Provider Communication Advisory Committee Minutes
(PCOM)

9:00a.m. - 12:00 noon
June 10, 2004
Southfield, Michigan

Members Present: (18)

Agenda Item	Discussion	Outcome/Action
Welcome and Introductions	Roll Call Two alternate members were introduced. Minutes from the March 2004 meeting were approved as written.	
Updates	National Beneficiary Phone Line Medicare contractors will begin migrating all beneficiary telephone numbers over to one standard 1-800-MEDICARE (1-800-633-4227) phone line during the summer months this year. As of October 1, 2004 all beneficiary correspondence, appeal letters, Medicare Redetermination Notices and the Beneficiary Website will indicate this new toll free number. Having one general phone line for beneficiaries to call will minimize confusion for the Medicare beneficiary community. This central call center will address general questions and transfer calls that require claim specific information to the carrier that has jurisdiction for the geographical location the service was provided. Change in IVR/Customer Service Toll-free Line Providers were pleased to hear that Wisconsin Physicians Service has added an additional phone line separate to the Provider Interactive Voice Response (IVR) system to better serve the provider community.	Providers were appreciative of information being distributed, and commented that they are surprised that they have not received questions from the beneficiaries in regards to this issue.

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Updates - *continued*	Change in IVR/Customer Service Toll-free Line – *continued* Having direct access to a representative has decreased time spent on the phone daily by their staff. While having a separate line for the Provider (IVR) has provided quicker connectivity for callers interested in obtaining claim status, verification of patient eligibility and general program information. Callers were reminded that once they reach the Provider IVR or the Call Center, there is no option to transfer from one line to the other. Callers will need to hang up and dial the designated phone number for the entity they wish to contact. New Provider IVR instructions are available at: www.wpsic.com/medicare/provider/ivr/shtml Top Claim Submission Errors For the first quarter this year the top claim submission errors were as follows: Individual Provider Required 1. Provider number entered is not an individual provider number, or no individual provider number was entered 2. Clinical Diagnostic Negotiated Rule Making Diagnosis code billed is not medically necessary 3. Independent Lab Billing EKG tracing or Specimen Procurement in Place-of-Service "Patient Home" (POS 12) Missing the narrative "*homebound*," in the extra narrative field	Providers stated that they believe many of these errors were the result of the HIPAA testing process. They commented that they believe these errors will be minimal next quarter.

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Updates - *continued*	Top Claim Submission Errors-*continued* 4. Procedure code not paid separately (always bundled), non-covered, or not valid for Medicare purposes Medicare Physician Fee Schedule Database (MPFSDB) lists status of B, G, I, N, or P for the procedure code billed You may obtain a copy of the MPFSDB at the following website: www.cms.hhs.gov/providers/pufdownload/rvudown.asp 5. Invalid "To" Date of Service Quantity billed doesn't match dates of service billed (claims deny when more than one unit is billed for a single date of service for a procedure code that only allows one unit per day.) The following top three reasons for initial claim determinations that were appealed most frequently during the period of October through December of 2003. • Diagnosis-All diagnosis related to the patient's condition are not always billed on the initial claim. • Medical Necessity – Medical documentation is not submitted at the claim level. • Noncovered Services – Services that are not-covered based on the processing guidelines. After reviewing 300 claims for the first quarter this year, we found that the top reason for initial claim determinations reversed at the appeal level were mainly due to the lack of documentation received on original claim, provider billing errors such as incorrect quantity, procedure code or the amount billed. And the required documentation necessary to support service rendered is only being provided at the request of the medical review area. ***For more information, please consult the Handout Packet for today's meeting.***	With the exception of category number 4, they are not sure why this category is remaining at high levels.

Provider Educational Activities Medical Review	Summer 2004 Seminar Schedule A seminar schedule was distributed indicating dates, address and topics of a varity of seminars being offered throughout the WPS four state jursidication. Many of the seminars being offered this summer were designed based on suggestions made by PCOM members and the Medicare Review department based on probe findings on various topics. Members are encouraged to routinely access the web following website for updates and discriptions of each seminar being offered: www.wpsic.com/medicare/provider/proved_seminar.shtml E-Mailing List Subscriber Initiative Outreach staff encourages the provider community to sign up for the free WPS e-mails that share timely updated news articles. If you are interested we ask that you register by accessing the www.wpsic.com website address. 2005 Fee Schedule and Disclosure Materials via CD-ROM. Members were pleased to hear that these materials will be available via the CD-ROM format. Members commented that the information they received last year via the CD-ROM format allowed them to distribute the material throughout their organization with ease. Comprehensive Error Rate Testing (CERT) There was a discussion regarding the lack of provider awareness in the state on the CERT testing process. Members expressed concern that although they are aware of the process, they are contributing this lack of awareness due to their participation as PCOM members. They are concerned that a contributing factor to the high error rate is that providers do not understand this is a legitimate request from a CMS contractor. Failure to return requested documentation to AdvanceMed may result in overpayment recovery actions.	 Members will distribute a copy of the letter throughout their communication network. They believe that people will be more willing to respond if they know the letter is received coming from a CMS contractor.

Medicare Review- *continued*	The following directions should be followed when photocopying, packaging and mailing the requested records: • Complete and attach the CERT Contractor cover sheet with the barcode for each record • Send the cover sheet with the barcode and the medical record(s) to **AdvanceMed** (not to WPS Medicare Part B). Records can be mailed to **AdvanceMed** for CERT at: CERT Operations Center Attention: Disposition Department 1530 East Parham Road Richmond, Virginia 23228 If the provider chooses, medical records for CERT can be faxed to **AdvanceMed** at 804-864-9980. A CERT Customer Service representative can be reached at 1-(804)-864-9940 for any **questions about the record request.** General questions regarding the CERT program may be directed to the Medicare B Contractor Provider Inquiry Phone lines by calling; MI (877)-567-7201 Failure to return requested documentation to AdvanceMed may result in overpayment recovery actions, and or referral to the Medicare contractor fraud unit and to the Office of the Inspector General.	Please note that questions about claims denials or appeals should be directed to **WPS** customer service, rather than AdvanceMed's Customer service.
EDI/HIPAA	Staff was pleased to hear that all members present have successfully completed the testing process and are now HIPAA complaint. *Next meeting is schedule for Thursday, September 9, 2004*	