

Provider Communication Advisory Committee Minutes (PCOM)

1:30pm – 3:30pm
Tuesday, June 15, 2004
Bloomington, Minnesota

Agenda Item	Discussion	Outcome/Action		
1. Welcome and Introduction	<ul style="list-style-type: none"> Rita welcomed members and asked members to introduce themselves. 			
2. Review of Minutes – March 16, 2004	<ul style="list-style-type: none"> Minutes from the March 16, 2004 meeting were approved. Action Items from March 16, 2004 meeting: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>ACTION: Provider had requested that WPS consider adding a description to the CPT codes listed in all policies.</p> </td> <td style="width: 50%; vertical-align: top;"> <p>ANSWER: Unfortunately adding descriptions makes the policy too long in length, impacting negatively the usefulness of the policy.</p> </td> </tr> </table> 	<p>ACTION: Provider had requested that WPS consider adding a description to the CPT codes listed in all policies.</p>	<p>ANSWER: Unfortunately adding descriptions makes the policy too long in length, impacting negatively the usefulness of the policy.</p>	
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3. Updates	<p>A. Customer Service – As of June 2, 2004 the IVR and Customer Service phone number has been split into 2 phone numbers. The IVR number will remain the same, the new Customer Service number is 866-359-1598. This should allow better access to the IVR and to the Customer Service staff as well as extended time with each. There is no longer an option to be transferred from one number to the next.</p> <p>Rita provided members with an attachment of the Provider Medicare numbers. MN phone hours have changed to 7am – 5pm.</p> <p>Rita updated members that with the Medicare Modernization Act of 2003, all carriers are required to replace their beneficiary phone numbers to the national 1-800-MEDICARE phone number. CMS intent is to migrate all Medicare carriers to the 1-800-MEDICARE in June or July of 2004; however, beneficiaries will not be notified until August to ensure all lines have been transferred. If beneficiaries have concerns regarding a specific claim or questions for the carrier, they will be transferred to the Customer Service staff.</p>			

B. Policy –

Members received an attachment regarding Local Carrier Decisions (LCDs). The existing Local Medical Review Policy (LMRP) will be converted to LCD.

Members were reminded that any coding instructions or reasons for denial would be on a companion document. If a companion document is required, it will be listed in the Notes section of the LCD. It is important to review both the LCD and the companion documents. The Notes section will also contain an explanation of what an asterisk means and what the italicized language means.

Q: How do providers handle codes that denied sporadically where no policy is found?

A: Bonnie stated that providers can go through the reconsideration process if they would like a code added to a policy.

Q: Are there codes that can be paid or denied, that are not connected to a LCD?

A: Yes. Codes can be denied or paid that are not based on a LCD.

Q: How do providers determine if a code is related to a policy?

A: Bonnie stated that by entering the ICD-9 code or CPT code into the Policy Index, the system will show policies that code is associated with.

Q: How do providers handle situations where the code was not associated with a policy?

A: Bonnie stated those situations would need to be looked at on an individual basis.

C. Medical Review

Rita reminded members that it is important to respond to requests for documentation for CERT and provided members with instructions on how to submit records for CERT.

Rita gave members a copy of the E/M probe results from 99213. This information is also available in the June Communiqué.

	<p>D. HIPAA</p> <p>Rita reminded members that there is a modification to the contingency plan. The contingency plan remains in effect. However, as of July 1, any non-compliant claims that are received will be paid under the paper payment floor instead of the electronic payment floor and encouraged members to make sure they were compliant. Rita stated that providers whose systems automatically resubmit claims when they have not receive a response in 14 days from Medicare, should eliminate this from their system. Because of the high volume of duplicate claims that are received, there could be a time when providers would be charged for duplicates.</p> <p>Q: Who can providers contact regarding electronic submission of MSP claims? A: Rita stated that articles have been published in the Communiqué, information is available on the website on how to submit MSP claims, or members can contact the EDI department with questions.</p>	
<p>4. One Time Notification</p>	<p>Incident-To-Services</p> <p>Rita stated that changes have been made to the Incident-To billing as of May 24, 2004. Providers are now required to bill Incident-To services under the supervising physician and paper submitters must also list the attending physician in Item 17 on the 1500 CMS Claim Form. CMS is currently working on the manualized instructions for electronic claims, but providers are required to bill services under the supervising physician. There is an article, MM3138, on MedLearn Matters.</p> <p>Q: What is the definition of Supervising physician and Attending Physician? A: In the context of the "incident-to" provisions, the "attending physician" is the physician who initially sees the patient, establishes the plan of care, and performs subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment. This is also what we have referred to as the ordering physician. The supervising physician is the physician who performed the direct supervising of the auxiliary personnel performing an incident-to service. The supervising physician MAY be the ordering/attending physician, but is not necessarily so.</p>	
<p>5. Beneficiary Education</p>	<ul style="list-style-type: none"> • There are educational materials available for providers who choose to take an active roll in assisting the beneficiaries learn more about the drug card. Training materials and brochures are available from the CMS website. WPS will be conducting seminars for Medicare Part D (Prescription Drug Card) with providers and beneficiaries. 	

<p>6. Provider Education</p>	<p>A. Summer seminars</p> <ul style="list-style-type: none"> ◆ An attachment was sent to PCOM members with all the current scheduled seminars. Outreach is working on the fall schedule and is expanding on their ways of conducting seminars to include more teleconferences, WEBEX seminars, as well as online and web-based training. Members were encouraged to email Rita with their preferences for seminars. <p>WSP will hold an Open House in MN this fall, tentatively scheduled for October. Members were asked to email Rita with suggestions for locations for the Open House and for breakout sessions. She would like to partner with other organizations, such as, Medicare Part A, Stratus Health, and the Health Insurance Counseling.</p> <p>Q: Is there was any way for MN providers to be able to access the PT seminars scheduled in MI?</p> <p>A: Rita stated that she will research this, but informed members that there are seminars scheduled for this fall in MN.</p> <p>B. 2005 Fee Schedule/Disclosure materials</p> <ul style="list-style-type: none"> ◆ CMS is allowing WPS to create a CD-ROM with the 2005 Fee Schedule. Providers are encouraged to email Amanda Bolger with their suggestions for what they would like changed or added from last year. <p>C. E-Mailing list initiative</p> <p>Members are encouraged to signup for the WPS and CMS ListServe. The ListServe offers providers the quickest form of communication with WPS and CMS. CMS is requiring WPS to increase their subscribers by 50%. If providers have concerns, which has stopped them from signing up, they should contact WPS so that their concerns can be addressed.</p>	<p>Members are encouraged to email Rita with what types of seminars they would like to see conducted.</p> <p>Rita asked for members' input on locations and breakout sessions for an upcoming Open House in MN.</p> <p>Rita will research to see if providers from one state would be able to teleconference into seminars in another state.</p>
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<p>7. Data Analysis</p>	<p>A. Most Common Claim submission error/Reason for Appeal</p> <ul style="list-style-type: none"> ◆ Rita stated that one of the top 5 claim submission errors were incorrect/invalid procedure codes. Rita questioned why there was a large increase in incorrect or invalid codes that are being submitted. She suggested providers access the database to see if the procedure code is an active code, deleted code or a Medicare approved code. There is a high volume of incorrect codes, codes that should always be bundled, and not valid for Medicare. Rita reminded members that as of January 2005 there would no longer be a 90-day grace period for codes. <p>Q: Will the published updated coding list be sent out by January 1 for LCDs and companion documents?</p> <p>A: Bonnie stated that codes on LCDs and companion documents are updated as they are received.</p> <p>Members stated that part of the error rate could be due to the current PHYSMED-009 LMRP. Because the policy does not give descriptions for ICD-9 codes the therapist find it difficult to code. Members further stated that many therapists are still billing with the old codes, which are being denied. Members felt that the new codes are more general than the specific codes that Medicare required in the past.</p> <p>Rita questioned if when this policy becomes a LCD, if something more could be done.</p> <p>Bonnie stated that it would not be possible due to the lengthy number of codes.</p> <ul style="list-style-type: none"> ◆ The number 2 top claim submission error was provider facility not being billed in Item 32. There has been a clarification on CR 2631 that informed providers that effective April 1, with the exception of place of service Home, Item 32 must be completed on all paper claims. The electronic version, CR 40101A does not require this be added if position 11 is the same as position 33 on electronic billing. An article was published on this issue in a recent Communiqué. ◆ As of October 1, 2004, there will no longer be a 90-day grace period for invalid diagnosis codes. 	
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	<ul style="list-style-type: none"> ◆ The word Home Bound must be in the documentation field if providers are using an independent lab for EKG tracing or specimen. ◆ Rita stated that MN had the highest unprocessable denials in the 4-state jurisdiction. After some investigation it was determined that some of the reasons for these were: <ul style="list-style-type: none"> ➤ Block 32 ➤ Duplicate denials that state “duplicate of another service on the same claim” ➤ Missing or invalid modifiers and codes <p>Rita requested members question their staff to see if these are occurring in their offices.</p> <p>Q: When using multiple modifiers is there was a required order for modifiers to be listed in?</p> <p>A: Rita stated that pricing modifiers must be listed first. She has noticed providers using the 99 modifier incorrectly. The 99 modifier is only used when there are more than 4 modifiers. Several claims are received with the 99 modifier being used on the line item and in the documentation field only 2 modifiers are listed, which is an incorrect use of modifier 99.</p>	
8. Round Robin	<p>Rita asked members to discuss the number one reasons their facilities call Medicare, the number one reason they send or call for Appeals, and their number one Medicare question/concern.</p> <p>Members offered common reasons their staff Called Medicare:</p> <ul style="list-style-type: none"> ● Insufficient information given on remits to determine why claim denied. Several members stated that insufficient information is given with remark codes, C016 in particular, to identify why the claim is being denied or recouped. Members asked if remark codes could be changed to state specifically why a claim is denied or recouped. <p>Rita and Amanda stated that the remark codes are CMS driven and CMS dictates which remark codes must be used for denials and recoups. Providers should contact Rita with their concerns.</p>	<p>Members should contact Rita with their requests for more specific denial and recoup remarks.</p>

	<ul style="list-style-type: none"> <p>Difficulties obtaining eligibility information, primary/secondary status and whether a beneficiary is in a nursing home</p> <p>Several members stated that they have difficulty obtaining information from SNAP on beneficiary's eligibility, primary/secondary status and whether they live in a nursing home from SNAP. Members also stated that records on a beneficiary's primary/secondary status are not being updated after the beneficiary's have contacted the COB unit.</p> <p>Amanda stated that enhancements for SNAP have been requested; however, information on eligibility, MSP, hospice, nursing home residence, require permission from CMS to access their CWF database, so it is unclear as to when or if these enhancements can be done. She also stated that carrier records on primary/secondary status are only updated after the COB Unit has done so.</p> <p>Why aren't all the reasons a claim is denied listed on remits instead of only the unprocessable denial?</p> <p>Member stated that they receive an unprocessable denial, they correct their error and resubmit the claim, which is denied again for a different reason. Why can't all the reasons for denial be listed on the first remit?</p> <p>Rita reminded members that the MCS system denies the claims with the first error and that providers should re-exam the entire claims before resubmitting.</p> <p>Denials based on beneficiary's address.</p> <p>Members stated that they are receiving a high volume of denials because the beneficiary's address does not match Medicare's address even after family members have contacted the Social Security office to have the address changed.</p> <p>Rita stated that Medicare receives the beneficiary's address from the Social Security office and is unable to change them. She will attempt to have a Social Security representative attend a future PCOM meeting to discuss this issue.</p> 	<p>Rita will contact Social Security to see if a representative can speak at a future PCOM meeting.</p>
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- **Denied claims for Mammograms due to incorrect codes.**
Member stated that they have been using the same Mammogram code for years and have received payment until recently. They emailed this to Contact Us and were told that this was a valid code and should not be denied, but it continues to deny.

Members should send their questions with an example of an ICN to “Contact Us”

Members offered common reasons for appeals:

- **Missing or Incorrect use of Modifiers.**
Members are finding they are requesting appeals because of missing or incorrectly used modifiers. This is an error they are currently working on within their office.

Rita reminded members that WPS has seminars in St Cloud this week on modifiers.
- **Denials due to incorrect edits.**
Member stated that several claims were denied because of incorrect edits from policies.

Bonnie stated there is a committee that is specifically addressing these issues. If you have a specific issue, please email Contact Us on the WPS website.
- **Denials on electronic claims when billing for 2 diagnosis codes.**
Members stated that they are receiving a large volume of denials on electronic claims when a patient is seen for 2 different complaints. Electronic claims do not allow for the linking of a diagnosis to a CPT code so when 2 diagnosis are billed on the same claim, Medicare looks at only the primary diagnosis and denies any codes for the second diagnosis. If they bill these on 2 different claims, the claims are denied for duplicate. Members are then required to call the Medical Review line to have the claims reviewed. However, the Medical Review line can only do 3 claims per call, so providers are required to call numerous times to have all their claims reviewed

Rita stated that she would work with EDI on this issue

Rita will research with EDI and report back.

- **Physical Therapy billing – PHYSMED-009**

Several members billing for physical therapy commented on the difficulties of billing PT services due to the new PHYSMED-009 policy, as it does not contain descriptions for the CPT codes listed. They have also noted that some services are not included, such as gait training for total knee where as gait training for a temporomandibular joint problem is.

Bonnie stated that issues where the procedure is paid for, but under what conditions it is paid for is in questioned, should be emailed to Dr. Brooks for consideration. However, if it is a new procedure that is not on the LMRP, it should go to reconsideration.

- **Numerous requests for documentation that has already been submitted, non-response to some of the submitted appeals.**

Members stated that they are receiving several request to submit documentation that they have already submitted and are not receiving responses on some of their appeals. Some members have been working with Julie to help resolve these issues.

Rita stated that members should email her if they continue to have difficulties.

Members offered their number one question/concern:

- **Obtaining Medicare Number on SNAP**

Member questioned if there is a way to obtain the Medicare number on SNAP if they have the correct Social Security number, but not the ending letter.

Amanda stated that this is on the schedule of enhancements where providers will only need one major element – name, birth date, or Social Security number.

	<ul style="list-style-type: none"> <p>Confusion due to the 30/60-day rule for PT/OT. Member stated that their number one question is on the 30day/60-day rule related to Physical Therapy/Occupational Therapy. Currently the 30-day rectification of a plan of care time frame starts with the doctors' visits, but the next 60-day rectification starts on the first day of therapy. This creates several questions/concerns regarding this issue. The American Physical Therapy Association has written CMS in April requesting clarification, but they were wondering if WPS could assist with this issue.</p> <p>Who do you call with questions on policies? Member asked who to call with questions on interpretation of policies.</p> <p>Amanda instructed members to use Contact Us on the WPS website. This enables WPS to keep a written record of the request and response, which gives WPS credit for their response, but also enables WPS to follow-up with the person if the provider has further questions regarding the response. The systems staff is currently working on an enhancement where providers will receive a copy of their questions back on email.</p> <p>Different responses by Customer Service Reps to the same question. Members expressed their frustration over receiving different answers to the same questions when they contact different Customer Service reps. Members questioned if it would be possible to have a direct rep that they could contact in these situations.</p> <p>Rita suggested that members take the name of the Customer Service rep when calling and ask to speak with a supervisor. Rita was unsure if it would be feasible to give all clinics a rep, but she will discuss this with management. She will bring this issue to the attention of the Customer Service Management.</p> 	<p>Rita will discuss this issue with Customer Service Management.</p>
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