

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

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

March 13, 2003

Southfield, Michigan

Facilitators:

Lydia Bean, Assistant Manager, Provider Education and Outreach (www.lbean@wpsic.com)

Matthew C. Friedrichs, Senior Analyst, Provider Education and Outreach (www.mfriedrichs@wpsic.com)

Members:

Tracy L. Baase, Karn Berdy, Erica Coleman, Melody Czapski, Kathy DiCenzo, Valarie J. Fane, Mo Fogel, Kelly Hawthorne, Gail Health, Martha Johnson, Marsha Kline, Judy Murray, Susan Pridemore, Diane Rebori Koski, Judy Shubow, Lynette Spry, Edres Thornton, Victoria Tran, Connie S. Waddell, Melissa Weintraub, Elizabeth Zahodne,

Guest Speakers: Beverly Bruner UGS, Patricia Iroegbu UGS, Julia Severson UGS

Agenda Item	Discussion	Outcome/Action
1. Welcome and Introductions	Meeting facilitators welcomed members to the first PCOM meeting held at the new meeting facility in Southfield, Michigan. Members began the meeting with brief round-table introductions to familiarize themselves with provider specialties present, further promoting networking activities within the forum.	
2. Provider/Supplier Communication Transmittal 146, Dated January 24, 2003	Members discussed the fundamental principles identified in this transmittal and agreed that no member is serving on any other Medicare Part B forum to date. Discussion focused on the intent of the forum, which is to educate provider/suppliers on programs, policies and new initiatives as they are disseminated by the Centers for Medicare and Medicaid Services (CMS).	

	<p>The primary function of the PCOM Advisory Committee is to assist the Medicare Part B carrier in the creation, implementation and review of training topics, educational materials, workshops, events and communication strategies in urban and rural areas throughout the state.</p> <p>This transmittal indicates that “a list of organizations or entities comprising the PCOM Advisory Group be listed on the contractors web-site.” The general consensus of this forum is to limit any information posted to the web-site specific to their participation on this group thus minimizing contacts made directly from the community to them.</p> <p>Members were encouraged to register for both the WPS and CMS list-serve communications, which are both free of charge. These services provide current up-to-date information on a variety of topics that will assist members in their daily functions relating to Medicare.</p>	
<p>3. Outpatient Physical Therapy Limitation Transmittal AB-03-018</p>	<p>Attendees expressed concern that monitoring services rendered to a beneficiary do not exceed the \$1,590.00 limitation may be problematic to the provider. This concern originates from a general belief that there may be more than one provider rendering this type of service, thus creating a situation that presents may unknowns to a provider attempting to track this on-goingly.</p>	
<p>4. Medical Review Strategy</p>	<p>The Medical Review focus for fiscal year 2003 has been disseminated. Highlighting components of the prepayment and post-payment process.</p>	

	<p>Review findings that result from this process are to be incorporated in the development of educational materials that are disseminated through workshops, events, monthly publications, WPS Web-site, email list-serves and shared with providers on a one on one basis.</p>	
<p>5. Medicare Part B Updates:</p> <ul style="list-style-type: none"> • Fee Schedule • Program Memorandums • EDI • HIPAA • Beneficiary Signature Requirements 	<p>Brief informational updates were provided specific to each of the following topics.</p> <ul style="list-style-type: none"> • Fee Schedule: The Consolidated Appropriations Resolution allowed a 1.6 percent overall update to physician fee schedule rates for 2003. Claims received by the Medicare Part B carrier process routinely for services submitted with 2003 CPT/HCPCS codes. Claims that are processed after March 1, 2003 for dates of service rendered in January and February with 2002 CPT/HCPCS codes will be adjusted in July 2003 to pay at the 2002 rates. This adjustment process will be initiated by the Medicare Part B carrier to recoup overpayments issued to the provider of service. • Program Memorandums: <ol style="list-style-type: none"> 1. Transmittal AB-02-180 Coverage and Billing for Home Prothrombin Time International Normalized Ratio (INR) Monitoring for Anticoagulation Management. Clarifies previous transmittal AB-02-64 dated May, 2002. Under the Carrier Claims Requirement section the following statement is deleted “This is a CLIA waiver test.” The use of the INR allows the provider of service to determine the level of anticoagulation in patients independent of the reagents used by laboratories. 	

Medicare Part B will reimburse for this service when used for patients with mechanical heart valves on warfarin when provided on or after July 1, 2002.

2. Transmittal AB-03-003 Noncoverage of Multiple Electroconvulsive Therapy (MECT) . The benefits of this service have not been verified through scientifically controlled studies, in addition to other studies performed, (MECT) may increase risk of adverse effects and cannot be considered reasonable and necessary and is a non-covered benefit as of April 1, 2003.
3. Transmittal AB-03-023 Deep Brain Stimulation for Essential Tremor and Parkinson’s Disease. This is a new benefit as of the April 1, 2003 for patients who become unresponsive to medical treatments or perhaps develop intolerable side effects from medications. This alternative treatment may be considered for symptom relief. This document defines both coverage and non-coverage criteria specific to symptoms, diagnosis, providers, service facilities and devices that must meet Food and Drug Administration (FDA) approval.
4. Transmittal AB-03-033 Promoting Colorectal Cancer (CRC) screening as a Part of National Colorectal Cancer Awareness Month. Colorectal cancer screening is the second leading cause of cancer-related deaths in the United States and one of the most preventable and curable cancers when detected early. The Screen for Life National CRC Action Campaign (SFL) informs individuals over the age of 50 on the benefits of receiving a CRC screening.

	<p>5. This document includes articles that may be used to promote awareness on the benefits of CRC screenings and various web-site addresses for additional information.</p>	
<p>6. Compliance of Medical Records</p>	<p>Representatives from United Government Services spoke on the top 10 reasons that claims are denied by UGS. Majority of these denials are linked to insufficient information received such as:</p> <ul style="list-style-type: none"> • No response to request for records • Physician documentation does not support observation room billing • Insufficient information • Lacks MD Orders • No documentation of unstable medical condition • Services provided are not identified as being provided in a rural health clinic setting • No documentation provided • Insufficient time allowed for Home Exercise Program/Functional Maintenance Program (HEP/FMP) to be established • Service is no reasonable and necessary <p>The primary focus of this presentation was on the financial impact made by the provider community not responding to the request of United Government Services to provide additional records. This accounts for approximately \$500,000.00 in denied services for the first quarter fiscal year 2003. To resolve this problem, all providers, especially physician practices, need to respond promptly when their billing service request additional records of them for purposes of the medical review process.</p>	

	<p>Presently, the Medicare Review area at UGS is noting a significantly higher number of claims and denials that are processed for laboratory services via automated billing systems. Providers are strongly encouraged to familiarize themselves with the National Coverage Decisions (NCD'S) for appropriate diagnosis and coding of laboratory services. Providers are also encouraged to contact UGS with questions or concerns.</p>	
<p>7. Medicare Part A Update</p>	<p>A representative from United Government Services referenced the following articles published in the February 24, 2003-2.0 Medicare Memo publication, in addition to those that may be found on the UGS web-site.</p> <p>HIPAA Update</p> <ul style="list-style-type: none"> • Providers are encouraged to participate in the HIPAA privacy implementation roundtable conference call on Wednesday, March 26, 2003 from 2:00-3:00 P.M. EST. • Registration is accessible through the UGS web-site for training sessions that are remaining this fiscal year. In addition, to training manuals that can also be obtained through the web-site. • Notice of Interest Rate for Medicare Overpayments and Underpayments has been changed to 10.75 percent. Program Memorandum AB-03-019, Change Request 2430. • Mammography Quality Standard act (MQSA), this file record layout has been updated by the Food and Drug Administration (FDA) Certified Digital Mammography Center Program. Refer to Program Memorandum AB-02-0149, Change Request 1729. Effective April 1, 2003. 	

	<ul style="list-style-type: none">• Providers were instructed how to submit claims to Medicare when there are multiple primary payers. Refer to Program Memorandum AB-03-011, Change Request 2050. Effective date July 1, 2003.• Implementation of the Financial Limitation for Outpatient Rehabilitation Services for Part A. Refer to Program Memorandum AB-03-018 dated February 7, 2003.• Program Memorandum AB-03-007, Change Request 2470, speaks to the implementation of the Ambulance Fee Schedule.• Remittance Advice Remarks and Reason code web-site: www.cms.hhs.gov/providers/edi/hippadoc.asp• Hospital Outpatient Prospective Payment System (OPPS) updates. Reference Program Memorandum A-02-129, Change Request 2503 outlines changes for OPPS in 2003.• No-Pay Bill for Medicare +Choice (M+C) Enrollees, provides how non-inpatient payment system (IPPS) hospitals should submit their (M+C) claims.• MSP information collection policies changes for hospitals. Refer to Program Memorandum A-02-021, Change Request 2104. Effective March 31, 2002.	
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