

Provider Communication (PCOM) Advisory Group Minutes – Chicago, IL

December 11, 2003 - 9:00 A.M. – 12:00 P.M.

Agenda Item	Discussion	Outcome/Action
Welcome and Introduction	<p>Roll Call</p> <p>Chairperson: Ellen Berra, eberra@wpsic.com J. David Bozarth, Assistant Manager Medical Director: Stephen Boren, M.D. Associated Anesthesiologists Dreyer Medical Clinic, S.C Edward Hospital First Care Ambulance Services Foot & Ankle Clinic of America Health One, Inc. Illinois Chiropractic Society Illinois State Medical Society Little Company of Mary Hospital McKesson HBOC Metropolitan Chicago Hospital Council Medi-Data Services, LTD Midwest Heart Specialist Mt. Sinai Medical Group Northwestern Medical Faculty Foundation (NMFF) Professional Medical Business Systems Quest Diagnostics University Of Chicago Hospitals & Physicians Group Wolcott, Wood & Taylor</p>	22 PCOM Advisory Group members and 3 WPS staff attended this meeting.
PCOM Material	<p><i>Material was sent via e-mail three days prior to the meeting</i></p> <ul style="list-style-type: none"> • From this meeting forward, agenda documents will be sent via e-mail prior to the meeting. Attendees are responsible for bringing the materials with them. 	<ul style="list-style-type: none"> • The members agreed to the idea. This will give them time to review the material before the meeting. There were no negative comments.
CD-ROM	<p><i>CD-ROM presentation:</i></p> <ul style="list-style-type: none"> • CMS granted the opportunity for this pilot project to only six carriers nationwide. • The CD-ROM contains information in the following 	<ul style="list-style-type: none"> • The documents for today's meeting include a survey on the CD-ROM. Members are asked to complete the

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	<p>categories: Provider Enrollment, Pricing and Fees, Provider Education, Provider Resources and Publications.</p> <ul style="list-style-type: none"> • Based on new legislation, fee schedule information is no longer current. Although, Medicare does not anticipate that CMS will authorize a release of a second CD-ROM, updated pricing information should be available by January 1, 2004. • Workshops – Introduction to Medicare Basics and Beyond the Basic information is on the CD-ROM • Ellen navigated the CD-ROM to show the ease of movement. • Also discussed were the bookmark and search features. 	<p>survey and return to Ellen Berra. Some surveys were returned after the meeting.</p> <ul style="list-style-type: none"> • Workshop information will allow providers to do in-house training.
<p>EDI / HIPAA : HIPAA Seminars</p>	<p>HIPAA:</p> <ul style="list-style-type: none"> • The deadline for HIPAA compliance was/is October 16, 2003. • Providers are encouraged to contact their systems staff and vendors to verify they are submitting in the 4010A.1 format. There has been anecdotal information that providers believe they are submitting a compliant format, but are not. • September 23, 2003 CMS announced that they would invoke a temporary contingency plan. The contingency plan means that we will continue to accept legacy formats beyond October 16. • Unless they meet one of the exceptions, providers should not submit paper claims. • CMS will investigate complaints regarding providers who are not HIPAA compliant. The provider needs to show a good faith effort toward compliance. • Providers not showing the good faith effort could be assessed penalties. • There are exceptions to requirements for billing electronically: 1. No method available. This would include roster billing, beneficiary claims, and claims where Medicare is secondary to two or more plans. 2. Small providers. This 	<ul style="list-style-type: none"> • Contingency plan is only for limited time, not an extension or delay, just an opportunity • Compliance date remains October 16 • Providers are encouraged to use the narrative record for additional information.

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	<p>is a physician office that has fewer than 10 full-time equivalent employees and they are not currently conducting a transaction electronically. 3. Extraordinary Circumstances. This could include power failure.</p> <ul style="list-style-type: none"> • CMS is working on a final rule for submitting attachments electronically. Until that time, providers can use the statement "Additional documentation available upon request" in the narrative record. If Medicare needs additional documentation a development letter will be sent to the provider. 	
Medical Policies	<p><i>Online CMS Manual System:</i></p> <ul style="list-style-type: none"> • Effective Oct 1, 2003, CMS began transitioning from a paper-based manual to a Web-based system for all users. • CMS will phase-out paper based manuals. • Providers can perform a search specifically for the manual section of the web site. • Paper-based manuals will be replaced with four new templates created to communicate program instructions and update the new Internet-only manuals: <ul style="list-style-type: none"> • Manual revisions • One-time notification • Business requirement • Confidential requirement templates <p><i>Medicare Learning Network Web Site:</i></p> <ul style="list-style-type: none"> • Site allows Medicare providers to obtain information they need • Provides: audience-specific web pages, web-based training modules, videos, publication, training materials, provider education events with on-line registration, questions and answers, and links to Medicare contractors. 	<ul style="list-style-type: none"> • Providers should check both sets of manuals for current policy and procedures • Information on E&M documentation should be shared with the provider community. • Providers are encouraged to evaluate their internal billing to verify the coding is correct.

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	<p><i>Medicare Coverage Database:</i></p> <ul style="list-style-type: none"> • Database allows users to search across NCDs, LMRPs and contractor articles/FAQs from a single point of entry <p><i>Evaluation & Management Documentation:</i></p> <ul style="list-style-type: none"> • WPS published several articles on E&Ms during 2003, October, November & December of the Communiqué • Articles are to assist providers in evaluating their billing of E&M visits to verify they are billed correctly. <p><i>Retired Medical Review Policies:</i></p> <ul style="list-style-type: none"> • Included a list of policies that have retired 12/01/03 and will remain on web site until 01/31/04 • After 1/31/04 providers wanting a copy can request it through the Freedom of Information Department. 	

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<p><i>Medical Director's Corner</i></p>	<p><i>CMS Chief Medical Officer:</i></p> <ul style="list-style-type: none"> • Dr. Susan Nedza took over the position of Chief Medical Officer for CMS Region V in mid-November to replace Dr. Trent Haywood, who moved to CMS Central Office. <p><i>Policies:</i></p> <ul style="list-style-type: none"> • The Medical Staff is working toward consolidation of all policies into Quad State policies. This should be completed by the end of January 2004. • Retired a number of policies <p><i>Open Door Forum:</i></p> <ul style="list-style-type: none"> • These are teleconferences sponsored by CMS and held on a periodic basic. CMS will do a presentation and then provide time for questions and answers from the attendees. There is a web site to sign up for a newsletter and notification of calls. http://www.cms.hhs.gov/opendoor 	<ul style="list-style-type: none"> • If a policy is retired, the rules and specifics no longer apply after the retirement date. • Providers discuss their issues, questions are answered and problems are addressed
<p>General Updates</p>	<p><i>Rate Allowances & Payment:</i></p> <ul style="list-style-type: none"> • CMS increased reimbursement rate for Influenza & Pneumococcal vaccines <p><i>New Diagnosis Code:</i></p> <ul style="list-style-type: none"> • ICD-9-CM, VO4.81, new code for influenza virus vaccine may be used for claims with dates of service on or after October 1, 2003 <p><i>Phone Numbers</i></p> <ul style="list-style-type: none"> • WPS provided a listing of the phone numbers for the Customer Service, Financial and MSP departments 	<ul style="list-style-type: none"> • After January 1, 2004 - required code
<p>Customer Service</p>	<p><i>Top Appeals:</i></p> <ul style="list-style-type: none"> • Modifiers 24 and 25 continues to be one of the top reasons for appeal requests • We receive a large volume of appeals with modifiers 59 and 	<ul style="list-style-type: none"> • The members are encouraged to share this information with the provider community.

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	<p>76 being added to the codes 71010 and 88305</p> <ul style="list-style-type: none"> • The documents provided to the members included a chart with explanations of the correct use of modifiers 24, 25, 59 & 76. <p><i>Top Claim Denials:</i></p> <ul style="list-style-type: none"> • Provider number(s) <ul style="list-style-type: none"> • Group number is entered but the individual number is not • Individual number does not belong to the group • Individual number is submitted without any reference to the group • Place of service not valid for procedure code <ul style="list-style-type: none"> • Denials are due to reporting a service that is professional and technical in nature, in an inappropriate place of service <p><i>Local Provider Education & Training (LPET) – Medical Review & Outreach:</i></p> <ul style="list-style-type: none"> • Medical Review and Outreach started a pilot program with a few select Podiatrists, who volunteered to receive a Comparative Billing Report (CBR) • May expand CBR to all Podiatrists in the four states for a defined period of time <p><i>Medical Review Strategy:</i></p> <ul style="list-style-type: none"> • Proactive Education – introducing and educating providers on the overall goals of the contractor Medical Review Program • Medical Review of Claims – will complete all reviews in a timely manner and will share on a one-to-one basis with the provider under review 	<p><i>Decrease the number of denials:</i></p> <ul style="list-style-type: none"> • Both the group number and provider’s individual number should be on the claim form • Verify with Provider Enrollment that the individual providers are listed with that group • Take care of end dating provider numbers for those no longer in the group • MPFSDB provides information about these types of procedures • Goal is for providers to self-assess their billing practices

