

# Provider Communication Advisory Committee Minutes (PCOM)

1:30pm - 3:30pm  
Tuesday, June 14, 2005  
Bloomington, Minnesota

Agenda Item	Discussion	Outcome/Action		
I. Welcome	<p>Members were welcomed and asked to update their information as needed on the Members' List.</p> <p>Rita discussed the PCOM charter. She stated that the purpose of the PCOM Advisory Group meeting is:</p> <ul style="list-style-type: none"> <li>• Assist the carrier in the creation, implementation and review of provider education strategies and efforts.</li> </ul> <p>The carrier will use the PCOM Advisory Group to provide updates and facilitate discussion on current issues.</p>			
II. Review of Minutes – March 15, 2005 Action items/Responses	<p>Minutes from March 15, 2005 meeting were approved.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b>Action Item:</b> Members were asked to submit suggestions for future topics for ACT (Ask-The-Contractor) teleconferences.</p> <p>Members were asked to submit suggestions on how to deliver training to small providers.</p> </td> <td style="width: 50%; vertical-align: top;"> <p><b>Response:</b> No suggestions were received. This will remain an open item and members were encouraged to submit suggestions to Rita.</p> <p>No suggestions were received so this will remain an open item. Members were encouraged to submit suggestions to Rita.</p> </td> </tr> </table>	<p><b>Action Item:</b> Members were asked to submit suggestions for future topics for ACT (Ask-The-Contractor) teleconferences.</p> <p>Members were asked to submit suggestions on how to deliver training to small providers.</p>	<p><b>Response:</b> No suggestions were received. This will remain an open item and members were encouraged to submit suggestions to Rita.</p> <p>No suggestions were received so this will remain an open item. Members were encouraged to submit suggestions to Rita.</p>	<p>Members should email their suggestions to Rita on future topics for ACT teleconference</p> <p>Members should email their suggestions to Rita on how to deliver training to small providers.</p>
<p><b>Action Item:</b> Members were asked to submit suggestions for future topics for ACT (Ask-The-Contractor) teleconferences.</p> <p>Members were asked to submit suggestions on how to deliver training to small providers.</p>	<p><b>Response:</b> No suggestions were received. This will remain an open item and members were encouraged to submit suggestions to Rita.</p> <p>No suggestions were received so this will remain an open item. Members were encouraged to submit suggestions to Rita.</p>			

	<p>Members were asked to submit examples of denials they are receiving for modifiers 76, 91 and 25.</p> <p>Members were asked to submit examples of ICNs with remark codes that do not provide enough information to resolve the issue of why the claim was denied.</p> <p>Member had asked if the HPSA Shortage area's will be listed in the Communiqué.</p> <p>Members had asked where to find the new fee schedules for the G0008, G0009 and G0010.</p> <p><b>Q:</b> Member asked for the website of the Medicare Fee Schedule?  <b>A:</b> The Physician Fee Schedule Relative Value File (MFSDB) can be found on <a href="http://www.cms.hhs.gov/providers/pufdownload/default.asp#rvu">www.cms.hhs.gov/providers/pufdownload/default.asp#rvu</a>.</p>	<p>No suggestions were received so this will remain an open item. Members were encouraged to email examples to Rita.</p> <p>Only one example was received so this will remain open item. Members were asked to send examples to Rita.</p> <p>Yes, HPSA's shortage area changes will be listed in the Communiqué.</p> <p>These codes are excluded from the MFSDB. Allowance for G0008/G0009 can be found in the May 2005 issue of the Communiqué, page 167. G0010 allowance can be found CR2530.</p>	<p>Members were asked to email examples of denials of modifiers 76, 91 and 25 to Rita.</p> <p>Members were asked to send examples to Rita of remark codes that give insufficient information.</p>
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<p>III. Beneficiary Education</p>	<p>A. Prescription Drug Plan (Medicare Part D) Update.  The main focus of beneficiary education for CMS and WPS at this time is the Prescription Drug Plan (Medicare Part D). CMS feels that approximately 70% of beneficiaries will ask providers questions on the drug coverage. The program begins in January 2006, with initial enrollment through May 2006. Medicare Part D is a voluntary plan for beneficiaries (with the exception of beneficiaries who are on Medicaid). However, beneficiaries who chose not to enroll with Medicare during the initial enrollment will be assessed a 1% increase in their premiums. Credible coverage is drug coverage through current employment plan, a retirement plan, or other insurance. Health care plans that are offering beneficiary’s drug plans will be sending a letter letting them know if their drug plan is considered a “credible plan”. Social Security will be sending applications to low income beneficiaries this month. Providers can order posters on the CMS website, (<a href="http://www.cms.hhs.gov/medlearn/drugcoverage.asp">www.cms.hhs.gov/medlearn/drugcoverage.asp</a>) that will have the numbers and websites for beneficiaries to use if they have questions regarding the new drug program.</p> <p>Q: Member questioned if beneficiaries could have primary and secondary coverage for drugs as they do with health coverage.  A: No beneficiaries will only have one drug plan.</p> <p>B. “Call-To-Action” Advisory Group -  MN has an advisory group, Call-To-Action, which consists of the MN Board of Aging, Social Security, Department of Commerce, Medicare Part A and B, MN Health Plans, AARP, and SHIPS. This advisory group works together to provide the same information to Medicare beneficiaries and providers. They created a “tool kit” that providers can reproduce as needed for use in their office. Each member present received a tool kit.</p>	
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<p>IV. Provider Education</p>	<p>A. ListServ -  Carriers must have 25% of providers signed up for ListServ by September 2005. Providers can sign up as many of their staff as they choose through the WPS website. Members were encouraged to send any of their suggestions for enhancements or comments regarding the ListServ to Molly Tull (<a href="mailto:molly.tull@wpsic.com">molly.tull@wpsic.com</a>).</p> <p>B. New website for WPS Medicare Part B - <a href="http://www.wpsmedicare.com">www.wpsmedicare.com</a>.</p> <p>C. Small Provider Education  WPS is looking for suggestions of training sessions for small providers (providers consisting of less than 25 employees) and ways to provide the training sessions. Members were encouraged to send suggestions for training sessions and how to provide the training sessions to small providers.</p> <p>D. “A Day with Medicare &amp; Partners” in Michigan -  There were over 350 attendees at the MI “A Day with Medicare &amp; Partners”. Among the speakers were representatives from CMS and Dr. Rosenberg, the WPS Carrier Medical Director for MI. The next “A Day with Medicare &amp; Partners” will be held this fall in Wisconsin. Members were asked to email Rita with their suggestions for sessions at the WI “A Day with Medicare &amp; Partners” and the future MN day.</p> <p>E. ILINK  WPS is in the process of setting up computer based training, ILINK, which similar to WEB-EX and allows participants to conference in by phone and at the same time follow a power point presentation on their computer. Participants will need access to a phone and the internet to participate in ILINK presentations. Further information will be available on the WPS website shortly.</p>	<p>Members should email their suggestions for enhancements or comments regarding the ListServ to Molly Tull.</p> <p>Members should email Rita with suggestions for training sessions for small providers and how to provide this training.</p> <p>Members should email Rita with suggestions for upcoming “A Day with Medicare &amp; Partners” seminars.</p> <p>Members should watch the WPS website for information on upcoming ILINK presentations.</p>
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F. CMS conference with Carriers -

In a recent conference with Carriers, CMS stated that their current beneficiary educational focus is the Medicare Part D Prescription Drug Program. Provider Education focus will be

- Reducing the CERT error rate
- National Provider Identification (NPI)
- 2006 seminars - CMS will be allowing WPS to charge for seminars in 2006. It is unclear as to what the charge will be at this time.

Members commented that charging for seminars may reduce the number of small providers that will be attending and larger providers may have difficulty getting approval to attend seminars from management before the sessions are filled.

Q: Member questioned if the size of seminars would be increased to allow more participants.

A: Carriers have found it difficult to procure larger spacing for seminars because most facilities require a minimum food/beverage purchase with the rental of their space.

G. General Medicare Index -

The General Medicare manual is intended as an educational guide for providers on general Medicare information. Members were given the index and asked to give suggestions for changes to the manual. This manual will be available on the WPS website and at seminars.

H. Practical Solutions Index -

The Practical Solutions manual is intended as an educational guide for providers on solutions to problems. Members were given the index from the Practical Solutions manual and were asked to give suggestions as to what they would like to see added, removed or changed. This manual will be available on the WPS website and at seminars.

	<p>Members suggested the following information should be added to General Medicare manual:</p> <ul style="list-style-type: none"> <li>• Provider Enrollment process</li> <li>• Definition of non-par and par providers</li> <li>• Guidelines for SNF and Home Health</li> <li>• EDI information</li> <li>• Comparison of the 1500 form sections with the electronic sections</li> <li>• Pre-pass edit information</li> </ul>	<p>Members should email Rita with suggested changes for either manual.</p>
<p>V. Round Robin</p>	<p>A. Determine why high volume of “duplicate denials” is occurring. Duplicate denials represent about 6% of the claims processed and have continued to increase over the past months. Duplicate denials are costly and time consuming for carriers and providers. Currently WPS is calling the top providers on the duplicate denials list to determine why they are submitting duplicate claims. Members were asked to investigate in their offices why duplicate claims are submitted.</p> <p>Q: Member stated that when they receive denials either unprocessable denials or other denials where the provider adds a modifier and resubmits the claim on one line of a multiple line claim their system does not allow them to resubmit just the line that was denied so they resubmit the entire claim. They questioned if this could be a reason for duplicate denials.</p> <p>A: This could account for some of the duplicate denials.</p> <p>B. ANSI/Remark codes where providers feel they are not receiving enough information to access why claims are being denied. Rita stated that this has been an on-going issue for providers, but she has not received any examples from the members to investigate. In many cases providers are not looking at both the reason code and the remark code. CMS has a new book on their website, Understanding the Remit Advise, to help providers understand claims adjustment and reason codes, and information on how to request changes to codes. There is a committee that meets in February, June and October to discuss change requests.</p>	<p>Members were asked to investigate in their offices why duplicate claims are submitted and discuss at the September meeting.</p> <p>Members should email examples of ANSI/ Remark codes that do not contain enough information to determine why a claim was denied for Rita to review and for discussion at the September meeting.</p>

	<p>Q: Member questioned what can be done with electronic remits that are cutoff and cannot be read. This issue is causing them to call Customer Service for the information that does not appear on their screens.</p> <p>A: Members should contact their software vendor and ask for assistance with this issue.</p> <p>Q: Member questioned how to determine what remark codes go with which line item.</p> <p>A: Rita asked for examples of what they are looking at. This will be a discussion for the September meeting.</p> <p>The goal for the September PCOM meeting is to work on both of these issues to find solutions.</p>	<p>Members should contact their software vendor for assistance with how their remits are appearing on their screens.</p> <p>Members should email examples of their questions on how to determine which remark code applies to which line.</p>
<p>VI. Updates</p>	<p>A. CR 3822 - Transmittal 547 - revision to the Health Shortage Area (HPSA) and Physician Scarcity Area (PSA). Copy of Change Request was given to members, effective 10/01/05 WPS Medicare will allow the bonus payment when the claim is submitted as global. It also states that providers can determine if they do not want to receive the bonus payment they should notify their carrier.</p> <p>B. MM3648 - Therapy Services  Effective June 6, 2005, a signed certificate is still required, but is not needed before billing. PHYSMED-001 has been removed from the WPS website and it stated that it is under revision and gives referrals to look at for changes.</p> <p>Q: Member stated that office visits are no longer required, so is it required to list the last date the beneficiary was seen.</p> <p>A: Rita asked member to email the question to her. She will research it.</p> <p>Q: Member questioned if providers could use a physicians referral as a signed certificate. They have had difficulties getting physicians to sign and return their certifications.</p> <p>A: Rita asked member to email the question to her. She will research it.</p>	<p>Members should email their questions to Rita to research.</p>

	<p>C. MM3843 = Continuous Positive Airway Pressure (CPAP) This is to notify the providers that the benefit has not been changed.</p> <p>D. MM3729 - Clarification on hospital and independent lab billing. Independent labs and hospital reference labs are no longer required to obtain the Medicare Secondary Payer information for beneficiaries. There is an article on pages 15 and 16 in the April Communiqué that discusses this issue.</p> <p>E. SE0516 - Modifier Edits for matching data to beneficiary records. CMS requires submitted claims beneficiary information must be a complete match what is on the Medicare beneficiaries Health Insurance Medicare Card.</p> <p>F. In addition members received informational handouts on the following:</p> <ul style="list-style-type: none"> <li>▪ MM3818 - Revised Coding Guidelines for Drug Administration Codes</li> <li>▪ MM3797 - Updated requirements for Autologous Stem Cell Transplantation (AuSCT) for Amyloidosis.</li> </ul>	
<p>VII. New Appeals Form</p>	<p>Rita distributed a new CMS Appeals form, 20027. The new form is also available on the CMS website.</p> <p>Q: Member asked for information on new appeals process. A: Effective October 1, 2004, all first level of appeals will be called Predeterminations. This includes appeals formally called reviews and reconsiderations. Contractors must complete all Redetermination with 60 days. Providers are notified of the Redetermination decision with the Medicare Redetermination Notice (MRN).</p> <p>The last step in the Carrier appeals process, the fair hearing level will be changed to Reconsideration as of January 1, 2006. These appeals will be rendered by a Qualified Independent Contractor (QIC).</p>	

	Information can be found in the Medicare Claims processing Manual Pub.100-04, Change Request 2620, Transmittal 97 and Medlearn Matters MM2620. Watch the WPS and CMS websites as well as the Communiqué for more information in the process as it becomes available.	
<b>Next PCOM Meeting</b>	<b>The next PCOM meeting is scheduled for September 20, 2005</b>	