

Provider Communications (PCOM) Advisory Group Minutes

9:30a.m.-12:00 noon

March 18, 2004

SpringHill Suites

Walker, Michigan

Members Present: (16)

Agenda Item	Discussion	Outcome/Action
Welcome and Introductions	<ul style="list-style-type: none"> • Roll Call • We had one new member that joined the group. • Minutes from the December 2003 meeting were approved as written. 	
CMS Presentation on Reform Legislation	<p>A representative from the Center for Medicare and Medicaid Services (CMS) provided a visual demonstration, highlighting Legislative Provisions for the new Medicare Approved Drug Discount Card. CMS began by presenting key concepts of this voluntary program. Indicated below is a summary of some of the requirements and benefits of the program that were discussed in detail.</p> <p>Beneficiaries that qualify for this program are entitled to a \$600.00 annual savings for prescriptions drugs beginning June 2004 through December 31, 2005. Once the beneficiary begins using the \$600.00 toward covered prescription drugs, they will be allowed to carry over any remaining balance over into 2005 if they do not use the entire amount of \$600.00 during 2004. Beneficiaries will have the option of verifying on-line through the internet or by dialing 1-800-Medicare which prescriptions are covered by each card sponsor offering a discount card in their geographical area. Enrollment in a Medicare-Approved Drug Discount Card plan will begin in May. Beneficiaries receiving outpatient drug coverage through plans such as: Medicaid, TRICARE For Life, Federal Employee Health Benefit Plan, or Group Health Plans are not entitled to the program and must be at or below 135% of the poverty line.</p>	<p>Information was very well received by those in attendance. Comments received were as follows:</p> <p>“This was a good thing, I would like to see more presentations like this from CMS.”</p> <p>“This presentation really helped me to better understand the drug benefit and how it will be administered.”</p>

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<p>CMS Presentation on Reform Legislation - <i>continued</i></p>	<p>Once qualified for this discount an individual will remain qualified even if there is a change in their circumstances such as enrolling into Medicaid. Any company offering a discount prescription drug card may charge up to a \$30 enrollment fee for 2004 and 2005, and may not change this enrollment fee during a calendar year. To qualify as a card sponsor the following criteria must be met:</p> <ul style="list-style-type: none"> • Applicant must be non-governmental • Have relevant organization experience • Be financially stable and reputable • Meet minimum service area and pharmacy network access standards • Administer the \$600 assistance • Provide negotiated prices on prescription drugs • Manage the eligibility and enrollment process • Provide good grievance process • Comply with HIPAA privacy provisions • Agree to provide data to CMS 	<p>Comments-<i>continued</i> “I’m concerned that drug companies may raise their prices after a beneficiary enrolls with a card sponsor, I’m glad to hear that CMS will monitor the companies that are participating in this program.</p>

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<p>CMS Presentation on Reform Legislation - <i>continued</i></p> <p>CMS Presentation on Reform Legislation - <i>continued</i></p>	<p>CSRs will be available at the individual card sponsor plans to assist Medicare beneficiaries with concerns by calling a toll-free number provided by the plan. They will be available to address concerns such as enrollment fees, prescription drug prices and other related concerns. All card sponsors must comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy provisions to protect healthcare information. Card sponsors may not co-mingle any other marketing materials with card program communications. CMS will oversee a grievance and complaint tracking system while maintaining records on the following:</p> <ul style="list-style-type: none"> • Savings garnered and shared • Appropriate management of the \$ 600 funds • Enrollment and disenrollment • Marketing Pharmacy network access • Customer service <p>Medicare Managed Care Plans (Part C plans/M+C/Medicare Advantage) and cost reimbursement plans have the option of offering “exclusive card” programs to their health plan member only, and or serving beneficiaries outside of their membership base. Eligible beneficiaries with \$600.00 may apply funds toward co-payments, deductible, non-covered drugs or drugs purchased after their drug benefit cap has been reach.</p> <p>Any Medicare patients with questions about the discount card program should be referred to the www.medicare.gov website or 1-800-Medicare (1-800-486-2048). TTY users should call 1-800-486-2048.</p> <p>Providers in Region V with general questions about the Medicare-Approved Prescription Drug Discount Card program should access CMS website: www.cms.hhs.gov/medicarerereform chidrugcard@cms.hhs.gov</p>	<p>Comments - <i>continued</i></p> <p>“My mother can not afford all the prescriptions that her doctor has prescribed, this program will help her out a lot.”</p>

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<p>Updates High volume telephone inquires</p>	<p>A quarterly update on the top two reasons for telephone inquires was provided by WPS staff and followed with a brief period for comments and suggestions as to why providers believe that these two categories continually remain to be high volume. Providers were asked to verify with their billing department to ensure that claim field elements are completed correctly. The CMS-1500 claim filing instruction are posted on our web site at: http://www.cms.hhs.gov/providers/edi/edi5asp . In addition to this instruction guide, providers are encouraged to reference the CMS-1500 Crosswalk to NSF and ANSI X12 4010A1 document available on at: http://www.wpsic.com/medicare/provider/pdfs/cms1500_xw.pdf</p> <p>Providers seeking further education regarding Medicare as a secondary payer may view the new MSP manual on the CMS web site at: http://www.cms.hhs.gov/manuals/105_msp/default.asp</p>	
<p>Updates – <i>continued</i> Extended Hours in Customer Service Department</p>	<p>WPS Medicare Part B has expanded the hours that Customer Service Representatives are available. In addition, WPS is streamlining access to our Financial and Medicare Secondary Payer (MSP) departments. These changes will allow us to investigate financial and MSP issues in a more efficient and timely manner.</p>	<p>Members commented that WPS may be experiencing higher than usual call volumes due to recent changes made to the automated phone system utilized by the Coordination of Benefit contractor.</p>

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<p>Updates - <i>continued</i> Change in Interactive Voice Response (IVR) Unit Phone Number</p>	<p>This Spring there will be a separate toll-free phone number for the Customer Service Call Center and the Provider Interactive Voice Response IVR unit. Individuals seeking claim status information may call the current toll-free IVR number at 1-877-567-7201 and individuals that have concerns requiring that they speak to a Customer Service Representative (CSR) may do so by dialing 1-866-234-7331. Various specialty groups that frequently utilize the IVR system expressed a note of thanks to staff of WPS for implementing an addition toll-free phone number this Spring. The change will free up lines coming into the Customer Service Department. Members were informed that once they reach the Provider IVR or the Call Center, there is no option to transfer from one to the other, as there is today. Callers will need to hang up and dial the designated phone number for the entity they wish to contact. New Provider IVR instructions will be available this Spring at: http://www.wpsic.com/medicare/provider/ivr.shtml</p>	
<p>CMS Secure Net Access Pilot (SNAP)</p>	<p>During a roundtable discussion on SNAP, members shared many awkward situations they have been confronted with in the past when attempting to verify patient eligibility and claim status. SNAP will provide a new world of technology providing detailed information on claims previously processed and confirmation of Medicare Part B eligibility for their patients. Information is available at: www.medicareinfo.com</p>	<p>Members believe that this technology will decrease time spent in the office when attempting to verify patient eligibility.</p>
<p>Most Common Reason for Appeals</p>	<p>Information distributed included bar graph charts that showed information on the top appeal requests, both telephone and written that were received over the past three months. The charts illustrated the relationships between the procedure codes originally submitted to the program for reimbursement and the claims that were originally submitted without the required modifiers.</p>	<p>Providers are looking to use this as a tool to conduct internal reviews in their offices prior to submitting services to the program for reimbursement.</p>

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<p>Updates – <i>continued</i> Provider Outreach Initiative – Comparative Billing Report</p>	<p>The Provider Outreach department implemented a pilot program that involved Podiatrists (specialty 48) giving them the opportunity to request a Comparative Billing Report (CBR). The CBR provides data on all CPT codes that are allowed by Medicare for Foot Care Services outlined in the LMRP FT-001. The CBR compares the requesting provider’s billed services allowed by Medicare from 01/01/03 through 12/31/03 against billed services allowed by Medicare for their peers within their individual state during the same time period. As a follow-up to any Podiatrist requesting a CBR, they will also receive a feedback survey that will assist WPS in making the decision to expand the availability of a CBR to other specialties to perform a self-assessment of their billing practice. Podiatrist interested in requesting a CBR may do so by contacting Teri Weiland at tweiland@wpsic.com</p>	<p>Members responsible for billing on behalf of the podiatrists commented that this would be a most useful tool to share with the physicians so that they can conduct a self-assessment of their billing practices in comparison to their peers within the state.</p>
<p>Follow-up to CD-ROM Disclosures and Fee Schedule Project CD-ROM Project Survey Results</p>	<p>Staff announced the results of feedback received on our 2004 Disclosure documents and Fee Schedules distributed via CD-ROM. Based on comments received, providers overwhelmingly welcomed the distribution of disclosure materials, fee schedules, and additional educational information via CD-ROM. In addition, providers encouraged us to continue using this new method of communication in the future. Hard copies of information were made available to those providers that indicated an inability to download the information from the internet or use the actual CD-ROM that was mailed to all providers that are enrolled in the Medicare program due to internal privacy regulations. Fortunately, that percentage was less than one percent. Members were asked to access WPS web site for the Revised 2004 Physicians Fee Schedule.</p>	

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<p>E-Newsletter Proposal - <i>continued</i></p> <p>Provider Education</p> <p>Elimination of the 90-day Grace Period for Billing Discontinued ICD-9-CM Codes</p> <p>Elimination of the 90-Day Grace Period for HCPCS Codes</p>	<p>Today, many articles are put in the electronic e-mail list, the monthly and quarterly Communiqué, web site news, and occasionally included in a manual. The same article may also be housed on the CMS' web site as a "Medlearn Matters" publication. Our hope is that we create an avenue for providers to print a specific article or an entire publication if they so choose.</p> <p>Members were encouraged to frequently access our web site for updates on the Spring and Summer education training series offered by WPS in the weeks ahead.</p> <p>The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets must be date of service compliant. As of October 1, 2004, CMS will no longer provide a 90-day grace period for providers to use when billing discontinued ICD-9-CM diagnosis codes on Medicare claims.</p> <p>The Health Insurance Portability and Accountability Act Transaction and Code Set Rule requires providers to use the medical code set that is valid at the time that the service is provided. As a result, CMS will no longer be able to allow a 90-day grace period for providers to learn about the discontinued HCPCS codes. Effective January 1, 2005, Medicare providers will no longer have a 90-day grace period for discontinued HCPCS codes for services rendered during January 1 through March 31 2005.</p>	
<p>EDI/HIPAA</p> <ul style="list-style-type: none"> • Contingency Plan 	<p>Is the HIPAA contingency coming to a close? The message that members were asked to share with fellow providers in the community is that the Contingency Plan will not last forever. Providers should be reminded that they are ultimately responsible for HIPAA compliance, not their software vendor.</p>	<p>When staff asked for a raise of hands to represent those providers represented in the group that were not HIPAA compliant, we were glad to see that no one hand was raised.</p>

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Beneficiary Activities	Beneficiary Outreach staff is distributing the CMS authored “The Facts about Upcoming New Benefits in Medicare” fact sheet regarding changes for 2004. The fact sheet is being distributed to all Medicare beneficiary events and to homebound beneficiaries in Illinois through the meals-on-wheels program. WPS is aggressively writing articles in both English and Spanish for publication in newspapers and our web site.	
Local Coverage Determination System	Due to the Benefit Improvement Protection Act (BIPA) section 522, providers will see many changes to Local Medical Review Policies (LMRP) posted to our web site over the next two years. LMRPs will be replaced by Local Coverage Determinations (LCD). In the future, each LCD will contain only reasonable and necessary information. Additional information that is found in the policies today, will appear in a companion document that will be made available separate from the policy itself.	