

# Provider Communications (PCOM) Advisory Group Minutes

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

September 18, 2003

SpringHill Suites

Walker, Michigan

## Facilitators :

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

## Members:

Lynn Accoe, Erin Bruder, Alice Covell, Barb Darrigan, Linda DeGroff, Elaine Gaipa, Mary Hyrns, Linda Inman, Sarah Lindsay, LuAnn Jenkins, Sarah Lindsay, Barbara Martin, Mary Nyssen, Victoria Tuttle, Bridget Smith, Kathryn Strang, Tami Stump, Jill Young,

Agenda Item	Discussion	Outcome/Action
1. Welcome and Introductions	Meeting facilitator began the meeting with a note of thanks for everyone taking time out of their busy schedule to participate in this forum.	
2. EDI/HIPAA	A letter of encouragement promoting testing HIPAA complaint transactions was received from Thomas A. Scully, Administrator for the Centers for Medicare & Medicaid Services, which opened discussion on the status and challenges incurred when testing HIPAA standard transaction and codes sets.	

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2. EDI/HIPAA	<p>The letter informs providers that claims must be HIPAA complaint to receive reimbursement from the Medicare Part B program. Any non-compliant claims received after the October 16, 2003 deadline will be returned, unpaid. Members viewed a HIPAA 101 video highlighting advantages of being HIPAA complaint, with specific information on electronic transactions available to assist the provider community in the following areas:</p> <ul style="list-style-type: none"> <li>• Claims submission</li> <li>• Electronic Remit Notice</li> <li>• Eligibility Inquiry</li> <li>• Claim Status Inquiry</li> <li>• COB Crossover</li> </ul> <p>Closing conversations on HIPAA compliance included information on the following: Helpful HIPAA resources, HIPAA transactions available by the carrier, EDI enrollment requirements, taxonomy codes and a web-site for the Washington Publishing Company (WPC) for Healthcare Provider Taxonomy Codes (HPTC) Crosswalk.</p> <p>Submitters who have tested successfully with the 837 version 4010 are not required to retest the 4010A1 version.</p> <p>The full Medicare requirements for EDI and the CMS Medicare EDI Enrollment language can be found in Section 3021.4 of the Medicare Carrier Manual (MCM). To view these requirements, please go to:  <a href="http://www.cms.hhs.gov/manuals/14_car/3b3006.asp#_3021_4">http://www.cms.hhs.gov/manuals/14_car/3b3006.asp#_3021_4</a></p>	Members are contacting vendors and clearinghouses to ensure that they are HIPAA compliant prior to October 16, 2003.

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3. Customer Service Issues	<ul style="list-style-type: none"> <li>• Remark Codes/Reason Codes</li> </ul> <p>The Center for Medicare Management, Provider Communication Group (PCG), has been reviewing both remittance advice reason codes, remark codes and the process for adding new or modifying existing reason codes and remark codes. PCG has requested the assistance of the provider community to capture these problematic situations where the remark codes and reason codes are confusing to the provider when attempting to correct the claim so that the claim may be resubmitted for payment consideration.</p>	Members will forward examples of these situations to carrier for consideration.
	<ul style="list-style-type: none"> <li>• CD-ROM Fee Schedule</li> </ul> <p>The Centers for Medicare &amp; Medicaid Services (CMS) has approved the distribution of Calendar Year (CY) 94 Medicare Physician Fee Schedules on CD-ROM. The CD-ROM will also include:</p> <ul style="list-style-type: none"> <li>• Participation (PAR) Agreement</li> <li>• “Dear Doctor” Letter</li> <li>• Fact Sheet</li> <li>• Participation (PAR) Announcement and Agreement</li> <li>• Other Disclosure materials</li> </ul> <p>In addition, to containing many educational references such as : Communiqué publications from the previous year, handbooks from WPS-Presented Seminars, links to important web-sites, a listing of Medicare acronyms and their meanings, frequently asked questions and much more. The CD-ROM will be available in late 2003.</p>	
	<ul style="list-style-type: none"> <li>• Inquires</li> </ul> <p>We are committed to providing information needed so that claims are submitted and processed correctly the first time they are received. This will alleviate providers having to spend time making an inquiry to determine denial reasons or calling to request reviews.</p>	

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3. Customer Service Issues	<ul style="list-style-type: none"> <li>• Inquires (continued) Wisconsin Physicians Service (WPS) is requesting the assistance of the Provider Community in identifying ways to reduce the top four telephone inquire categories received by the Medicare Provider Customer Service Representatives (CSR's). WPS has inquired as to the reasons why a provider may need this type of information to aid in the development of educational materials to better service the provider community.</li> <li>• Patient eligibility inquiries continue to be one of the top reasons for telephone reviews. Providers are encouraged to test for HIPAA transactions 270/271 v4010x092A1 which will enable the provider to receive patient eligibility information electronically, saving valuable time.</li> <li>• CSR's report that a large volume of their calls are to request claim status. Medicare cannot provide that information and therefore must instruct the caller to utilize the Interactive Voice Response (IVR) system. WPS is currently testing with submitters HIPAA transactions 276/277 which will provide claim status electronically.</li> <li>• The third category of high volume provider telephone inquires received is to obtain the Provider Summary status. Providers are also encouraged to test HIPAA transactions 270/271 to receive this information electronically.</li> </ul>	Members are contacting their programmers, vendors and clearinghouses to encourage system enhancements be implemented that will transmit this type of information.

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	<ul style="list-style-type: none"> <li>• Medical Review Probe Findings</li> </ul> <p>In August 2002, WPS Medicare Part B received a report from the Statistical Analysis Center regarding a review of Physical and Occupational Therapy services identifying 97 providers who had provided Physical and Occupational Therapy without the beneficiary having seen the physician within 30 days of the treatment.</p>	

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4. Education	<ul style="list-style-type: none"> <li>• Medicare Provider Education Open House</li> </ul> <p>WPS would like to extend an invitation for you to attend this all day event. Providers, Medical Society members, and Association members from all four states are encouraged to come and spend a few hours or the whole day with us (lunch is on your own). Highlights of the Open House include a presentation by Kenneth Bussan, MD regarding correct billing of E&amp;M services, a live demonstration of the WPS web site and other CMS web sites, and the opportunity for you to have a one-on-one meeting with a member of our staff to resolve any issues you have been struggling with. Sign up quickly as space is limited. We look forward to meeting you!</p> <ul style="list-style-type: none"> <li>• Upcoming Seminars</li> </ul> <ol style="list-style-type: none"> <li>1. Please look for upcoming seminar schedule and registration process, now available on the following WPS web-site:  <a href="http://www.wpsic.com/medicare/provider/proved_seminar.shtml">www.wpsic.com/medicare/provider/proved_seminar.shtml</a> </li> </ol>	

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4. Education	<ul style="list-style-type: none"> <li>• Physical Therapy</li> </ul> <p>There has been a lot of information published recently on the implementation of the financial limitation on outpatient rehabilitation services. Generally speaking, the limitation will limit the amount of reimbursement Medicare can make for outpatient rehabilitation services. There are two separate limits: for 2003 - \$1590 in Medicare approved amounts for Occupational therapy and \$1590 in Physical therapy (including speech pathology.) This limitation was to take effect for services dated July 1, 2003 and after. The limitation was delayed until after September 1, 2003. The limits would be yearly limits. Service provided on an outpatient basis directly or under arrangement with the hospital would not be subject to this limitation.</p> <p>There are modifiers that providers should use when billing for services provided under a therapy plan of care.</p> <p>GN - Services delivered under an outpatient speech-language plan of care</p> <p>GO - Services delivered under an outpatient occupational therapy plan of care</p> <p>GP - Services delivered under a physical therapy plan of care</p> <p>Claims from physicians (all specialties) and non-physician practitioners, including specialty codes "50", "89" and "97" do not have to contain modifiers for the codes reflected in the publications with a "+" sign. All other services under this limitation would need the modifiers.</p> <p>We published the listing of codes with the "+" sign in the March 2003 Communiqué. Providers have been having difficulty understanding this concept. Physician specialties have billed codes without the appropriate modifiers when required and the services have been denied.</p>	

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<p>4. Education</p>	<ul style="list-style-type: none"><li>• Physical Therapy-(continued) The July 2003 publication indicated that all specialties performing these services should be using the modifiers. Medicare published information in the August 2003 Communiqué to indicate that the application of the limits would begin September 1, 2003. However, the modifiers, when appropriate, would still be required on all services dated July 1, 2003 and after.  Medicare has recently received another Program Memorandum on this issue dated August 22, 2003 (copy attached.) This gives a complete listing of the codes with the "+" sign. Again, these codes, if billed by a physician specialty and the service is not under a rehabilitation plan of care, then the modifiers are not required. The original publication in March 2003 included procedure code 29580, application of an Unna boot. The original publication did not include the "+" sign meaning that the modifiers should be submitted. Providers were not submitting the modifiers and claims were denying. We have published this information again in the July 2003 publication and the code does not require the modifiers. Medicare has performed a mass adjustment on this code.</li></ul>	
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