

Provider Outreach and Education Advisory Committee Minutes (POE-AG)

10am – 12pm (EDT)

March 20, 2008

Hosted by: Michigan

Attending Members:

MI - Bronson Hospital, Continuum Management Services, Henry Ford Health Systems, Michigan Medical PC, Michigan State Medical Society (MSMS), Mid-Michigan Physicians PC, National Government Services, Professional Practices Resources, Sturgis Hospital, University of Michigan Health Systems

IL - Central Illinois Kidney & Dialysis, Christie Clinic, Elite Medical Solutions, First Care Ambulance Services, Healthcare Management Alternatives, Illinois Chiropractic Society, Little Company of Mary Hospital, McKesson Corporation, MedOffice Solutions, Midwest Heart Specialists, Practice Management, Quest Diagnostics, Resurrection Health Care at St. Joseph Community Health Center, SIU Physicians and Surgeons, Springfield Clinic

WPS Part B Staff: Provider Outreach staff: J. David Bozarth, Mark Kirchberg
 Medicare Publications staff: Holly O’Neal
 Medicare Administration staff: Emily Drewitz

Agenda Item	Discussion	Suggestions/Questions	Outcome/Action
Welcome and Introductions	POE staff welcomed members to the Provider Outreach and Education Advisory Committee (POE -AG) teleconference.		WPS staff introduced themselves, and asked all participants to do the same, in the following order: on-site attendees, Michigan participants (call-in), and Illinois participants (call-in).
Review of Minutes from December 6, 2007 Action/Outcome List from the September meetings	Members approved the minutes from the December 6, 2007 POE-AG meeting as written. Action/Outcome List: Members requested information of situation where billing Part B is appropriate even when the patient is enrolled in a Medicare Advantage Plan.		Providers may only bill the Advantage Plan if the HMO is a risk/restricted HMO. However, if the HMO is a cost-type HMO the provider may bill either the HMO or Medicare Part B Carrier, depending on the situation. Providers can find more about this at CMS Pub 100-04 in Chapter 1 of the IOM at www.cms.hhs.gov/manuals/download/cim104c01 .

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	<p>Members suggested WPS Medicare includes a “HOME” key or link on our Website.</p> <p>Providers are receiving requests for repayment from the original primary payer indicating that Medicare should pay as primary. These requests are received after the Medicare timely-filing limit date. What should providers do?</p> <p>Members want to know whom they should bill when a patient has a Medicare Advantage plan and the patient is enrolled in Hospice.</p> <p>Member questioned on what actions are necessary when a provider dies.</p>		<p>The red/white/blue WPS Medicare banner at the top of the each page serves as a “HOME” key.</p> <p>The only recourse with Medicare is to submit the claim and appeal the timely-filing denial. It may also be helpful for the provider to discuss this issue with the original payer.</p> <p>Medicare B services are billed through the Advantage Plan. Services provided within the Hospice facility itself are billed to Medicare Part A.</p> <p>Providers should submit an 855I form to report a provider’s death.</p>
Medicare Publications Update	<p>Customer Satisfaction Survey This survey is used by the Centers for Medicare & Medicaid Services (CMS) to evaluate WPS Medicare as a contractor.</p> <p>Listserv WPS Medicare is required by CMS to have a certain percentage of their providers signed up for the Listserv. Medicare Publications encouraged members to sign up for the WPS Medicare Listserv if they have not already done so and to please encourage providers they are in contact with to sign up. Providers can sign up on the WPS Medicare Website or by contacting WPS Medicare.</p> <p>Communiqué Beginning April 2008, there will be separate editions of the Communiqué for Legacy providers and MAC providers.</p>	Medicare Publications is requesting all providers take the Customer Satisfaction Survey that is on the WPS Medicare Website even if they have taken the survey in the past.	<p>WPS Medicare uses it to ensure that we are meeting the needs of our provider community and to make improvements to the WPS Medicare Website.</p> <p>Co-Chairperson distributed a sign up sheet to members who were present in person. He also stated that members could download a sign up sheet on the WPS Medicare Website. Sign up sheets can be faxed back to 312-228-6280.</p>

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		<p>One member mentioned that members of their office staff are having difficulty locating the Fee Schedule. They have been looking in the News & Update section of the Website.</p> <p>Member asked which Search Engine WPS Medicare uses.</p>	<p>Holly will share members' comments with the Medicare Publications Department.</p> <p>WPS Medicare uses Google.</p> <p>Members can send specific comments/suggestions regarding the WPS Medicare Website to Medicare Publications or to co-chairpersons.</p>
Provider Education	<p>A. How to Reduce Calls to Medicare - WPS Medicare receives a high volume of calls from providers asking for claim information that is available through the Interactive Voice Response (IVR) or through the Remittance Advice (RA). Providers can find a complete listing of the Remarks codes and their descriptions on the following website: http://www.wpc-edi.com/hipaa/.</p> <p>B. IVR Satisfies Non-complex Requests - The IVR can provide patient eligibility, claims status, provider summary, checks deductibles and pricing. The IVR is available 24 hours a day, 7 days a week. Complete instructions on the use of the IVR system are available on the WPS Website at: http://www.wpsmedicare.com/part_b/selfservice/ivr.pdf. Members received a handout with information regarding the IVR.</p> <p>C. How to get the most out of your Customer Service Contact - Members received a handout detailing the information a provider should have available when they call the Provider Inquiry telephone line.</p>	<p>CMS does not fund providers for these calls so WPS Medicare is asking for providers' assistance to reduce calls.</p> <p>When calling the IVR, providers will need to use their Provider Transaction access number (PTAN) used on the claim.</p> <p>WPS Medicare's CSRs have the knowledge and expertise to respond to provider questions; however, if they determine your issue is complex, they</p>	<p>Staff encouraged members to use the IVR for claim obtaining information.</p> <p>In the event that the specialist cannot respond to your request during the call, WPS Medicare will research the issue and respond to the provider within 10</p>

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	<p>D. WPS Medicare Website - The WPS Medicare Website has multiple articles and educational tools to help provider offices understand the Medicare program and submit claims appropriately. Providers can access the Website 24 hours a day, 7 days a week. Providers can also access a Computer Based Training (CBT) on Navigating the Website on the following Website: http://www.wpsmedicare.com/tutorial_help.shtml.</p> <p>E. Education Schedule - Members received a 2008 Education schedule for WPS Medicare's Legacy states; however, some of these events are not finalized.</p> <p>F. Remark Codes - CMS recently issued the Medicare Learning Network (MLN) Matters Article MM5800. This MLN provides updates to the Reason/Remarks codes used on the Remittance Advice. The additions and changes are effective January 1, 2008. WPS Medicare is looking for educational programs they can do on Remark/Reason codes, such as the reasons for denials or denial or rejections and what action a provider should take next, if any. WPS Medicare hopes that this will reduce the time spent by providers researching the denial or rejection. In addition, WPS Medicare is requesting members send the Top 5 Reason/Remark codes that cause their office to call Medicare.</p>	<p>may escalate your call to a specialist.</p> <p>We will post most programs to the WPS Website approximately 6-8 weeks prior to the date for each event.</p> <p>POE staff reminded participants to look to new programs (in-person, MediaSite, CBTs, and teleconferences) posted to the education schedule on the WPS Medicare Website throughout the year.</p>	<p>days.</p> <p>Staff encouraged members to use WPS Medicare's Website and the CMS Website as these are valuable resources for Medicare rules, regulations and claim processing guidelines, and can answer many of the providers' questions.</p> <p>The 2008 Education schedule lists dates and locations for a number of in-person events in all four legacy states (WI, IL, MI and MN).</p> <p>Providers should refer to the Education Schedule on the WPS Medicare Website for up-to-date listings and registration at http://www.wpsmedicare.com/part_b/education/education_schedule.shtml.</p> <p>Chairpersons asked members to send the Top 5 Remark/Reason codes that cause them to call WPS Medicare by March 27, 2008.</p>

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	<p>G. Ask-the-Contractor Teleconference (ACT) Survey - The Medicare Modernization Act (MMA) requires Medicare contractors to hold ACT Teleconferences. WPS Medicare hosts ACT Teleconferences on a quarterly throughout the year. WPS Medicare no longer publishes a topic for these ACTs; instead, WPS Medicare encourages providers and billing staff to call with any Medicare questions they deem appropriate. WPS Medicare staff is available during the call to provide education, program updates, answer questions, and take feedback.</p> <p>H. Responses on Purchased Diagnostic Testing Members received a handout with the Suggestions/Actions on the Purchased Diagnostic Testing that POE received from POE AG members.</p> <p>I. A Review of the Change Request Process - CMS communicates new or changed policies and/or procedure in the CMS Program Manual to the Carriers through Change Requests. The cover page or transmittal page summarizes the new/changed material and instructions. The Change Request gives both effective date and implementation date of change. These dates may not always be the same to allow Carriers time to adjust the claims processing system in order to carry out the changes.</p>	<p>Member stated they find the ACT teleconferences a valuable format especially for individuals who are new to Medicare.</p>	<p>Chairpersons asked all members to complete a brief, one-page survey provided, regarding awareness and participation in ACTs, and fax them to co-chairperson at 312-228-6280.</p> <p>We encouraged members to view the Mediasite presentation on Purchased Diagnostic Testing, now available on the WPS Website.</p>
Member Issues	<p>J. Authorized Access to CMS Computer Services (AACCS) CMS will be announcing new on-line enterprise applications. This will allow Medicare fee for service providers to access, update and submit information over the internet. These applications include Provider</p>	<p>Providers should register for access through a new CMS security system, Individual Authorized Access to CMS Computer Services – Provider Community (IACS-PC) now because it</p>	<p>CMS is recommending that providers set up their on-line account now even though these applications are not available.</p>

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	Enrollment, Chain and Ownership system (PECOS) and Provider Statical and Reimbursement Reports (PS&R) system.	may take weeks to process the applications. Members received a handout regarding this system.	
Updates	<p>A. National Provider Identifier (NPI) Updates As of March 1, 2008 NPI numbers was required on all claims. CMS did not grant any waivers for the WPS Medicare jurisdiction. Providers may continue to include their Legacy numbers as well on claims. Providers who have not already tested should begin testing immediately by submitting a small number of claims with only their NPI numbers.</p> <p>B. Erythropoieses Stimulating Agents (ESA) CR 5699 stated effective January 1, 2008 CMS is implementing expanded reporting requirements for all claims billing for administrations of an ESA. Effective with the implementation of CR5699, the most recent Hematocrit or Hemoglobin reading along with one of the three new modifiers will be required effective January 1, 2008. For claims that include codes J0881, J0882, J0885, and J0886 and Q0481 the Hematocrit or Hemoglobin readings are required in item 19 in the narrative field of the CMS-1500 paper form or Loop 2400 in the A segment for electronic claims. Providers will use a two position numeric element when reporting test results with a decimal implied. Claims that do not contain this information will be deemed Unprocessable and returned to the provider.</p> <p>In addition to the test result, CR5699 also establishes three new modifiers to report when billing J0881 and J0885 for all non-ESRD claims. Modifier EA is used to report ESAs for Chemo-induced anemia, EB is used</p>	<p>As of May 23, 2008 all covered entities are expected to use NPI numbers only on all claims submitted. Providers will need to enter name and address in Box 32, but do not need to enter NPI or legacy identifier in this field.</p> <p>Member asked if a policy has been created for ESA.</p> <p>Member stated another good source of information for ESA is the Michigan Society for Hematology and Oncology. Their Website is www.msho.org.</p> <p>The implementation date for CR5699 is April 7, 2008. Providers are not required to use the new modifiers until the actual implementation date.</p>	<p>NPI Enumerators are responsible for assisting health care providers in applying for their NPIs and updating their information in the National Plan and Provider Enumeration System (NPPES). MLN Matters SE0751 gives clarification on the NPI Enumerator's responsibilities.</p> <p>Co-chairperson stated WPS Medicare is working on a draft policy for ESA.</p>

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	<p>to report ESAs for radio-induced anemia and EC is used to report ESAs for non-chemo/radio anemia. If more than one modifier is used, the claim will be returned with Reason code 125 and Remark code N63.</p> <p>C. Comprehensive Error Rate Testing (CERT) The CERT program measures the error rate for improper Medicare Fees for Service payment. An improper payment is any payment made by the Medicare Claims Processing Contractor that should not have been made or was made for the wrong amount. The November 2007 Improper Medicare Fees for Service Payments Report includes claims submitted between April 1, 2006 – March 31, 2007, which also includes some MAC contractors. There were several small improvements from 2006 to 2007 in the areas of incorrect coding and medically unnecessary services and a larger reduction in the CERT rate was the improvement of insufficient documentation errors. A copy of this report can be obtained on the CMS Website as well as the WPS Website for Legacy providers at www.wpsmedicare/Part B/Business/all_error.pdf.</p>	<p>Member stated there are several instances when the provider bills the Medicare carrier and is paid for the claims only to find out months later that the patient is covered by Advantage HMO. Are these considered CERT errors?</p> <p>Member asked if CERT errors are reversed if it is determined that the claim was paid correctly.</p>	<p>Co-chairpersons did not believe this would be considered a CERT error.</p> <p>Co-chairpersons will research this and notify members.</p>
Open Discussion		<p>Member questioned the Listserv message sent Wednesday, March 5, 2008 regarding providers who perform services in multiple locations. To her understanding, it is a requirement for providers to update their practice locations. Member stated she has several clients who have not updated their information in a number of years. She questioned if these providers do not update with NPI will their claims begin</p>	<p>Co-chairpersons referred member to contact the Provider Enrollment Department to answer this question.</p>

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		denying on a specific date.	
Next scheduled meeting	The next POE-AG meeting is scheduled for June 5, 2008. This will be a teleconference only meeting.		