

Provider Communication Advisory Committee Minutes (PCOM)

1:30pm – 3:30pm

June 17, 2003

Bloomington, Minnesota

MEMBERS: HealthPartners, MN Department of Human Services, Rapid Return Medical Billing, Mankato Clinic, CentraCare Clinic, Park Nicollett, MN Medical Association, Mayo Clinic, North Clinic, Aspen Medical Group, University of MN Physicians, Stratis Health, St Mary’s Duluth Clinic, MN Chapter American Physical Therapy Association

Agenda Item	Discussion	Outcome/Action
1. Welcome and Introduction	Rita welcome those present and asked that everyone introduce themselves.	
Review of Minutes from March 18, 2003 meeting.	<p>Rita updated the members on action items from the last meeting:</p> <p>Q: Where information was obtained for claims submission errors and how accurate it is. A: This question will be answered in the Data Analysis portion of the agenda.</p> <p>Q: Current HIPAA regulations state that signatures are not required when releasing information for treatment, payment, or organization. A: This is correct. The information shared with us or with one another does not require a signature.</p> <p>Q: Claims are being submitted with zero in the charge allowed field. Rita had questioned what this meant. A: Claims supervisor stated that providers are sending in claims with zero in the charge field. Our system will delete these charges. Rita asked members why they would submit bills with zero in the allowance field?</p>	

	<p>Member stated that their system is using a dummy code that indicates a no-charge, but it is not suppose to come onto claims. She will check to see if these are being sent in error.</p> <p>Q: What type of documentation requirement is there for claims. A: This issue is still under discussion. However, when documentation is required on an electronic claim, providers should put “additional information available” in the comment field of the electronic claim. A system generated letter will be sent to the provider asking for additional information. When a provider receives this letter, they should submit documentation, op report, op notes with the letter. In addition, this procedure should also be followed when submitting a 22 modifier. In the past our office would hold a claim with a 22 modifier for 5 days waiting for the documentation. This will no longer occur. The procedure stated above should be followed.</p> <p>Rita stated that at the last meeting someone stated that they were going to send her an email regarding E&M services, documentation and procedures. She has not received the email and is unsure who was going to send it. If you would like to speak with Rita regarding this issue, please see her after the meeting or email her with your question.</p>	<p>Member will check to see if claims system is sending in error</p>
<p>3. Listserv</p>	<p>Rita reminded members that if you have not signed up for the Listserv, you should do this through the WPS website. Updated information, such as, HIPAA will be given on the Listserv.</p>	
<p>4. Transition of Benefit Integrity workload to Trust Solutions</p>	<p>Rita introduced Linda Mann, PSC Fraud Information Specialist with Trust Solutions. Handouts provided.</p> <p>Linda Mann stated that Trust Solutions is a Medicare Program Safeguard Contractor (PSC). Trust Solutions is contracted by CMS to perform Medicare safeguards. They are currently contracted by CMS to perform Benefit Integrity for Home Health and Hospice claims. As of July 1 the Medicare Part B Benefit Integrity will be transitioned from WPS to Trust Solutions. All Carriers and Intermediaries throughout the United States that currently handle Benefit Integrity workload, specifically Fraud and Abuse, will be transitioned to PSC’s as of July 1. It is important for providers to be aware that if they receive requests from Trust Solutions for records, that they must comply as they have in the past for WPS. If you have questions or would like to verify these letters, please use the contact list provided.</p>	

	<p>Trust Solutions will focus on situations of intent and knowledge to defraud the Medicare program for both Medicare Part A and Medicare Part B for the state of MN. Trust Solutions website is trustsolutionsllc.com. There is a specific page on the website for providers on Fraud Awareness, Fraud Prevention as well as information on the transition.</p> <p>Q: Will the letters from Trust Solutions be sent to the central office at a Clinic or would it be sent to someone's attention? This is a Frustrating issue for most providers especially those with large Offices. The correct department does not always receive the letters.</p> <p>A: Trust Solutions is currently working with WPS to obtain a list of Contact names. If however, a letter is not received by the correct unit in a timely fashion, please contact Trust Solutions. Rita commented that CMS has requirements to where carriers can send letters.</p>	
<p>5. Updates</p>	<p>A. Beneficiary Outreach - CMS has reinstated some funding for Beneficiary Outreach that is prioritized toward activities that reach Medicare beneficiaries that are impacted by language, location, literacy or culture.</p> <p>B. July Fee Schedule – On May 1 WPS's system was updated to price January and February dates of service at the correct 2002 fee. Automatic adjustments will still be done on July 1 for claims processed between March 1 and May 1. Please be aware that there will be some overpayments from this. The details on how these will be done have not been completed at this point. Providers should receive 1 refund letters for the total amount and will be based on the group numbers. Updates will be in the Communiqué and the Listserv when they become available.</p> <p>Q: As it stands today it would come under 1 group number, would it list the beneficiaries involved.</p> <p>A: This detail has not been decided.</p> <p>Q: Will this go to the main office address.</p> <p>A: Rita stated that it probably would go to the practice address as this is a CMS directive.</p>	<p>Members should forward any suggestions they have for groups that would benefits from this outreach to committee chairperson.</p> <p>Members should continue to watch for updates in the Communiqué and the Listserv.</p>

Q: Would this occur July 1? First week in July?

A: Rita stated they are currently working on all of these details.

C. HIPAA –

Rita stated that 88% of the electronic submitters in all 4 states have not begun testing. WPS is asking providers for their assistance in reaching all providers to begin testing immediately. Rita provided handouts of the HIPAA brochures for all members. There is free HIPAA training available through CMS (handout was given).

Q: Is the 88% true for MN?

A: Rita stated the 88% is from the 4 states area.

Q: Many providers may feel that they do not have to test because they use a Clearinghouse or WPS's software. In those cases they wouldn't have to test would they?

A: Rita stated that it's the provider's responsibility to insure that testing is completed.

Q: What about the situations where submission of a paper claim is required with an invoice attached. Has a determination been made?

A: No determination has been made.

D. Medical Review –

Medical Review requests that providers submit documentation when requested by Dyncorp (AdvancedMed) for the CERT program. Dyncorp is an independent contractor who is responsible for doing random sampling of the claims by carriers nation wide. Dyncorp has their own Medical Staff that reviews claims to be sure that contractors have made decisions that are accurate and based on sound medical policy. If Dyncorp does not receive the information that is requested and claim does not support medical necessity, it would be determined that the claim should not have been paid and an overpayment letter will be sent.

Q: Does the letter state they are a CMS contractor?

A: It does state in the body of the letter that they are a CMS contractor.

Members should continue to check the Communiqué and Listserv.

	<p>Q: Has anyone ever worked with CMS regarding the concern of where the letters are sent?</p> <p>A: Rita suggested that providers go to the CMS website and voice their concerns regarding this issue. If you have any questions or concerns regarding the CERT program, there is an article in the September 2002 Communiqué. Janet Silversmith, MN Medical Association, stated that Medical Associations from Region 5 meet twice a year with CMS at the regional level and they bring in national staff depending on the topics. They have a meeting scheduled in August and she will bring this issue to their attention.</p> <p>E. Financial – There is a workgroup who are presently reviewing WPS’s overpayments and refund process. The workgroup is working on clarifying the language in the overpayment letters. Accounting staff is seeing several letters from providers that do not contain the needed information, why are you refunding? Who are you refunding for – Beneficiaries name and HIC number not included? There are system limitations and staff can only work one beneficiary per check per day. If a check is received for more than one beneficiary, refunds for each individual beneficiary must be handled one at a time and by one department at a time. This creates delays. WPS is asking that provider’s send separate refunds for each individual beneficiary and provider, separate MSP refunds.</p> <p>Q: Why is it a provider sends in a refund on an overpayment request on time, but the Financial Department does not process this check and the overpayment is offset? Then the provider has to wait for a refund of the offset amount. Sometimes its easier to ignore the overpayment letter and let it offset.</p> <p>A: One of the reasons this is occurring is that the overpayment letters are not being returned with the checks or the overpayment refunds are added to voluntary refunds and are therefore not identified as overpayment refunds until the check is worked. It was suggested that providers send in overpayment refunds on a separate check and include a copy of the overpayment letter with it to identify it as an overpayment refund. Please send concerns and suggestions to Rita.</p>	<p>Janet Silversmith will bring this issue to the attention of CMS at the Region 5 meeting in August.</p> <p>Providers should send in overpayment refunds on a separate check and include a copy of the overpayment letter with it to identify it as an overpayment refund.</p> <p>Members should send concerns and comments to the committee chairperson.</p>
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	<p>Q: Is the refund request done by group number or by provider number. A: Rita will check into this</p>	<p>Committee chairperson will research this issue and provide an answer at the next meeting.</p>
<p>6. Data Analysis</p>	<p>A. Claims Submission Errors – The number one claim submission error for this quarter was the provider/billing number. Providers are entering the group number, and either an individual provider number is not indicated or the individual member indicated does not belong to the group. There has been significant increase in the volume of errors since transition. In some instances the providers have changed their specialty and the billers continue to use their old provider number. Rita recommended that members discuss this with the staff submitting the claims.</p> <p>Q: Member stated that there is also an issue with conflicting messages given by the EDI department and the Provider Enrollment department regarding what the correct numbers are.</p> <p>Q: How long does it take to get a new provider number from the Provider Enrollment number? Their experience is that it is taking 3-4 months. A: Rita was unfamiliar with the length of the process.</p> <p>B. High Volume of Telephone calls. The highest volume of telephone calls being received were regarding beneficiary eligibility and provider status. A detailed explanation was given out as a handout. Handouts gave examples, information and questions that providers ask staff to reduce the number of calls.</p> <p>Q: Is there anything that can be given to beneficiaries to explain eligibility? A: Rita stated that CMS has list of questions under the MSP section that can be asked of the beneficiaries to determine who is primary and who is secondary.</p>	<p>Rita will discuss this issue with both departments to resolve the issue.</p> <p>Rita will follow-up with the Provider Enrollment Department and provide an Answer at the next meeting.</p> <p>Members will review handouts and information given with their staff and provide Chairperson feedback and suggestions on how to educate in these areas to reduce claim submission error and calls.</p> <p>Members should check the CMS website and they can requests brochures from Rita.</p>

Q: Member stated that beneficiaries will tell them that they have spoken with Medicare and corrected their records, but when the provider bills the records are incorrect. What can be done?
A: Rita stated that Medicare records are set up by the COB unit and the Provider should have the beneficiaries contact the COB unit directly to have their records corrected.

C. Appeals –
Discussion of why initial claim denial are reversed at appeal level. The main reason: Lack of documentation showing Medical Necessity.

Rita stated that Providers should be sure to use the correct Medigap information and number on the 1500 forms.

Q: Member asked how the Medigap process work?
A: Rita explained the Medigap and Crossover processes.

D. New Provider Monitoring –
New provider monitoring report and comparison was shared with the members.

Within the first 3 months after obtaining a provider number a baseline is established for a new provider. The number of denied lines is divided by the number of lines billed to get baseline percent. If baseline is higher than provider's peers (same specialty), provider is educated on issue causing denial.

Q: Member asked if the facilities could be notified as well as the new providers with educational issues that Medicare has found. This would enable the facilities to monitor the educational results.
A: Rita will research this issue

E. Unprocessable denials –
Are providers reviewing denials? Is the staff reviewing denials communicating with staff billing regarding unprocessable denials?

Providers should share this information with internal staff as well as outside meetings and report their efforts to the Chairperson via email.

Member will contact Rita if she Has a further question.

Members should give chairperson suggestions on what to include on the website for new providers.

Rita will research this issue and Bring report at the next Meeting.

Members will discuss with internal staff and give feedback to chairperson regarding ways to educate staff to decrease these denials.

	<p>F. Remark Codes – Discussion on CMS’ sponsored National Workgroup who is working on concerns/changes to the remark codes and ANSI messages found on the Explanations of Benefits.</p> <p>Q: Can the remark codes be moved next to the denial code? A: Member stated that this is a HIPAA compliance and cannot be moved. Remark codes must come secondary.</p>	<p>Members should email chairperson with examples of the most confusing messages.</p> <p>Member should email this as a suggestion to the chairperson to be discussed by the workgroup.</p>
<p>7. Education</p>	<p>A. Upcoming Seminars Members received a schedule of the Summer workshops and an outline of future 2003 update seminars.</p> <p>B. Beyond the Basic Workbook Rita asked for 3 volunteers to review “Beyond the Basic Workload” handbook and give suggestions and feedback.</p> <p>C. Frequently Asked Questions – Rita asked for input on frequently asked questions in their facilities. These questions and the answers are put on the WPS website.</p> <p>D. Medicare Learning Network Satellite Broadcast – WPS does not have the capability. WPS would like to share the resources of this process. None of the members were familiar with this process.</p>	<p>Members should email Chairperson with suggestions/feedback regarding educational programs.</p> <p>Volunteers will email chairperson with suggestions/feedback regarding handbook.</p> <p>Members will email chairperson with frequently asked questions in their facilities.</p>
<p>8. Feedback</p>	<p>The main focus of the PCOM meeting for providers and the carrier is to assist each other in the creation of provider education strategies. Feedback/suggestion forms were given to members to use to give the carrier suggestions/feedback on topics for PCOM meetings. CMS does not want duplication on educational efforts. Rita suggested that providers look at the website/newsletters. If they feel information is missing or needs to be changed, please email suggestions to Rita.</p>	<p>Member will email chairperson with suggestions/feedback on educational issues.</p>
<p>9. Next Meeting</p>	<p>September 16, 2003</p>	