

# Provider Communication Advisory Committee Minutes (PCOM)

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

March 18, 2004

Springfield, Illinois

Members: Health Alliance Medical Plans, Central Illinois Kidney & Dialysis, St. Mary's Good Samaritan Physicians, Prairie Cardiovascular, Rehberger Chiropractic, Carle Clinic Assoc., Healthcare Network Assoc., SHIP, St. John's Hospital, SIU School of Medicine, Springfield Clinic, Quincy Medical Group, Cancer Treatment Center, Christie Clinic

Agenda Item	Discussion	Outcome/Action
1. Welcome and Introductions	<ul style="list-style-type: none"> <li>• Roll Call</li> <li>• Members were welcomed to the new location, the Ramada Limited Northfield in Springfield</li> <li>• There were no outstanding issues from the last meeting.</li> </ul>	
2. Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003	<p>A CMS representative from Chicago Regional Office gave an extensive PowerPoint presentation on the Medicare-Approved Drug Discount Card.</p> <p><i>For more information, please consult the Handouts Packet for today's meeting.</i></p>	<p>Q&amp;A followed presentation. The CMS representative offered to be available for future meetings.</p>

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3. CD ROM	<p>Results from the 2004 Physician Fee Schedule and Disclosure Report CD-ROM PCOM Members as Users Surveys were reviewed. Results were positive overall. Of those responding, 100% found the CD-ROM easy to use. In regards to overall satisfaction with the product, 89% responded “Great! Do it again next year!” The handout includes an Executive Summary indicating the additional educational information contained in the product, the cost savings (primarily in postage) and the evaluation plan to measure customer satisfaction with the CD-ROM initiative. An additional benefit of this pilot program was increased provider usage of our website by 26%.</p> <p><i>For more information, please consult the Handouts Packet for today’s meeting.</i></p>	<p>Members want this offering again in 2005. One suggestion was made to add a Communiqué index to the 2005 CD-ROM edition.</p>
4. Beneficiary Outreach	<p>Spring is a busy time of travel for our Outreach group. The staff is distributing the CMS authored fact sheet about new Medicare benefits at all their events. They are also intensifying efforts to update the beneficiary pages on our website. In addition, Beneficiary Outreach has had several health-related articles published in Native American newspapers in Wisconsin, Michigan and Minnesota, with a total circulation of 29,000. They are currently contacting Spanish newspapers and hope to initiate a similar campaign for the Hispanic communities.</p> <p><i>For more information, please consult the Handouts Packet for today’s meeting.</i></p>	<p>Members were asked to contact WPS with suggestions or feedback.</p> <p>Members were asked to display the fact sheet for Medicare beneficiaries to see.</p>

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<p>5. General Updates Information</p>	<p><u>Financial</u></p> <p>Members were reminded that an overpayment letter goes to the practice address, rather than the billing address. A question from the audience was raised concerning a situation in which a response had been given to Financial (recoupment), but their office was placed on offset anyway. The member were informed that there is currently a backlog in financial work and were reminded that counselors have been instructed to set up an overpayment if a customer calls regarding the status of a voluntary overpayment.</p> <p>There was a discussion regarding a contractor’s option of not recouping minimal dollar overpayments. A member requested that provision in writing along with the specific amount and the chair will investigate and respond accordingly. Another member related an issue their organization has with a rural health facility’s unwillingness to accept a refund of monies they have collected in error in the past. There is no Statute of Limitation for returning funds in Illinois and the member wanted to know if Medicare imposed one. Generally speaking, the IRS will recoup as far back as seven years, but there is no actual statute in force presently. One member suggested referring issues such as the aforementioned to Region 5 (CMS) and this had already been done and can be documented by the member involved.</p> <p><u>CMS Secure Net Access Pilot (C-SNAP)</u></p> <p>This is a secure web site that is a new source of patient eligibility and claim data. In terms of eligibility information, it includes Part B and Risk HMO dates. In regards to claim status, SNAP discloses whether the date of service was processed, pending or rejected (unprocessable), the processed date and check information (date of check and check number). Comments from users have been favorable to date. A question was posed from a member as to whether or not there was any limitation on the amount of time you can be on SNAP. There was initially, but the time restrictions have since been relaxed. A committee</p>	<p>Members were Advised not to call for status wait for WPS to contact them.</p> <p>The chairperson sent e-mail to all members as a follow-up to the question about the dollar amount threshold and timeframe for overpayments. Excerpts from the <i>CMS Online Manual(IOM): Publication 100-6, Medicare Financial Management (MFM), Chapter 3</i> were attached for clarification.</p> <p>The name and phone Number of the Contractor assistant Manager with Oversight of this Project was given to the committee and the access URL; <a href="http://www.medicareinfo.com">www.medicareinfo.com</a>.</p>

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<p><i>General Updates Continued</i></p>	<p>member suggested that C-SNAP provides an excellent opportunity to offer an electronic version of the newsletter index, which is currently not available in any form. One member wanted to know if a link to the COB (Coordination of Benefits) contractor was available. There is no availability at the present time. There was a discussion concerning the CWF (Common Working File). Currently, a single provider can send in one claim for a patient containing incorrect information and the claimant's files could be updated erroneously.</p> <p><u>MEDLEARN Matters</u></p> <p>This is a new educational resource for Medicare providers designed to inform them of important changes to the Medicare system in an easy-to-understand format. Articles will be placed on the Medlearn Web site on the new <i>Medlearn Matters...Information for Medicare Providers</i> page. Articles can be viewed at <a href="http://www.cms.hhs.gov/medlearn/matters">www.cms.hhs.gov/medlearn/matters</a>. A question was raised whether or not this replaces the one-time notification.</p> <p><u>Elimination of the 90-Day Grace Period</u></p> <p>1. <i>HCPCS Codes</i> - Effective January 1, 2005, Medicare providers will no longer have a 90-day grace period to use discontinued HCPCS codes for services provided the first 90 days of the year. Failure to comply will cause your claims to be returned unpaid; HCPCS codes must be valid at the time of the service, beginning January 1.</p> <p>2. <i>ICD-9-CM Codes</i> – Medicare systems will begin enforcing HIPAA standards on October 1, 2004, requiring that ICD-9-CM codes submitted on claims must be valid at the time the service is rendered.</p> <p><b><i>For more information, please consult the Handouts Packet for today's meeting.</i></b></p>	<p>Members were Encouraged to enroll in this feature.</p> <p>The CWF issue will be forwarded to CMS.</p> <p>The one-time notifications will appear on this Web site in addition to CMS Articles from 2003 – 2004, 2003 Program Memos and Transmittals, and Medicare Modernization Act (MMA).</p> <p>Members were given the annual HCPCS update website:  <a href="http://www.cms.hhs.gov/providers/pufdownload/anhpcdl.asp">www.cms.hhs.gov/providers/pufdownload/anhpcdl.asp</a> and the ICD-9-CM website:  <a href="http://www.cms.hhs.gov/medlearn/icd9code.asp">www.cms.hhs.gov/medlearn/icd9code.asp</a>. Members were encouraged to pay</p>

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		close attention to any changes and as PCOM members Keep their colleagues Informed of any Changes.
6. Local Provider Education and Training (LPET)	<p>Provider Education is currently conducting a pilot program with Podiatrists in WI, IL, MI and MN, allowing them to request a Comparative Billing Report (CBR) through April 30, 2004. The report provides data on all CPT codes that are allowed by Medicare for Foot Care services as outlined in the LMRP FT-001. The CBR compares a provider's billed services allowed by Medicare from 1/1/03 – 12/31/03 against billed services allowed for their peers within their individual state during the same period. The goal being to make available proactive educational tools for those interested in self-assessing their billing practices and to address issues they may have in billing Medicare. Each report will include a survey so the practitioner can provide feedback to us on the product.</p> <p><i>For more information, please consult the Handouts Packet for today's meeting.</i></p>	<p>The Chair identified the contact person from Provider Education. Request forms were distributed. Members were encouraged to share the forms with colleagues and if information is requested please take the time to complete the survey and return to WPS. We will be assessing this service to possibly extend to other specialties in the future.</p>
7. Policy	<p><u>Implementation of Local Coverage Determinations (LCD)</u></p> <p>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. Similarities/differences of the two types of provisions were discussed.</p> <p><i>For more information, please consult the Handouts Packet for today's meeting.</i></p>	<p>Members were advised to visit the WPS website to view 2 of the LMRPs that have been converted to LCD: CV-026 and PATH-031.</p>

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8. Customer Service	<p><u>Top Phone Calls</u></p> <p>Phone calls regarding unprocessable claims continue to be one of the top reasons why providers contact Customer Service. We are asking that providers verify with their billing departments that they are checking to ensure that items on the CMS-1500 claim form are complete. There is also an article in the December 2003 <i>Communiqué</i>, pages 109-113, regarding the Medicare Carriers Manual (MCM) revisions for jurisdictional and unprocessable claims. We also receive many phone call inquiries regarding MSP claims. Some reflect a need for further education in terms of MSP claims processing. Providers may view the new MSP manual on the CMS Web site.</p> <p><u>Top Appeals</u></p> <p>Medicare evaluates the top reasons for appeals. The top appeal requests, both telephone and written, over the past three months include:</p> <p><i>Procedure Codes</i> – The jurisdictional top ten adjustment summary by procedure code for the past quarter included the following: 99213, A0425, 88305, 71010, 99212, 99214, 99232, 76075, 93010 and 98941.</p> <p><i>Modifiers</i> – The jurisdictional top ten adjustment summary by first modifier field for the past quarter included the following: 26, 59, 25, 24, 91, 76, 79, GA, RT and GP. The 26 modifier outdistanced the rest listed by a vast margin.</p> <p><u>New Provider Customer Service Hours</u></p> <p>In Illinois, Customer Service lines are open from 8:00 AM to 4:30 PM. MSP lines are open from 7:00 AM to 3:30 PM.</p> <p><u>Phone Number Changes</u></p> <p>In the Spring of 2004, there will be separate phone numbers for the</p>	<p>Members were given the website for claim filing instructions: .  <a href="http://www.cms.hhs.gov/providers/edi/edi5asp">www.cms.hhs.gov/providers/edi/edi5asp</a>  And the website for the MSP manual:  <a href="http://www.cms.gov/manuals/105_msp/default.asp">www.cms.gov/manuals/105_msp/default.asp</a></p> <p>The Chair impressed to the members that the current inquiry number</p>

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<i>Customer Service Continued</i>	<p>Customer Service Call Center and the Provider Interactive Voice Response (IVR) unit. This change will free up lines coming to our Customer Service Representatives and allow them to focus on your more complex issues as well as provide expanded access to the self-service IVR application. We will publish when this change goes into effect.</p> <p><b><i>For more information, please consult the Handouts Packet for today's meeting.</i></b></p>	<p>will still be available as access to the IVR. If the current number is dialed after the Spring, the caller will be connected to the IVR. Once in the IVR there is no option to be forwarded to a counselor. The caller will have to hang up and redial the new number to speak with a counselor. The caller will have to determine prior to making the call whether they need a counselor or the IVR will fill their calling need.</p>
9. EDI/HIPAA	<p><u>Inactive Electronic Billing Submitter Ids</u></p> <p>WPS performs routine submitter maintenance and could inactivate an office's submitter ID if it has not been used within the last six months.</p> <p><u>Status of HIPAA Contingency Plan</u></p> <p>Members were asked to keep in mind that the Contingency Plan was not designed as a long-term resolution. The deadline for compliance was/is</p>	<p>Members were asked if they have been issued a submitter ID for electronic submission of claims to Medicare and have not been using it, but still intend to, please call us on the EDI Hotline at 877-567-7261.</p> <p>Members were advised this could reasonably be viewed as a first step</p>

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<p><i>EDI/HIPAA Continued</i></p>	<p>October 16 of last year. This interim is an “opportunity” for those who are still non-compliant to become compliant. CMS is stipulating that, effective July 1, if you are filing claims in a non-HIPAA format, your payment floor will be auto-adjusted to 28 days (the current payment floor for paper claim receipts).</p> <p><u>Effect of Contingency on Paper Claims</u></p> <p>Even under the contingency, electronic claim submission is mandatory unless you meet any of the limited exceptions listed in today’s handout for this section. There was a question regarding whether or not the method of filing attachments had changed. A member also asked if scanning (paper claims) would be available after July. and</p> <p><i>For more information, please consult the Handouts Packet for today’s meeting.</i></p>	<p>toward claim rejection, even though CMS’ stance has been “softened” from direct return of claims to imposing a penalty for non-compliance. Regardless, the effect will be a delay in payment to providers. It was stressed that testing is crucial and the phone numbers for the EDI Call Center are included in the supporting handouts.</p> <p>Members were encouraged to check Medlearn Matters for additional information on the subject, supported by CMS. Filing of attachments has not changed, we are still requesting that you enter the phrase “ADDITIONAL INFORMATION AVAILABLE UPON REQUEST” in the narrative field. We have been given no news on the continuation of scanning paper claims.</p>

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10. Illinois Provider Education	<p><u>Winter Teleconferences</u></p> <p>Several staff members from Provider Education throughout the jurisdiction participated in the sessions. Some of the topic conferences were booked to capacity early. There were some topics that lent themselves better to teleconferences than others. We felt that “gray area” topics did not go particularly well. Some of the topics are being expanded to seminars, either full or half-day. Teleconference topics included:</p> <ul style="list-style-type: none"> <li>• HIPAA</li> <li>• MPFSDB</li> <li>• Financial</li> <li>• MSP</li> <li>• Waiver of Liability/ABN</li> <li>• Top Claim Submission Errors</li> </ul> <p><u>Provider Education Activities Survey Results</u></p> <p>Requested topics for presentation in order of preference were:</p> <ol style="list-style-type: none"> <li>1. Documentation</li> <li>2. New Physician Education</li> <li>3. Top 10 Denials</li> <li>4. Mental Health</li> <li>5. Modifiers</li> <li>6. Understanding Medical Policy</li> <li>7. Waivers/ABNs</li> <li>8. Beyond the Basics</li> <li>9. Introduction to Medicare Basics</li> <li>10. Medicare Physician Fee Schedule Data Base (MPFSDB)</li> <li>11. ESRD</li> <li>12. MSP</li> <li>13. Foot Care</li> <li>14. Consolidated Billing</li> <li>15. PT/OT</li> <li>16. Remittance</li> </ol>	<p>Members were asked if there were topics they thought would work well as teleconferences and to advise WPS of any topics they would like to see presented in the future.</p> <p>Members were asked to review the survey results and advise the Chair of any comments they wish to add.</p> <p>Members were also advised the Introduction to Medicare Basics is being combined with New Physician Education for the upcoming series offerings.</p>

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	<p>The most popular format requested remains seminars/workshops, with half-day mode as the top time frame.</p> <p><u>Electronic <i>Communiqué</i> Proposal</u></p> <p>The monthly newsletter will no longer be in pdf format that resembles quarterly version. It will be accessible via a Table of Contents from the Publications page and would go to that article. A question was asked as to how many users are allowed on C-SNAP and if it is based on tax ID; we will check and respond.</p> <p>The suggestion was again made from a committee member that an index for the newsletter would be beneficial.</p> <p>Overall, the upcoming change in the <i>Communiqué</i> was not warmly welcomed by the advisory group.</p> <p><u>Computer-Based Training Pilot</u></p> <p>The benefits and features of this pilot would be similar to those on Medlearn. There would be no cost to providers and would also represent substantial cost-savings to the Medicare Trust Fund (travel, facility, refreshment and other expenses). The program could also be accessed via the Internet, therefore, there would be no need to download, nor would there be wait time for dial-up users.</p> <p><b><i>For more information, please consult the Handouts Packet for today's meeting.</i></b></p>	<p>Member were notified by e-mail that there is no limit on users per office but all office staff should be registered and have their own user name.</p> <p>Members were asked To notify the chair If they have topics They would like to see.</p>

<p>11. Open Discussion</p>	<p>An issue was voiced by a member regarding a specific case dealing with a patient and a co-pay for another health insurance contractor (supplemental).</p> <p>Another attendee inquired if others were seeing incorrect UPIN denials. Specifically, the denial stated that an FDA certification number was required and did not apply for the particular claim.</p> <p>The issue of delays in provider enrollment was mentioned.</p> <p>The next meeting is scheduled for Thursday, June 17.</p> <p><b><i>For more information, please consult the Handouts Packet for today's meeting.</i></b></p>	<p>The group was solicited to see if others have experienced similar situations. Several members suggested reviewing the doctor's contract and contacting the insurance company.</p> <p>The group discussion resulted in a recommendation contact EDI if claims submitted electronically and resubmit.</p> <p>Members were advised there is a current backlog and, adding to the delay, the implementation of the PECOS system has slowed enumeration somewhat. This should be a temporary setback at best.</p>
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