

**Provider Communication Advisory Committee Minutes
(PCOM)**

8:30 a.m. - 12:00 noon

June 24, 2004

Chicago, Illinois

Members: (21)

Agenda Item	Discussion	Outcome/Action
1. Welcome and Introductions	<p><i>Roll Call</i></p> <p>Chairperson: Ellen Berra, eberra@wpsic.com Medical Director: Stephen Boren, M.D. sboren@wpsic.com</p>	21 PCOM Advisory Group members and 3 WPS staff attended this meeting.
2. PCOM Material	<p><i>Material by e-mail</i></p> <ul style="list-style-type: none"> • All meeting materials are forwarded to members via e-mail. There was a discussion on the viability of this. <p><i>Information distributed during meeting:</i></p> <ul style="list-style-type: none"> • CMS WebSite Wheel – Information / innovative ways to find websites on CMS. • Provider Interactive Voice Response System – discusses the Provider IVR system and provides helpful hints for using it more effectively. • Written Request for Review card - these cards were formulated by the Customer Service Department and detail the information that should be contained in a written request for review. • 2004 UPIN Supplement Directory on CD-ROM – complete version of the UPIN directory. • Resident New Physicians Guide – CMS has put together material for physicians new to the Medicare program. 	<ul style="list-style-type: none"> • Members reported no difficulties in downloading the material and reported that by receiving the material prior to the meeting they could prepare questions. • Items were distributed to members. • Members were encouraged to share this information with their medical professionals.
3. Customer Service	<p><i>Phone Number Changes effective May 13, 2004:</i></p> <ul style="list-style-type: none"> • There is now separate phone numbers for the Customer Service Call Center and the Provider Interactive Voice Response (IVR) unit. • The time limits for use of the IVR have been expanded and depending on call volume, a provider can stay on line for 10 to 15 minutes per call. 	<ul style="list-style-type: none"> • By dialing separate Provider IVR and Call Center numbers providers will gain better access to both.

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	<ul style="list-style-type: none"> There is no option to transfer from one to the other, one will need to disconnect and dial the designated phone number. <p><i>Provider Medicare Telephone Numbers:</i></p> <ul style="list-style-type: none"> Listing of telephone numbers for specific departments. (WI, IL, MI, MN). <p><i>Customer Services Reporting:</i> Top Claim Submission Error findings for the period of February 1 – March 31 of this year were presented to the committee. In addition, appeals statistics were shared in the categories of: Types of Initial Claim Determinations Appealed Most Frequently, Reasons for Initial Claim Determinations Reversed at the Appeal Level and the Top Five Types of Services Most Frequently Appealed.</p> <ul style="list-style-type: none"> There was a discussion concerning diagnosis information contained on the request for service form. At times, the information is not complete and causes the lab service to be denied. Clinical lab representatives cannot change the diagnosis coding provided by the physician offices. The denials are causing numerous review requests for the Labs. <p><i>Beneficiaries New Phone Number:</i></p> <ul style="list-style-type: none"> 1-800-633-4227 - CMS will soon migrate all current Medicare contractor's beneficiary telephone numbers over to the standard 1-800-MEDICARE. Beneficiaries will call this number for all questions regarding Medicare claims and services. If information is requested concerning specific claims, the CMS Customer Service staff will forward the call to the individual carrier. 	<ul style="list-style-type: none"> Updated telephone listings were distributed to the members. Providers are encouraged to use the link from our web site to the CMS web site for Clinical Laboratory coverage information. Members are encouraged to share information with the provider community on the top denial and review request information. Julius Cintron of Quest Diagnostic will put together a short article on this subject. Ellen will work with Julius to see about publication. Members were directed to the CMS flyer in their packet of information. Members are encouraged to display the information in their offices to direct beneficiaries to the new number.
4. Financial/ Medicare Secondary Payer (MSP)	<p><i>Voluntary Refunds</i></p> <ul style="list-style-type: none"> Members were provided with the most recent instructions/documents for returning a voluntary refund. Providers were reminded that if they discover an overpayment they should simply refund the overpayment using the form. Contacting the Customer Service staff results in more work for both the provider and carrier staff. 	<ul style="list-style-type: none"> Providers can make copies of the form and information to share with the provider community.

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	<ul style="list-style-type: none"> Members were also presented the recent CMS Fact Sheets on ‘Complying With MSP Requirements’ and ‘Collecting, Submitting, and Updating Beneficiary Insurance Information To Medicare,’ that provide answers to the most commonly asked questions surrounding MSP and the COB (Coordination of Benefits) contractor. 	<ul style="list-style-type: none"> Cheryl Erins of Mount Sinai Medical Group will forward the material she is currently using to train her staff on MSP. This information will be evaluated for possible inclusion in a future Communiqué and to share with PCOM members.
5. EDI/HIPAA	<p><i>Extended Payment Floor:</i></p> <ul style="list-style-type: none"> Effective July 1, Medicare is modifying its HIPAA contingency plan. While non-compliant electronic claims will still be accepted, payment for such claims will be extended an additional 13 days. This means these claims will be subject to the same 28-day payment floor as those submitted on paper. This will effect claims received on or after July 6, 2004. Currently WPS is at the following compliance rates <ul style="list-style-type: none"> IL 87% WI 95% MI 70% MN 95% <p><i>If Your Vendor Isn’t HIPAA Compliant, Neither Are You:</i></p> <ul style="list-style-type: none"> The committee was given a copy of a CMS Medlearn Matters article urging providers to understand the requirements of HIPAA, the Medicare HIPAA Contingency Plan and its impact and the need to verify HIPAA compliance by those who bill on behalf of their offices. 	<ul style="list-style-type: none"> A suggestion by the members was to do a one-page letter to all non-compliant providers giving them the web sites and resources on how to become compliant. Check with your vendor or clearing house to verify that they are submitting HIPAA compliant claims.
6. General Updates	<p><i>Fair Hearing Officers:</i></p> <ul style="list-style-type: none"> CMS is moving the Fair Hearing process to a more regional approach. WPS will no longer perform this function. <p><u><i>CMS Medlearn Matters – “Incident-to-Services”</i></u></p> <ul style="list-style-type: none"> This article both clarifies and standardizes the method of indicating the ordering and supervising professionals when submitting claims to Medicare. The impact statement from this publication is “<i>the billing number of the ordering physician (or other practitioner) should not be used if that person did not directly supervise the auxiliary personnel.</i>” 	<ul style="list-style-type: none"> This should be a transparent process for providers. This indicates to providers that the provider the billing number represents must be the one providing the service or the one on-site supervising the person providing the service.

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	<p>The implementation date for this was May 24, 2004.</p> <ul style="list-style-type: none"> • If the supervising physician were not the physician directing the patient care, that provider's information would be placed in the electronic equivalent to Field 19. <p><i>SNAP (CMS Secure Net Access Pilot):</i></p> <ul style="list-style-type: none"> • On-line system for claim status, patient eligibility & customer service information available 24 hours a day 7 days a week. • WPS had been conducting this as a pilot project working very closely with the specific members and CMS. • WPS now has the opportunity to provide access to all interested parties. • WPS will send the information following registration to the provider's practice address. <p><i>Medicare Carriers Manual (MCM)Box 32 – 1500 form:</i></p> <ul style="list-style-type: none"> • Effective April 1, 2004 services provided in all locations except the patient's home should show the physical location of that service (street address, town, state and zip code) in box 32 of the 1500 form or the equivalent electronic section. • Medicare's payment is based on the zip code of where services were performed. <p><i>PECOS:</i></p> <ul style="list-style-type: none"> • CMS provided information concerning the Provider Enrollment process and the PECOS system. • CMS acknowledges some initial difficulties, but the process is getting smoother and carriers are able to issue the provider numbers in a more timely fashion. • WPS is providing information on our web site concerning the time frames and what receipts dates are currently being processed. 	<ul style="list-style-type: none"> • For more complete information, members are encouraged to visit the CMS web site and take a look a Change Request 3138. • The packet of information has the instructions and forms to have access. Members are encouraged to share this information with the provider community. • Members are encouraged to share the web site information with the provider community.
7. Local Provider Education & Training (LPET)	<p><i>Carrier Error Rate Testing (CERT):</i></p> <ul style="list-style-type: none"> • AdvanceMed will request documentation on a certain number of claims from each contractor. • The development letters are sent to the physician's practice address not billing address. • If no documentation is received or if the documentation does not 	<ul style="list-style-type: none"> • Members are strongly encouraged to share this information with the wider provider community. • When returning documentation, the physician office should return the cover sheet with the barcode. Providers can

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	<p>support the services billed, then an overpayment will be assessed to the physician and the claim will contribute to the error rate.</p> <ul style="list-style-type: none"> • The error rates assessed by AdvanceMed determine if the carrier has need of further action on the particular services. • AdvanceMed has let the carriers know of a particular concern with PT/OT services. When submitting documentation, the physician's office should include not only the service dates in question but also the initial plan of care. Without the plan of care, the service will be denied. <p><i>CPT Code 99213:</i></p> <ul style="list-style-type: none"> • A probe on this code was a direct result of CERT error rates. • Illinois had an error rate of almost 16% based on non-receipt of documentation. • The article provides the results of the review and identifies the errors found. <p><i>LPET Seminars & Workshops offerings:</i></p> <ul style="list-style-type: none"> • Physical Therapy/Occupation Therapy • Mental Health • Foot Care • Modifiers • New Providers-Medicare Basics • Evaluation & Management (E/M) documentation 	<p>submit the documentation either by mail or FAX. The response should be submitted to AdvanceMed not WPS.</p> <ul style="list-style-type: none"> • Members are encouraged to use the information contained in the probe result to evaluate their internal documentation. • These are half-day sessions. • Interested parties can register on line.
8. Medical Policy	<p><i>Implementation of Local Coverage Determinations (LCD):</i></p> <ul style="list-style-type: none"> • The Benefit Improvement Protection Act (BIPA) §522 created Local Coverage Determinations (LCD) that consist only of reasonable and necessary information. LCDs will replace Local Medical Review Policies (LMRP) over the next two years. <p><i>Medical Policy and How to Comment on Draft LCDs:</i></p> <ul style="list-style-type: none"> • The committee was furnished with a handout detailing the proper method of commenting on draft LCDs on-line. Providers can follow the path as illustrated by a PowerPoint demonstration that gives them step-by-step instructions, beginning with the WPS WebSite. 	<ul style="list-style-type: none"> • Members are encouraged to access the draft policies and make comments. WPS would prefer the comments during the formulation process. The web site is http://www.wpsic.com/medicare/policies/open_mt_g_on_draftpol.shtml

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9. A Day With Medicare	<p>“ADWM”:</p> <ul style="list-style-type: none"> • Held at the Levis Faculty Center on the University of Illinois campus in Urbana. A number of informative breakout sessions were offered and well attended throughout the day. Several exhibitors and partners, all with a direct link to Medicare, staffed booths and were available for questions. Feedback was favorable for the event and we benefited from valuable lessons learned from a similar event ‘The WPS Open House’ held in Madison last October. 	<ul style="list-style-type: none"> • WPS plans to host another event, probably in Michigan or Minnesota.
10. Provider Education Updates	<p><i>Provider Education Seminar Schedule:</i> The topics to be covered include the following:</p> <ul style="list-style-type: none"> • Health Insurance Portability & Accountability Act (HIPAA) • Practical Solutions to Your Medicare Claim Denials • Physical Therapy/Occupational Therapy • Mental Health • Foot Care • Modifiers • New Provider-Medicare Basics • Beyond the Basics • Evaluation & Management (E/M) documentation • Eye Care • Introduction to Basics & Medical Policy <p><i>2005 Fee Schedules and Disclosure Materials:</i></p> <ul style="list-style-type: none"> • Medicare will make the information available via CD-ROM, which has become an important cost-effective measure for the contractor. In addition, the CD-ROM will include other valuable information and resources, such as education materials used in seminars and conferences. 	<ul style="list-style-type: none"> • There are half-day or all day sessions. • Register on-line or contact us at 618/ 998-5240. • Course descriptions are summarized in the material.
11. Beneficiary Information	<p><i>Medicare Approved Drug Discount Cards:</i></p> <ul style="list-style-type: none"> • Most of the outreach efforts by our beneficiary education staff this quarter are focused on the Drug Discount Assistance Program. This group has appeared at locations throughout central and southern Illinois with programs designed to promote this landmark in Medicare legislation and to provide an overview of the new benefit. 	<ul style="list-style-type: none"> • Members were directed to the CMS handout that discusses the resource information available from CMS.

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Open Discussion	<p><i>Purchased Services</i></p> <ul style="list-style-type: none"> • Members questioned how information should be reflected for purchased technical and purchased interpretation services. • Information has been published in the ANSI crosswalk guide available on our web site. • Information is also available in the Medicare On-Line Manual 100-4, Chapter 1, Section 30.2.9 purchased technical components, 100-4 Chapter 1, Section 30.2.9.1 purchased professional components. There is also information in On-Line Manual 100-4, Chapter 13, Section 20.2.4. • The claim for purchased technical components should reflect "Yes" to the question in Box 20 of the 1500 form. The claim should show the purchase price of the technical portion and the claim should show who actually performed the service and where it was performed. Both parties should be enrolled in Medicare Part B. • Basic instructions for purchased interpretations are that the billing provider's internal file should show who performed the interpretations and the cost of the interpretation. The provider interpreting the service does not see the patient, the provider interpreting the service did not order the service and that the provider billing has performed the technical component. 	<ul style="list-style-type: none"> • Members can access information on the 1500 form/electronic HIPAA compliant claim crosswalk at http://www.wpsic.com/medicare/provider/pdfs/cms1500_xw.pdf

The meeting was adjourned at 12:00 P.M.

Next PCOM Advisory Group meeting will be held on **Thursday, September 23, 2004**