <p>As March is Cancer Awareness Month, J. David introduced brochures from the American Cancer Society.</p>	<p>J. David Bozarth reviewed a letter, given to the PCOM Advisory Group members, that discussed the new requirements and focus of PCOM Advisory Group. Unlike the former Provider Education and Training (PET) Advisory Committee, the new PCOM Advisory Group is to identify and address issues that are of concern to the broad provider/supplier audience. The PCOM Advisory Group direction is to educate provider/supplier, their staff, and their peer groups about fundamental programs and policies, new initiatives and significant changes to the Medicare program.</p> <p>Dr. Zange expressed her view concerning the anonymity of the member because the e-mail address identifies the person. Greg responded that the PCOM Advisory Group members are the representatives of the specialty group or practice. The members should ask themselves if they are willing to be the voice of the group to express its concern.</p>
<p>Medical Policy Updates</p>	<p>Dr. Stephen Boren, CMD in Illinois acknowledged the presence of the PCOM Advisory Group representative from Mount Sinai Hospital. He gave a brief summary of draft Local Medical Review Policies (LMRP) presented at the last CAC meeting.</p> <p>Dr. Boren reviewed the instruction given in the Medicare Carrier Manual (MCM) Rev. 1780 regarding Supervising Physicians in Teaching Settings guidelines. He emphasized the importance of provider proper documentation in the patient's medical records.</p> <p>Dr. Boren announced the date for the Open LMRP meeting which will be held on April 9, 2003, 1:00 P.M. CST; 2:00 P.M. EST. The list of LMRPs to be presented may be copied from the WPS Medicare B web site. He also announced the elimination of the</p>	<p>A question was raised regarding how to obtain a new specialty code. Someone said to go to the specialty society or organization. Another suggestion was to go to CMS' administrator. Examples of specialties that currently do not have designated specialty codes are electrophysiology, retinal surgeons. These specialists are bundled into cardiology and Ophthalmology. The problem is when two providers with the same specialty bill on the same day, one service is denied. The service may be allowed on appeal with proper documentation.</p>

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	<p>Medical Director's Corner in the monthly bulletin. Examples are Capsule Endoscopy – a draft LMRP that was presented at the last CAC meeting in January 2003 is a misnomer. The patient must have had an upper/lower endoscopy before this procedure could be allowed. If there is no history of a previous upper/lower endoscopic procedure, capsule endoscopy will be denied.</p>	
Break		
Postpayment Medical Review Update	<p>With the division of outreach activities now falling into two major activities, 1) Provider Communication (PCOM) and 2) Local Provider Education and Training (LPET), contractors' Provider Education staff must now have more frequent interaction with Medical Review (MR) staff, and join forces with MR to satisfy several initiatives.</p> <p>Overpayment letters, including educational information and probe findings, are sent to the provider at the conclusion of probe review. The provider has 30 days to refund the overpayment. On day 31, interest accrues if payment is not received. On the day 40, recoupment begins.</p> <p>The Medical Review Goals for FY 2003 are:</p> <ul style="list-style-type: none"> • Educate providers regarding current error trends in billing • Promote provider self-evaluation and correction in billing errors • Focus review and continued education on providers with consistently high error rates • Promote increased customer satisfaction <p>Improved customer service is the focus in 2003. Scripted responses were developed through the Customer Service Clinical Support Unit to address common provider inquiries as well as partnership with the Customer Service area and other departments to identify pertinent issues affecting the provider community.</p>	<p>Barbara gave a slide presentation on Medical Review stating that the 2003 Medical Review strategy, with emphasis on education, is:</p> <ul style="list-style-type: none"> • FY 2002 carry-over (Podiatry and Psychotherapy) • Physical Therapy • Nail Debridement • Medical Management for psychiatric diagnoses • Diagnostic Testing • Customer Satisfaction <p>Prepayment or Postpayment Medical review originates from:</p> <ul style="list-style-type: none"> • Prior Medical Review Projects • Benefit Integrity Referrals • OIG Referrals • Fraud Alerts • Data Referral as a result of data analysis utilizing the BESS file • Referrals from the CMDs, CAC members <p>Prepayment Medical Review Process consists of:</p> <ul style="list-style-type: none"> • Initial data analysis • Random sample of 100 prepay claims from providers exhibiting probable billing issues after data analysis • Request medical records from the providers • Medical Probe Review

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		<ul style="list-style-type: none"> • Progressive Corrective Action (PCA) • Identification of overpayment • Possible referral to Benefit Integrity Possible additional corrective action
Health Insurance Portability and Accountability Act (HIPAA)	J. David reported on the development of a Fall 2003 HIPAA seminar. He is also working on the final rule on security/privacy and informed the members that there is a list of web site addresses in the meeting packet that can be consulted regarding the HIPAA implementation process.	A question was asked concerning the validity of some vendors. Some charge exorbitant fees to bring them to compliance. Greg suggested they check CMS' list of valid vendors.
Customer Service, FY 2003 Updates/Fee Schedule, Advanced Beneficiary Notice (ABN), and PT Guidelines	<p>A slide presentation was made regarding the Inquiry and Data Analysis Program, which lists the top ten claims submission errors in Illinois. The top are:</p> <ul style="list-style-type: none"> • Service filed 1 year after the date of service are late file billing. • Errors in billing clinical diagnostic laboratory tests that did not follow the Negotiated Rule Making. <p>The top telephone inquiry and submission error is eligibility. The top provider written inquiry and submission error is claim status not given. Copies of the Special Edition of the CY 2003 Physician Fee Schedule were distributed, as well an implementation packet and an article clarifying the correct format for obtaining a patient's one-time authorization as outlined in the MCM Section 3047. Members were told a blank signed 1500 claim form does not give the provider permission to submit any and all future claims to Medicare. Providers must provide beneficiaries with a form that contains specific elements in order for the signature on file (SOF) to be valid one-time authorization giving permission to submit claims for payment of Medicare benefits to the provider.</p>	

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Transmittal AB-03-023, AB 03-018, AB 03-003	<p>The following Program Memorandums were distributed and discussed:</p> <ul style="list-style-type: none"> • PM AB 03-023, the National Coverage Decision on Deep Brain Stimulation for Essential Tremor and Parkinson’s Disease; • PM AB 03-018, Implementation of the Financial Limitation for Outpatient Rehabilitation Services. Beginning with claims submitted for dates of service on and after July 1, 2003, the financial limitation for PT (including speech-language pathology) and OT. There are separate limitations of \$1590 for each type of provider annually per beneficiary. • PM AB 03-003, a notification regarding MECT services performed on or after April 1, 2003, which will not be covered by Medicare. 	
Q&A, Summary and Adjournment	<p>A concern was expressed regarding WPS' implementation of 156 edits and their corresponding severity listed in the December 2002 Communiqué when the edits would be changed again upon final implementation of HIPAA.</p> <p>Another question raised was regarding the March 2003 Communiqué article on modifier 99. With the recent system coding enhancements, the system can now recognize up to four position modifiers. Previously, because of system limitations, it could only recognize two positions on a given detail line. When is this change effective?</p>	<p>J. David responded the change in the edits was needed because there four jurisdictional States in WPS and they have to be differentiated. Questions regarding these edits should be sent to Lisa Cuocci.</p> <p>Barbara will ask when the new guidelines for modifier 99 are effective and if modifier 99 may be used if there are less than four modifiers in box 19. (The answers are: The new guidelines are now in place. If there are less than five modifiers in box 19, the 99 modifier will not be allowed and the claim will be returned as unprocessable. This answer was e-mailed to all members of the PCOM Advisory Group.)</p>
The meeting was adjourned at 12:00 P.M. Next PCOM Advisory Group meeting will be held on June 26, 2003		