

Provider Communication Advisory Committee Minutes (PCOM)

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

December 11, 2003

Springfield, Illinois

Members: (19)

Agenda Item	Discussion	Outcome/Action
1. Welcome and Introductions	<ul style="list-style-type: none"> • Roll Call • Announcement of the retirement of the representative from Central Illinois Kidney & Dialysis and introduction of her replacement • There were no outstanding issues from the last meeting. 	
2. CD-ROM	<p>Members were given a live visual demonstration of the new CD-ROM and its usefulness. A committee member suggested that the CD-ROM initiative presents an excellent opportunity to include a <i>Communiqué</i> Index in the product. Screens previewed included:</p> <ul style="list-style-type: none"> • Provider Enrollment • Pricing and Fees • Provider Education • Provider Resources • Publications • CD-ROM Help Topics <p>The committee reviewed a Q and A handout on the CD-ROM and was then presented with a survey regarding the product, which was to be completed and returned at the conclusion of the meeting.</p>	<p>Surveys were collected at the end of the session. Members were advised that the surveys will be analyzed and the results will be shared in a future meeting and contribute to future CD-ROM offerings.</p>

	<i>For more information, please consult the Handouts Packet for today's meeting.</i>	
3. Beneficiary Outreach	<p>The audience was provided with handouts on Medicare 2004 updates, focusing specifically on changes expected to impact beneficiaries. Topics addressed included:</p> <ul style="list-style-type: none"> • Part A benefits • Part B benefits • Outpatient Therapy Service • Cancer Screenings • Diabetic Supplies <p><i>For more information, please consult the Handouts Packet for today's meeting.</i></p>	Chairperson suggested the handouts may be displayed in the providers' offices.
4. General Updates Information	<p>The Financial and MSP departments have new toll-free telephone numbers, which will allow staff to resolve issues of this nature more efficiently and timely. These were shared with the participants in a handout. The 2004 Fact Sheet containing Medicare news for the new year was presented to the committee. Highlights included:</p> <ul style="list-style-type: none"> • HIPAA Compliance • The New Online CMS Manual System • Medicare and You 2004 • Medicare Physician Web Site • Medicare Patient Brochures Available to Physicians • Medicare Learning Network Web Site • Advance Beneficiary Notices (ABNs) • CMS Publication of Nursing Home and Home Health Quality Measures <p>A separate handout was distributed on the new diagnosis code for influenza virus vaccine claims.</p>	An attendee asked if they get an overpayment letter should they call the Customer Service Hotline or the Financial Hotline? The chair advised that when calling about a particular overpayment the questions should be directed to the Financial Hotline.

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5. Local Provider Education and Training (LPET)	<p>The committee was provided with handouts regarding targeted LPET issues. The <i>Communiqué</i> is publishing a series of articles on Evaluation and Management (E&M) Documentation, the goal being to improve the accuracy in both the documentation and billing of these services by physicians.</p> <ul style="list-style-type: none"> • Modifier 25 – This is only to be used when a significant and separately identifiable E/M visit is rendered on the same day as a minor surgical procedure. This item generated some discussion among the group with one member inquiring as to whether or not there had been a recent change in the description of modifier 25. • Documentation of History and Exam for E&M Services – Three key components must be considered in determining the correct level of E/M service: History, Exam, and Medical Decision-Making. Under History, the category of Past, Family and/or Social History (PFSH) is critical and often overlooked in the billing process. The statements “non-contributory” or “negative” are not considered valid documentation. • Examination – At the present time, both the 1995 and 1997 E/M guidelines are still in effect for documentation of the physical examination. Examination templates/checklists are considered acceptable forms of documentation, however they must clearly demonstrate the level of examination performed (see handout for web site address detailing documentation requirements). 	<p>The chair will investigate any changes to the modifier 25 description and respond to the committee.</p> <p>Attendees confirmed they use both 1995 and 1997 guidelines and will continue until notified otherwise.</p>

	<p><u>LPET/Medical Review</u> – Medicare Outreach is conducting a pilot program with select Podiatrists who will receive a Comparative Billing Report (CBR). The report provides data on all CPT codes allowed by Medicare for foot care, along with a comparison of the practitioners’ billed services against those of their peers. This same project is being considered for other specialties with demonstrated needs for additional education.</p> <p><u>Medical Review Strategy</u> – WPS will implement two primary approaches, Proactive Education and Medical Review of Claims, with the goal of reducing the claims error rate to below 5%. The current topics of review are Physical Therapy, Foot Care, Mental Health and New Provider Monitoring. Focus areas for 2004 include Diagnostic Testing, Clinical Pathology and E&M Services.</p> <p><i>For more information, please consult the Handouts Packet for today’s meeting.</i></p>	
<p>6. CMS Announcement</p>	<p>CMS has announced the transition from a paper-based manual system to a Web-based system, which began October 1. The online CMS Manual System, as it has been titled, is located at http://www.cms.hhs.gov/manuals. Other sites available for review include the Medicare Learning Network and the Medicare Coverage Database.</p> <p><i>For more information, please consult the Handouts Packet for today’s meeting.</i></p>	<p>Q. A member asked whether or not the intermediary will follow suit and offer an online manual.</p> <p>A. This is not a carrier manual. It is offered by CMS and has incorporated the MCM, MIM and CIM. The intent of this new manual is</p>

		<p>to streamline Medicare guidelines and alleviate duplication. The chair also provided a copy of the CMS website page that lists the publications that make up the manual. This was offered to demonstrate the website to access for the information.</p>
<p>7. Policy</p>	<p><u><i>Evaluation and Management Documentation</i></u> It is the goal of WPS Medicare Part B to assist in educating providers and their staff on documentation guidelines when billing E&M services. Toward that end, we have published a series of articles on this topic in the <i>Communiqué</i>, October through December of this year. Documentation is vital in substantiating the services rendered, establishing medical necessity and supporting the level of service billed.</p> <p><u><i>Retired Policies</i></u> Since medical policies are constantly updated and revised, to be consistent, it is necessary to retire certain policies periodically. All current Local Medical Review Policies (LMRPs) can be found on the web site at: http://www.wpsic.com/medicare/policies/pol_home.shtml.</p>	<p>The chair reminded attendees that LMRPs are typically retired to be replaced by National Coverage Provisions (NCPs). Also, policies usually have CMS language that can be identified by italicized words. That language is still in effect even if</p>

	<p>(See handout for list of policies to be retired 12/01/2003.) Retired LMRPs are not available on the web site. You may request a hard copy of a retired LMRP by writing the Freedom of Information Unit.</p> <p><i>For more information, please consult the Handouts Packet for today's meeting.</i></p>	<p>the LMRP is retired.</p>
<p>8. Customer Service</p>	<p><u>Top Appeals</u> Medicare evaluates the top reasons for appeals. The top appeal requests, both telephone and written, over the past three months include: <i>Modifiers</i> – The addition of modifiers 24 and/or 25 to E&M codes continues to be one of the top reasons for appeal requests. In addition, the Review Department received a large volume of appeals with the modifiers 59 and/or 76 added to codes 71010 and 88305. (See chart in handouts for completed descriptions of modifiers 24, 25, 59 and 76.)</p> <p><u>Top Claim Denials</u> The top reasons for claim denials over the past quarter include:</p> <p><i>Performing provider does not equal billing provider</i> – This is generally caused by one of three reasons:</p> <ol style="list-style-type: none"> 1. The group number is entered but the individual number is not 2. The individual number does not belong to the group 3. An individual number is submitted without any reference to the group <p><i>Place of service not valid for procedure code</i> – Many of these denials are due to reporting a service that is professional and technical in nature, in an inappropriate place of service. For</p>	<p>Members were advised to verify the validity of a modifier before billing to Medicare.</p> <p>Again, members were reminded to verify coding of claims before billing to Medicare.</p> <p>Verification will reduce denials and resubmission of claims.</p> <p>One member stated they call often for eligibility because they never know if the COB contractor has changed the eligibility</p>

	<p>assistance, the Medicare Physician Fee Schedule Database (MPFSDB) provides information about these types of procedures.</p> <p><u>Top Phone Calls</u> Top phone calls received in our call centers over the past quarter include:</p> <ul style="list-style-type: none"> • Unprocessable Claims • Eligibility Information • Claim and/or Review Status <p><i>For more information, please consult the Handouts Packet for today's meeting.</i></p>	<p>information of a patient. Other members agreed. COB contractor is difficult to contact.</p>
<p>9. EDI/HIPAA</p>	<p><u>How to file an attachment for Medicare</u> Eventually, all claims, with a few limited exceptions, will be filed electronically to Medicare. The final rule on attachments has not been written. In the interim, if an electronic submitter has additional documentation required by Medicare, this can be indicated in the narrative segment using the statement "DOCUMENTATION AVAILABLE UPON REQUEST." If the additional documentation is needed for Medicare to make a payment determination, a development letter will be sent. If the information is not returned in a timely manner, the claim will be returned as unprocessable.</p> <p><u>Contingency Plan</u> HIPAA requires electronic transactions be in the 4010A.1 format, effective October 16, 2003. On September 23, CMS announced they would invoke a temporary contingency plan. This is for a limited time only. Providers billing and receiving</p>	<p>Q. One participant inquired if MSP claims with paper attachments are being denied. A. No, until the Contingency Plan is over, paper attachments for MSP claims are acceptable.</p> <p>Members were advised that at this time we can not accept information submitted in the</p>

	<p>non-compliant formats should test and move into production on the HIPAA formats as soon as possible or risk possible cash flow problems.</p> <p><i>For more information, please consult the Handouts Packet for today's meeting.</i></p>	<p>PWK segment of electronic files. CMS created a multi-carrier and multi-intermediary work group to implement the PWK segment. This chair is on that workgroup. An update to the project will be provided at the March PCOM.</p>
<p>10. Workbook Feedback Summary</p>	<p>At a previous PCOM meeting, the chair asked for and received two volunteers to review the current edition of our <i>Beyond the Basics</i> workbook. The results from committees throughout the four-state jurisdiction were compiled in a database and a summary handout regarding these was distributed to the group. The findings will be considered when Provider Education revises the workbook for the next travel series that includes <i>Beyond the Basics</i> as part of the curriculum.</p> <p><i>For more information, please consult the Handouts Packet for today's meeting.</i></p>	<p>The members were asked to review the feedback that has been compiled to date and advise the chair, either via email, phone or in person at the March 2003 meeting of any additional comments or suggestions they may have.</p>
<p>11. Illinois Provider Education</p>	<p>A review of the upcoming winter schedule of Provider Education offerings was held, with a reminder that HIPAA sessions are once again slated for the first part of the new year. This class along with Surgery and Skilled Nursing Facility (SNF)/Consolidated Billing (CB) (Minnesota only) complete</p>	<p>Surveys were collected at the end of the session. Members were advised that the</p>

	<p>the list of in-person seminars for January, February and March 2004. Scheduled teleconferences include:</p> <ul style="list-style-type: none"> • Financial • HIPAA • Medical Policy • Medicare Physician Fee Schedule Database (MPFSDB) • MSP • Top Claim Submission Errors • Waiver/Advance Beneficiary Notice (ABN) <p>Participants were also given a survey for Provider Education Activities and asked to complete it before departing. The survey includes a variety of medical topics, some of which we have never presented and some of a more traditional nature. On a scale of 1 – 10, with 10 being the most effective, members were asked to rate the 16 listed subjects, according to their personal preferences. The document also allows them to choose a format in which they would like to see the topic presented, (e.g., seminar, workshop, teleconference, web-based training, etc.). Finally, they have the opportunity to select a time frame for the presentations, such as full-day, half-day, one hour or other.</p> <p><i>For more information, please consult the Handouts Packet for today's meeting.</i></p>	<p>surveys will be analyzed and the results will be shared in a future meeting</p>
<p>12. Open Discussion</p>	<ul style="list-style-type: none"> • In closing, the chair advised the group of a possible change of venue for the Springfield PCOM. Details regarding the possible move to an alternate location will be forthcoming. • Members were also asked for comment on the possibility of changing our method of distribution of meeting handout materialsThe committee was asked to begin thinking about 	<p>By majority rule, the committee agreed to continue meeting on Thursday.</p>

	<p>issues they would like to see addressed in the approaching quarter. The chair proposed a return to a former practice of the meetings in dealing with “live” issues, affecting providers directly in their day to day work environments. The chair suggested possibly breaking in to teams and brainstorming ideas that could be considered by the providers or carrier depending on the problem.</p>	<p>It was decided that beginning with the next meeting in March 2004, packets will be forwarded to members via email prior to the meeting date so that they can download, print and bring the handouts with them to the PCOM.</p>
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