

Provider Communication Advisory Committee Minutes (PCOM)

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

December 1, 2005

Springfield, Illinois

Members: (15)

Agenda Item	Discussion	Outcome/Action
1. Welcome and Introductions	<ul style="list-style-type: none"> • Roll Call • There were no outstanding issues from the last meeting. • In addition to the sign-in sheet, the current membership address list was circulated for any possible corrections. 	
2. Provider Educational Activities	<p><u>A Day with Medicare</u></p> <p>Members were advised that the next “A Day with Medicare” event will be held on Monday, February 13, in Waukesha, Wisconsin. Due to the past success of this open-house style forum, these meetings will continue on a regular basis, with the location determined on a rotation basis among the four states of the jurisdiction.</p> <p>General sessions, a presentation by WPS Medicare Carrier Medical Director, and other valuable break-out presentations, demonstrations and face-to-face encounters will once again offer a positive meeting opportunity for WPS Medicare, its customers and Centers for Medicare and Medicaid Services (CMS) representatives. As in the past, Medicare partners and various departments within WPS Medicare will have informational booths set up at the event to offer educational opportunities and answer general questions. We also anticipate offering live demonstrations of the Medicare Part B/CMS Websites and the CMS Secure Net Access Pilot (C-SNAP), among others.</p>	<p>Several members were on hand for the Illinois event last year.</p>

<p>Provider Educational Activities (cont.)</p>	<p><u>Small Provider Education (PETs)</u></p> <p>Since the first Small Provider Education and Training (PET) Advisory Group meeting (Chiropractic Care) on August 25 in Champaign, IL, three additional groups have had inaugural sessions. To date, Foot Care, General Practitioner and Chiropractic Care-Demonstration Area groups have met and the Physical Therapy PET is scheduled to kickoff in early 2006.</p> <p><u>CD-ROM</u></p> <p>CMS has decided not to place the 2006 fees on the CD-ROM this year in order to have greater flexibility for making any last minute changes to the 2006 payment rates. Placing the fees on the carrier Web site assures that providers will have the most current and correct information.</p> <p>In addition to enrollment information, the CD-ROM will feature supplementary educational tools, resulting in a multi-faceted resource. It will contain:</p> <ul style="list-style-type: none"> • <i>Communiqué</i> archive • Handbooks from WPS presented seminars • Links to important Websites • A listing of Medicare acronyms and their meanings • Frequently Asked Questions (FAQs) • The latest HIPAA data • Downloadable forms • Helpful hints for using the CD-ROM • Medicare prescription drug program information <p><u>2006 Seminar/Teleconference Schedule</u></p> <p>Provider Outreach and Education has released the seminar/teleconference schedule for the new year. Topics for the remainder of 2005 and 2006 include:</p> <ul style="list-style-type: none"> • Beyond the Basics • Modifiers 	<p>The committee was invited to offer suggestions for potential candidates for membership in the upcoming PETs.</p> <p>CD-ROMs will be mailed to members in the immediate future.</p>
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<p>Provider Educational Activities (cont.)</p>	<ul style="list-style-type: none"> • New Provider Medicare Basics • Practical Solutions to Your Medicare Claim Denials • Skilled Nursing Facility – Consolidated Billing • Advance Beneficiary Notice (ABN) • Appeals • Chiropractic Care Demonstration Project • Clinical Lab • Comprehensive Error Rate Testing (CERT) Program • Lunch-N-Learn with WPS Medicare “General Medicare” • Mental Health • Oncology <p><u>E-Medicare & You</u></p> <p>A free information packet on electronic resources at WPS Medicare is now available upon request. The packet contains information for those considering buying a computer for the office for the first time. Some of the information contained in the packet includes:</p> <ul style="list-style-type: none"> • Getting Started: A Guide to Figuring Out What Computer Fits Your Needs • Computer Myths Vs. Facts • Three Simple Steps to Connecting to the Internet • Glossary of Electronic Terms • Tips for Finding the Information You Want on the WPS Medicare and CMS Websites • Protecting Your Computer: Security and Anti-Virus Basics • Self-Service Tools for You: Getting Paid Faster <p><i>For more information, please consult the Handouts Packet for today’s meeting.</i></p>	
<p>3. MedPub</p>	<p><u>MEDLEARN MATTERS – Medical Review Additional Documentation Requests (ADRs)</u></p> <p>To get a more accurate depiction of a patient’s condition, contractors are</p>	

MedPub (cont.)

allowed to request additional information from a physician before and after a specific service. Physicians and/or staff should be prepared to respond to ADRs within 30 days.

MEDLEARN MATTERS – MMA – Changes to Chapter 29 – General Appeals Process in Initial Determinations

The Medicare claim appeals process now requires a new second level in the administrative appeals process called a reconsideration.

Reconsiderations will be processed by Qualified Independent Contractors (QICs). This article focuses on the general appeals process for first level determinations and provides information such as:

- CMS decisions subject to the administrative appeals process
- Minor errors and omissions
- Who may appeal
- Provider or supplier appeals when the beneficiary is deceased
- Parties to an appeal
- Steps in the appeals process

MEDLEARN MATTERS – MMA – Changes to Chapter 29 – Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Date May 1, 2005)

Requests for redeterminations of appeal decisions (determinations) should go either to the Qualified Independent Contractor (QIC), the Administrative Law Judge (ALJ), or the Hearing Officer (HO), depending on whether the claim is a Part A or Part B claim; whether the Medicare contractor who issued the initial claim decision is a fiscal intermediary or a carrier; and the date the claim was issued.

A request for redetermination must be filed within 120 days of the date of receipt of the notice of initial determination (either the Medicare Summary Notice (MSN) supplied to the beneficiary or the Remittance Advice (RA) supplied to the provider).

MedPub (cont.)

MEDLEARN MATTERS – National Modifier and Condition Code To Be Used To Identify Disaster Related Claims

To accommodate the emergency health care needs of beneficiaries and providers affected by Hurricane Katrina and any future disasters, the Centers for Medicare & Medicaid Services (CMS) has created the following new condition code and modifier, effective for dates of service on and after August 21, 2005. The new condition code is “DR (Disaster related)” and the new modifier is “CR (Catastrophe/Disaster Related).”

MEDLEARN MATTERS – Physician Voluntary Reporting Program Using Quality G-Codes

This article provides information about CMS’ Physician Voluntary Reporting Program (PVRP). It will assist physicians in understanding this new voluntary reporting program and the use of G-codes to report data about the quality of care provided to Medicare beneficiaries.

MEDLEARN MATTERS – Claim Status Code/Claim Status Category Code Update

This is a reminder item regarding the periodic update of certain code sets used as a result of the Health Insurance Portability and Accountability Act (HIPAA). Effective January 1, 2006, the Medicare Claims processing system will update its lists of Health Care Claims Status Codes and Health Care Claims Status Category Codes with all applicable code changes posted online with the “new as of 10/05” and prior date designations.

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets. Claim Status Category Codes and Claim Status Codes are used in the Health Care Claim Status Inquiry and Response (276/277) transactions:

- Claim Status Category Codes indicate the general payment

<p>MedPub (cont.)</p>	<p>status of the claim.</p> <ul style="list-style-type: none"> • Claim Status Codes provide more detail about the status communicated in the general Claim Status Category Codes. <p><u>MEDLEARN MATTERS – Implementation of Carrier Guidelines for End Stage Renal Disease (ESRD) Reimbursement for Automated Multi-Channel Chemistry (AMCC) Tests (Supplemental to Change Request 2813)</u></p> <p>The ESRD 50/50 rule requires the billing laboratory to identify AMCC tests ordered and to classify them according to the following categories:</p> <ol style="list-style-type: none"> 1. AMCC test ordered by an ESRD facility (or MCP physician) that is part of the composite rate and is not separately billable; 2. AMCC test ordered by an ESRD facility (or MCP physician) that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity; and 3. AMCC test ordered by an ESRD facility (or MCP physician) that is not part of the composite rate and is separately billable. <p>This proportion (or percentage) of composite tests to non-composite tests is used to determine whether separate payment may be made for all tests performed on the same day for the same beneficiary.</p> <p>When billing Medicare for ESRD-related AMCC tests, laboratories must identify which tests, if any, are not included within the ESRD facility composite rate payment. Ensure the tests are properly identified. When billing for AMCC tests, the laboratory must identify the appropriate modifier for each test, as follows:</p> <ul style="list-style-type: none"> • Modifier “CD” – AMCC test has been ordered by an ESRD facility (or MCP physician) that is part of the composite rate and is not separately billable. • Modifier “CE” – AMCC test has been ordered by an ESRD facility (or MCP physician) that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity. • Modifier “CF” – AMCC test has been ordered by an ESRD 	
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<p>MedPub (cont.)</p>	<p>facility (or MCP physician) that is not part of the composite rate and is separately billable.</p> <p><u>MEDLEARN MATTERS – MMA – New G Code for Power Mobility Devices (PMDs)</u></p> <p>This article is based on Change Request (CR) 4121, which announces that a new G Code (G0372) has been established to recognize the additional physician service and resources required to establish and document the need for PMDs.</p> <p>The new G code is only payable if all of the information necessary to document the PMD prescription is included in the medical record after a face-to-face examination of the beneficiary, and the prescription is received by the PMD supplier within 30 days after the face-to-face examination.</p> <p><u>MEDLEARN MATTERS – Updates to Home and Domiciliary Care Visits Related to CPT Codes 99321 – 99350</u></p> <p>This article and related CR3922 provide information on place of service (POS) codes to be included with the Current Procedural Terminology (CPT) codes for home and domiciliary care visits. Specifically, POS code 13 should be used where the POS is an assisted living facility and code 14 should be used for group homes, effective for services on or after April 1, 2004. Use of the correct codes will help Medicare make prompt and correct payments for these services.</p> <p><u>MEDLEARN MATTERS – MMA – Erroneous Guidance – Basis to Waive Penalty</u></p> <p>Providers and suppliers may not be subject to a penalty if the basis for the penalty that would have otherwise been applicable was that the provider acted in accordance with erroneous guidance from the Medicare program.</p>	
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MedPub (cont.)

Medicare can grant a waiver of a penalty when **ALL of the following conditions are present:**

- The guidance was erroneous.
- The guidance was issued by the Secretary of the Department of Health and Human Services or was issued by a Medicare contractor (carrier, fiscal intermediary, durable medical equipment regional carrier (DMERC) or regional home health intermediary (RHHI)) acting within the scope of the contractor's Medicare contract authority.
- The guidance was in writing.
- The guidance related to the furnishing of an item or service or to the submission of a claim for benefits for furnishing such item or service with respect to the provider or supplier submitting such claim.
- The guidance was issued timely.
- The provider or supplier accurately and fully presented the circumstances relating to such items, services, and claim to the Medicare contractor or to the Centers for Medicare & Medicaid Services (CMS), and did so in writing.
- The provider or supplier followed the guidance provided by the Medicare contractor (or by CMS).

MEDLEARN MATTERS – Calendar Year 2005 Payment for Medicare Part B Radiopharmaceuticals Not Paid on a Cost or Prospective Payment Basis

In accordance with section 303(c) of the Medicare Modernization Act (MMA) of 2003, effective January 1, 2005, drugs and biologicals not paid on a cost or prospective basis are paid based on the Average Sales Price (ASP). However, section 303(h) of the MMA of 2003 provided for the continuation of the payment methodology under Medicare Part B, prior to the MMA for radiopharmaceuticals, effective January 1, 2005. Therefore, the payment allowance limits for radiopharmaceuticals are based on the payment methodology under Part B, as of November 2003.

<p>MedPub (cont.)</p>	<p><u>MEDLEARN MATTERS – Key Medicare News for 2006 for Physicians and Other Health Care Professionals</u></p> <p>This Special Edition article is being provided to help Medicare physicians and health care professionals keep informed about important Medicare initiatives and additional new Medicare benefits available in Calendar Year (CY) 2006. As providers make their decisions to enroll in or terminate enrollment in the Medicare participation program, CMS encourages them to take this opportunity to review some important news, especially upcoming news for 2006. CMS believes this information provides significant benefits to providers and their Medicare patients, and it will encourage providers to enroll in, or stay in, the Medicare participation program in order to take full advantage of the upcoming changes.</p> <p><i>For more information, please consult the Handouts Packet for today's meeting.</i></p>	
<p>4. Beneficiary Educational Activities</p>	<p><u>Medicare Part D Update (MEDLEARN MATTERS Special Edition)</u></p> <p>This article highlights the differences in how drugs are covered and which drugs are covered by Medicare Part B and the new Medicare prescription drug coverage (Part D). It also offers additional guidance on the effect of Part D on vaccines given to Medicare patients in a physician's office. Those currently billing Medicare Part B for drugs or for vaccines may wish to pay particular attention to this article.</p> <p>Reminders:</p> <ul style="list-style-type: none"> • Drugs covered under Fee-For-Service (FFS) Medicare Parts A/B that are paid to institutional providers (hospitals, SNFs, etc.) as part of a bundled payment are paid by fiscal intermediaries (FIs). • Drugs covered under FFS Medicare Part B that are billed by physicians and suppliers are paid by carriers (including DMERCs). • FIs and carriers do not, and will not, pay claims for Part D drugs. Providers should not submit claims for Part D covered drugs to 	

<p>Beneficiary Educational Activities (cont.)</p>	<p>FIs or carriers.</p> <ul style="list-style-type: none"> • Drugs covered under Part D are paid by Medicare Part D Drug Plans, such as Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs), for enrolled beneficiaries. • Providers must have a contractual relationship with a Medicare Part D Drug Plan to bill these plans for drugs provided to enrolled beneficiaries. A state specific list of Medicare Part D Drug Plans can be found at http://www.medicare.gov/medicarerereform/map.asp on the CMS web site. <p><u>Flu Shots</u></p> <p>During the 2004-2005 flu season, there was a shortage of flu vaccine. To ensure beneficiaries would be able to receive a flu vaccination, the Centers for Medicare & Medicaid Services (CMS) made an exception to allow the payment of beneficiary –submitted flu claims for services provided by non-enrolled providers. This was a one-time event due to the flu vaccine shortage.</p> <p>Medicare can no longer process and pay for flu shots submitted by the beneficiary with a 1490S form, by non-Medicare or opt-out providers. For dates of service 6/1/05 and after, providers who offer flu shots to Medicare beneficiaries must submit claims to Medicare for these patients.</p> <p>Flu vaccine coding and allowances were also reviewed with the committee.</p> <p><u>2006 Medicare Deductible, Coinsurance & Premiums</u></p> <p>The amounts for 2006 are: Part A Hospital Deductible: 1st through 60th day: \$952 Coinsurances: 61st through 90th day: \$238/day 91st through 150th day: \$476/day</p>	
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<p>Beneficiary Educational Activities (cont.)</p>	<p>Skilled Nursing Facility: Coinsurance: 1st through 20th day: \$0 21st through 100th day: \$119.00/day</p> <p>Part A Premium: \$393 per month for those who must pay a premium \$216 per month for those who have 30-39 quarters of coverage</p> <p>Part B Deductible: \$124 per year Co-insurance: 20 percent Premium: \$88.50 per month</p> <p><i>For more information, please consult the Handouts Packet for today's meeting.</i></p>	
<p>5. Other Issues</p>	<p><u>NPI</u></p> <p>Under the National Provider Identifier Regulation (that was published in the Federal Register on January 23, 2004), a health care provider who is a covered entity, as defined at 45 C.F.R. & 160.103, is required to obtain a National Provider Identifier (NPI) by May 23, 2007. To apply online, visit: https://nppes.cms.hhs.gov</p> <p>The new CMS web page dedicated to providing all the latest NPI news for Fee-For-Service (FFS) Medicare providers is: http://www.cms.hhs.gov/providers/npi/default.asp While this page is dedicated to the FFS community, it contains helpful information and links that may benefit all health care providers.</p> <p><u>EDI – Medicare Remit Easy Print (MREP) and Electronic Funds Transfer (EFT)</u></p> <p>Members were reminded of the advantages of MREP, such as:</p> <ul style="list-style-type: none"> • Easy navigation and viewing of the ERA using your personal computer; • Print the ERA in the Standard Paper Remittance (SPR) format; 	

<p>Other Issues (cont.)</p>	<ul style="list-style-type: none">• Search capability that allows providers and suppliers the ability to find claims information easily;• Print and export reports about ERAs including denied, adjusted and deductible applied claims;• Easy-to-use method to archive, restore, and delete imported ERAs <p>Additionally, the benefits of EFT were reviewed, including:</p> <ul style="list-style-type: none">• Faster communication and payment notification/receipt• Faster account reconciliation through electronic posting• Automation of follow-up action• Paperwork reduction• Detailed information• No waiting for the mail• Elimination of lost checks and Standard Paper Remittances <p><u>New IVR</u></p> <p>WPS Medicare implemented a new speech enabled IVR on November 11, 2005. Providers have the ability to obtain beneficiary eligibility information from an IVR. This allows providers to check eligibility on an unlimited number of Medicare beneficiaries on one call; providers will not be limited to three per call. Besides beneficiary eligibility, the following information is available:</p> <ul style="list-style-type: none">• Claim Status• Check Information• Deductible• Procedure Code Pricing• Phone Numbers• Addresses• Appeal Rights <p>The IVR will still be able to accept touch tone entries; however use of the voice recognition feature will be strongly recommended for eligibility inquiries.</p>	
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Other Issues (cont.)	<p><u>Educational Curriculum Questionnaires</u></p> <p>Members were asked to complete two brief questionnaires to help Provider Education design teleconferences on the topics of Evaluation & Management Services and Oncology.</p> <p><i>For more information, please consult the Handouts Packet for today's meeting.</i></p>	
6. Open Discussion	<p><u>2006 PCOM Calendar – Confirmed</u></p> <p>Dates for 2006 PCOM meetings were disclosed to the group:</p> <ul style="list-style-type: none"> • March 16 • June 15 • September 14 • December 7 <p><i>The next meeting is scheduled for Thursday, March 16, 2006.</i></p>	<p>A member suggested an index guide for the newsletter would be a welcome addition to the web site.</p>