

# Provider Communication Advisory Committee Minutes (PCOM)

1:30pm – 3:30pm

Tuesday, September 16, 2003

Bloomington, Minnesota

| Agenda Item   | Discussion  | Outcome/Action  |  |   |  |
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| Welcome and Introductions   | Sharon Fletcher and Annamarie Pulvermacher, Provider Outreach in the Madison office welcomed members and asked them to introduce themselves.  |   |  |   |  |
| I. Review of minutes and discussion on action items from June 17, 2003  | <p>A. June 17, 2003 minutes approved.</p> <p>B. Sharon updated members on the action items from the last meeting.</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b>Action:</b><br/>Can the address where Advanced Med sends their request be changed? Janet Silversmith, MN Medical Association, will bring this issue to CMS at the Region 5 meeting in August.</p> </td> <td style="width: 5%; border-left: 1px solid black; border-right: 1px solid black;"></td> <td style="width: 45%; vertical-align: top;"> <p><b>Answer:</b><br/>Janet was not present to give update. Sharon stated that Dr. Bussan, CMD in Madison, is also working on this issue.</p> </td> </tr> </table> <p><b>Q:</b> What is the difference between Advanced Med and Trust Solutions?<br/> <b>A:</b> Advanced Med is the entity that requests documentation from Providers for the CERT program. Trust Solutions is the Medicare Program Safeguard Contractor (PSC) which handles Benefit Integrity workload, specifically Fraud and Abuse.</p> <p><b>Q:</b> Should we respond to request for documentation from both entities?<br/> <b>A:</b> Yes</p> <p><b>Q:</b> Does the letter from Advanced Med come with a CMS logo or a Medicare logo?<br/> <b>A:</b> At present they do not. Dr. Bussan is currently working on this issue.</p> <p><b>Q:</b> What provider address is currently used, billing or practice?<br/> <b>A:</b> It is currently going to the practice address not the billing address.</p> | <p><b>Action:</b><br/>Can the address where Advanced Med sends their request be changed? Janet Silversmith, MN Medical Association, will bring this issue to CMS at the Region 5 meeting in August.</p> |  | <p><b>Answer:</b><br/>Janet was not present to give update. Sharon stated that Dr. Bussan, CMD in Madison, is also working on this issue.</p> | Open item to be discussed at the next meeting. |
| <p><b>Action:</b><br/>Can the address where Advanced Med sends their request be changed? Janet Silversmith, MN Medical Association, will bring this issue to CMS at the Region 5 meeting in August.</p> |   | <p><b>Answer:</b><br/>Janet was not present to give update. Sharon stated that Dr. Bussan, CMD in Madison, is also working on this issue.</p>   |  |   |  |

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|  | <p><b>Action:</b><br/>Are refund requests done by group number<br/>Or by the provider number</p> <p>Members having problems with receiving<br/>Conflicting information from the Provider<br/>Enrollment Department and EDI on provider<br/>Numbers.</p> <p>Members questioned if the facilities could be<br/>Notified as well as the physician when there<br/>are educational issues.</p> <p><b>Q:</b> If there are multiple managers, do you work your way to the right one?<br/><b>A:</b> Yes. Annamarie stated that they identify why they are calling and<br/>requests to speak to the involved party.</p> <p><b>Q:</b> At last months meeting, it was discussed the time it takes to get a new<br/>provider number. In some instances it is taking 3-4 months. Is this a WPS<br/>issue or a CMS issue?<br/><b>A:</b> Provider Enrollment is current at this time. Delays may occur in processing<br/>Applications due to errors made by the provider's in filling out applications.<br/>This continues to be an issue in the Provider Enrollment area.</p> <p><b>Q:</b> Why does Provider Enrollment return the application for each individual<br/>error rather than listing all the errors at once?<br/><b>A:</b> CMS requires carriers to stop processing an application and return it to<br/>the providers when an error is discovered.</p> | <p><b>Answer:</b><br/>Provider number</p> <p>Sharon stated that neither<br/>department is aware of this issue.<br/>Members should be contacting<br/>Provider Enrollment with<br/>questions regarding the provider<br/>numbers and EDI with questions<br/>on where to put the numbers<br/>on electronic claims.</p> <p>Annamarie explained the new<br/>provider monitoring process.<br/>She stated that the billing<br/>manager is contacted in the<br/>provider's office and educational<br/>issues are discussed with those<br/>who do the billing.</p> | <p>Rita will investigate<br/>timelines and<br/>guidelines.</p> |
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|  | <p><b>Action:</b><br/>Rita distributed surveys to the members and asked for their input on issues and seminars. No response was received.</p> <p><b>Q:</b> Has WPS considered having an expert available for coding questions?<br/>Customer Service responses can be conflicting and confusing.</p> <p><b>A:</b> Contractors are instructed by CMS not to do coding for providers. Providers are encouraged to utilize their associations for coding questions. Medicare Customer Service is limited to providing guidance on coding as it relates to claim filing issues. This is why their responses can be conflicting and confusing. Customer Service staff are not trained coders.</p> <p><b>Q:</b> What should the response time be for Contact Us?</p> <p><b>A:</b> CMS requires carriers respond within 45 days. WPS is within 14 days in WI. The Marion office handles these questions for MN.</p> <p><b>Q:</b> Why can't CSU answer financial questions? In particular those checks that have a FCN number, but not Medicare numbers. Should these questions be directed to the website instead of calling Customer Service.</p> <p><b>A:</b> Sharon stated that Customer Service should be able to answer provider's questions, with a few exceptions where the assistance of the Financial Department is required. She will investigate this issue.</p> <p><b>Q:</b> Why are providers receiving withholding information on remits that do not include Medicare numbers? The only information included is FCN number, dollar amount, group/clinic that it should be applied to and either no Medicare number or a fictitious Medicare number.</p> <p><b>A:</b> Carriers are required to follow CMS guidelines in regards to what is included on remits. Provider's who need more assistance than Customer Service can provide, should send their questions through Contact Us on the WPS website. All questions should again be placed to Customer Service or the website for tracking purposes.</p> | <p><b>Answer:</b><br/>Sharon requested members email Rita with issues, seminar requests, issues with remark codes, frequently asked questions, etc. Sharon stated that Larinda Power, Madison office, is on a workgroup that is working on updating remark codes.</p> | <p>Rita will send survey to members with minutes.</p> <p>Members are strongly encouraged to sign up for Listserv.</p> <p>Sharon will check the response time for MN.</p> <p>Sharon will investigate situations where Customer Service has been unable to answer financial questions.</p> <p>Sharon will investigate who providers should direct their questions to and if Medicare numbers can be included on all remits.</p> |
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| <p>II. Updates/Discussion Items</p> | <p>A. CD ROM Initiative<br/> This fall the fee schedule will come on CD-ROM instead of paper. Sharon provided members with a handout on what will be included on the CD-ROM. If members have suggestions of what they would like to see on the CD-ROM that is not on the list, please send them to Rita. October 15 is the deadline for creating the CD-ROM.</p> <p><b>Q:</b> Will the Medicare Fee Schedule DataBase be on the CD-ROM?<br/> <b>A:</b> Sharon will submit that as a suggestion. Annamarie stated that they are asking for suggestions for items that do not need to be updated quarterly. CCI edits will not be included, but CMS has them listed on the their website.</p> <p><b>Q:</b> Who will these CD-ROM's be mailed to?<br/> <b>A:</b> They will be mailed to the same place as the paper packets were in the past.</p> <p>B. HIPPA<br/> Sharon reiterated the importance of testing. She also stated that CMS has been working with carriers on a contingency plan come October 16. A decision is expected to be made on the contingency plan on September 25. CMS is on comment time right now for requirements for billing electronically and by paper. Providers who would like to make a comment, can do so on the Federal Registry. WPS doesn't expect the list of things that can come in on paper to be very long.</p> <p><b>Q:</b> In the recent HIPPA seminar that Lisa Cuocci present, she stated that she was writing an article HIPPA documentation requirements for the October Communiqué. Is it possible to have the article on the website prior to October?<br/> <b>A:</b> Sharon stated that the article is in draft form at this time and is being reviewed by other departments for their input. In addition to Lisa's EDI perspective and the choices that providers have to indicate documentation or not, a suggestion was made to include a list of definite situations that documentation is required and a list of situations that documentation is not required. Sharon stated that she will investigate to see if it can be placed on Listserv and the website prior to October.</p> | <p>Sharon will submit the Medicare Fee Schedule Data Base for the CD ROM</p> <p>**Note on 9/22/03 CMS announced implementation of the contingency plan. Providers are still encouraged to test. A temporary delay has been granted. A Listserv message is being sent.</p> |
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|                            | <p>C. Financial Limitation on Physical Therapy.<br/>Sharon stated that there were several articles and program memorandums, which created a lot of confusion on this issue. Providers should check the article dated 09/05/03 on the website, which clearly states what needs a modifier and what does not and who needs to use a modifier.</p> <p>D. Crossover<br/>All of Medicare's crossover partners have tested for October 16 and have past the tests. Sharon states that providers have questioned why sometimes the remit gives the names of the crossover companies and sometimes not. If claims have been crossed over they will show up on the remit regardless of whether the crossover companies name is present or not. Each trading partner signs a contract with WPS and specifies in this contract whether their name appears on the remit.</p> <p><b>Q:</b> Why is it that sometimes the remark code shows a crossover is present on the remit, but nothing is at the bottom or sometimes it states the crossover companies name, but not the remark code and sometimes it states nothing, but they still receive a payment from the crossover company? The majority of this occurs with Blue Cross Blue Shield.</p> <p><b>A:</b> Sharon asked for examples of these situations be faxed to Rita at 952-885-2900 and she will forward them to the manager of the Crossover Department.</p> <p><b>Q:</b> Does Medicare crossover to more than 1 secondary insurance.</p> <p><b>A:</b> Medicare will crossover to what is on the files received from the trading partners. If the beneficiary requests that this not be done, they must contact the crossover companies and requests this. It is important for beneficiaries to note that changes may be made at the crossover company the day of their request, but Medicare's files will not change until the crossover company sends new files to Medicare.</p> | <p>Sharon will see if Lisa Cuocci's article can be placed on the website or on Listserv prior to October.</p> |
| <p>III. Medical Review</p> | <p>A. Physical Therapy<br/>Handout given to members. Medical Review placed an article in the August Communiqué regarding their probe for this service.</p> <p>B. Nail Debridement<br/>Handout given to members. Medical Review placed an article in the September Communiqué regarding their probe for this service.</p>   |   |

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|  | <p><b>Q:</b> In order for Physical Therapy services to be medically necessary, the physician must refer beneficiary to Physical Therapy, the Physical Therapist writes out a plan of care, that plan of care must be signed by the physician and then 30 days later a new plan care needs to be written and signed by the physician and the patient must physically go to see the physician. It is a challenge to get the patient back into see the physician every 30 days. There are physician who do not want to see the patient again or there are patients who are referred by specialty physicians who have a 3-4 month wait for appointments. There is nothing in the Physical Therapy notes that verify the physician saw that patient within the 30-day period. How does Medicare know if the patient is being seen by the physician every 30-days?</p> <p><b>A:</b> Sharon stated that the system would be able to indicate if they were seen by that physician, but she was unsure if Medical Review uses this or requests documentation from the referring physician.</p> <p><b>Q:</b> Does Medicare track the education made to physicians? And who do you notify that this education has been done?</p> <p><b>A:</b> Medicare is tracked on our Provider Tracking System. Only the physician is contacted for education.</p> <p><b>Q:</b> Shouldn't the facilities be notified as well as the physicians when there is a need for education? The facilities could do proactive education for all of their physicians to be sure they are all aware of the issue.</p> <p><b>A:</b> This is a good point. Medicare should consider expanding education to all the physicians within the facility rather than just the one pulled for the probe.</p> <p><b>Q:</b> Who is responsible for doing the education?</p> <p><b>A:</b> The Medical Review staff who does the probe, sends out the letters or makes a call to the physician.</p> | <p>Chairperson will check to see if a recent article has been published in the Communiqué regarding the need for physicians to see the patients every 30-day to be in compliance.</p> <p>Sharon will check to see what Medical Review uses to be sure patient is being seen every 30 days.</p> |
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| <p>IV. Policy</p>                      | <p>A. What is a “policy”<br/>Members were given a handout with the definitions of LMRP, NCD, and NCP to dispel any confusion between them, where they come from, who is responsible for them, what do they mean. Italicized language on policies is always CMS national language where as regular font is carrier language.</p> <p>B. Retired policies<br/>Please note that because a policy is retired the guidelines do not change. Copies of retired policies are only on the website for a short period. Members can obtain a hardcopy through the freedom of information. Italicized language (CMS language) will always be in place even though the policy has been retired.</p>   |  |
| <p>V. Financial</p>                    | <p>A. Skilled Nursing Facility request refunds<br/>The Financial Unit has reported a high volume of calls from providers questioning why they are getting requests for refunds due to SNF consolidated billing. It is the provider and SNF’s responsibility to know what type of stay they are in and bill the right entity (Part A or PartB). This has not been happening. There was nothing in our system or the Common Working File (CWF) to identify situations where a Part B claim was paid prior to CWF knowing that the beneficiary was in a Part A stay. As of February an edit was added that looks at all Part B services paid incorrectly during a Part A stay and creates a report identifying overpayments. The system has gone back to 2001 dates of service. Members were given a handout on the CMS website pertaining to this issue.</p> <p><b>Q:</b> Is there anywhere on the CMS website that gives a list of services not covered under the consolidated billing services?</p> <p><b>A:</b> There is not a list on the website. It is up to the SNF to identify services not related to the patient’s plan of care. CWF cannot distinguish between services. If providers have received a refund request on a service not related to the plan of care, they must refund the full amount and request a review.</p> |  |
| <p>VI. Provider Education Seminars</p> | <p>A. Fall series<br/>At present MN does not have many seminars planned. Evaluation and Management Codes and Physical Therapy are two of the upcoming educational seminars. Members are encouraged to make suggestions for seminars, such as, Modifiers and Global Surgery. Medical Review education is driven through statics (LPET) and they notify Provider Outreach to assist them with education.</p>   | <p>Members are encouraged to submit suggestions for fall seminars.</p> |

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|                            | <p><b>Q:</b> WI holds a Medical Society Symposium annually, why isn't there one in MN?</p> <p><b>A:</b> The WI Medical Society initiates these seminars and has requested WPS to participate as speakers. Members should contact the MN society and request they initiate a symposium. WPS would be willing to participate as speakers.</p> <p><b>Q:</b> Could there be seminars conducted on Trust Solution, their roles, how do they work?</p> <p><b>A:</b> A representative from Trust Solutions presented a Power Point presentation at the last PCOM meeting. Trust Solutions has indicated that they would be willing to do seminars/presentations for providers. Members who are interested should contact Trust Solutions.</p> <p>Sharon stated that there are still a few openings for the Madison office's open house scheduled for October 7 &amp; 8. Members interested should registered on-line or contact the Madison office.</p>  | <p>Members should contact the MN Medical Society and request a symposium</p> <p>Members should contact Trust Solutions to set up seminars.</p> |
| <p>VII. Claim Analysis</p> | <p><b>A. Claim Submission Errors</b><br/> Top claim denial reports are received on a monthly basis by state.</p> <ol style="list-style-type: none"> <li>1. Unprocessable claims (denial code CO16) are one of the top claim denials. Examples of these are invalid procedure codes, provider number difficulties (incorrect placement on claim, place of service does not match the provider number, etc.).</li> </ol> <p><b>Q:</b> How can one charge be unprocessable on a claim and the remaining claim pays?</p> <p><b>A:</b> There are two ways that claims are denied in the system as unprocessable. Claims are denied for errors on the top portion of the claim. Errors occurring in the top portion will cause the entire claim to be denied. Claims without errors are then subjected to edits on a line-by-line basis, which allows claims to deny one charge, but not all charges. Remark codes are listed under the line when denying for that line.</p> <p><b>Q:</b> Why can't Customer Service assist in determining why a claim is denied as unprocessable?</p> <p><b>A:</b> Customer Service should be able to assist, however, the remark codes should tell providers why the claim was denied. If remark codes are unclear, CMS should be notified that the remark code is confusing or unclear or contact WPS and we will contact CMS.</p> |  |

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|  | <p><b>Q:</b> Why are claims that are determined to be unprocessable being forwarded to Blue Cross Blue Shield which pay the claims in full?</p> <p><b>A:</b> The trading companies determine Crossovers. If they requested that all claims are sent to them regardless of denials, Medicare must comply. It is the trading partner's decision to then pay or deny the claim.</p> <p>2. Purchased Diagnostic Testing.<br/>Multiple purchased diagnostic testing cannot be submitted on one claim, they must be billed separately. It is also important to fill out all the required fields.</p> <p>3. Item number 11 must be filled out with a None if Medicare is primary. Any other information listed in this area or left blank when Medicare is primary will cause the claim to be denied as unprocessable.</p> <p><b>B. Top Telephone Calls</b></p> <p>1. Eligibility information. There is a large volume of calls requesting eligibility information. Customer Service has a limited number of employees, therefore, providers should be going through their normal process to determine eligibility and call only when other avenues have been exhausted. Shortly there will be a format option in EDI that will allow providers access to eligibility information in real time.</p> <p>2. Claim status. Customer Service does not give claim status unless the IVR is down. If providers need assistance learning the IVR system they should contact WPS.</p> <p>3. Provider summary status. There will be a HIPPA (277/276) transaction that will be able to give summary status through EDI.</p> <p><b>Q:</b> Does the PCA software given out by WPS provide eligibility information and summary status?</p> <p><b>A:</b> No it does not.</p> <p><b>C. Appeals Workgroup</b></p> <p>1. A study was conducted earlier in the year. The study showed that there was a large volume of review request because no documentation was received the first time. Providers are requesting reviews because their claims are being denied even though they sent the documentation after it was requested. In the majority of these situations the claim is being denied because documentation was not received within the 45 days required. Claims will not be reopened if the documentation is received</p> | <p>Sharon will check with Crossover Manager to see how many of the crossover partners receive CO16.</p> |
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after the 45-day period. Medical Review is sending out follow-up letters informing provider with a high volume of denials because documentation was not received.

**Q:** Letters were received regarding this issue, however, they included a time frame of November 1 – March 31. During this time frame there was a period of 60 days when request letters did not print in WPS system and when they did print some of them from the earlier time frame were past the time submission deadline. Providers have contacted Medical Review staff regarding this issue, but have not received a call back if this is part of the issue?

**A:** WPS is aware of the problem with the first round of letters. The purpose of This letter is to inform providers that they have high volumes of denials for lack of documentation and to suggest that providers look at their process in responding to these letters. The letters do not trigger the Medical Review department to conduct probes on those providers.

**Q:** In situations where a claim was denied for lack of documentation it is sometimes difficult to obtain the documentation within the 45-days. It has been easier to resubmit the charges. Can providers continue to resubmit?

**A:** The process will change this year. Providers who do not submit on time or chooses to ignore the request with the intention of resubmit in hopes that it will not be pulled by Medical Review again, will not be able to rebill. They will be required to request a review. As of October 16 resubmitting on paper with documentation will not be accepted.

2. The 76 modifier is another high volume appeal. The Appeals Department is unclear as to why the 76 modifier is not submitted with the original claim. WPS is requesting providers to examine their processes to correct this situations especially in labs, pathology and radiology. At the time of conversion a list of codes that could be quantity priced was published; however, there is now a greater number of codes that cannot be quantity priced, so WPS has recently published a list that cannot be quantity priced.

**Q:** Member stated that her biller is hesitant to send a claim in with attached notes because if there are any denials on the claim, it creates more steps for to have to reprocess that claim must then drop to paper rather than correct it on paper.

Members should evaluate their process for handling documentation request to ensure it is received within the 45-day requirement.

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|  | <p><b>A:</b> Sharon stated that the list of what situations would require documentation will be included in Lisa Cuocci article and should assist with these issues. Electronic claims, as of October 16, will allow providers to mark a box that states that documentation is available upon request. If documentation is needed the provider will be notified. If no documentation is needed, the claim will go through the system. You may also use the narrative field if documentation will fit.</p> <p>3. Remark Code B15 – Payment adjusted because procedure or service is not paid separately. A handout with the a description of bundling was given to members to assist them in understanding this process. If it is a B status on the database, it is always bundled and should not be billed to Medicare or the beneficiary and well as CCI situations.</p> <p><b>Q:</b> Do providers ever receive this remark code in error?</p> <p><b>A:</b> It is possible. Please send examples of ICNs only, no Medicare numbers with an explanation of what happened and the Outreach Department will investigate to see if there is a systems error.</p> <p><b>Q:</b> Will the pricing for flu shots be updated due to the cost increases? And if so when will providers be notified?</p> <p><b>A:</b> WPS has not received updates as yet. Updates will be posted on the website and Listserv.</p> <p><b>Q:</b> In the September 15 updates it discussed new place of service requirement 72 for rural health clinics. Is it correct that when billing for rural clinics that place of service 72 must be used in addition to the modifier or the claim will deny?</p> <p><b>A:</b> Yes it will be mandatory to use place of service 72.</p> <p><b>Q:</b> Why are claims with M0064 now denying when in the past they have been paid? Customer Service has been unable to answer this question.</p> <p><b>A:</b> Sharon asked that she send the question through on Contact Us and in request that it be sent to Sharon Fletcher and she will investigate.</p> | <p>Members should go to the WPS website, <a href="http://www.wpsic.com/medicare/provider/provhome.shtml">www.wpsic.com/medicare/provider/provhome.shtml</a>, under News &amp; Alerts or check the Listserv.</p> <p>Sharon will investigate this situation and respond to member.</p> |
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