

Provider Communication Advisory Committee Minutes (PCOM)

1:30pm – 3:30pm

Tuesday, September 21, 2004

Bloomington, Minnesota

Agenda Item	Discussion	Outcome/Action		
I. Welcome and Introductions	Rita opened the meeting by welcoming members and asked that they introduce themselves.			
II. Review of Minutes – June 15, 2004	<ul style="list-style-type: none"> • Minutes from the June 15, 2004 meeting were approved. • Action Items from June 15, 2004 meeting: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>ACTION:</p> <ul style="list-style-type: none"> ✓ Member asked if providers could be conferenced into seminars held in other states? ✓ Member stated they received a high Volume of denials based on Beneficiary’s address didn’t match. Medicare’s records even after provider spoke with Social Security. ✓ Member receiving large volume of denials on electronic claims when a patient has 2 diagnosis codes. </td> <td style="width: 50%; vertical-align: top;"> <p>ANSWER:</p> <p>At this time WPS is unable to offer this due to equipment and costs involved. This may be possible in the future.</p> <p>Social Security was contacted, but no response has been received at this meeting. Rita is attempting to have a Social Security representative come to a PCOM meeting.</p> <p>Rita discussed this with EDI and they stated that electronic claims and paper claims are handled the same. Providers may use up to 4 diagnosis codes and they can be linked. Providers should contact Customer Service with specific examples.</p> </td> </tr> </table> 	<p>ACTION:</p> <ul style="list-style-type: none"> ✓ Member asked if providers could be conferenced into seminars held in other states? ✓ Member stated they received a high Volume of denials based on Beneficiary’s address didn’t match. Medicare’s records even after provider spoke with Social Security. ✓ Member receiving large volume of denials on electronic claims when a patient has 2 diagnosis codes. 	<p>ANSWER:</p> <p>At this time WPS is unable to offer this due to equipment and costs involved. This may be possible in the future.</p> <p>Social Security was contacted, but no response has been received at this meeting. Rita is attempting to have a Social Security representative come to a PCOM meeting.</p> <p>Rita discussed this with EDI and they stated that electronic claims and paper claims are handled the same. Providers may use up to 4 diagnosis codes and they can be linked. Providers should contact Customer Service with specific examples.</p>	<p style="color: red;">Rita will let members know what Social Security’s response is to the issue of wrong beneficiary address.</p>
<p>ACTION:</p> <ul style="list-style-type: none"> ✓ Member asked if providers could be conferenced into seminars held in other states? ✓ Member stated they received a high Volume of denials based on Beneficiary’s address didn’t match. Medicare’s records even after provider spoke with Social Security. ✓ Member receiving large volume of denials on electronic claims when a patient has 2 diagnosis codes. 	<p>ANSWER:</p> <p>At this time WPS is unable to offer this due to equipment and costs involved. This may be possible in the future.</p> <p>Social Security was contacted, but no response has been received at this meeting. Rita is attempting to have a Social Security representative come to a PCOM meeting.</p> <p>Rita discussed this with EDI and they stated that electronic claims and paper claims are handled the same. Providers may use up to 4 diagnosis codes and they can be linked. Providers should contact Customer Service with specific examples.</p>			
III. Updates	<p>A. Customer Service</p> <ul style="list-style-type: none"> • 1-800-MEDICARE is now receiving all beneficiary calls coming into the carriers. Beneficiaries calling the former WPS Beneficiary number are automatically being switched to the 1-800-MEDICARE. As of October, when beneficiaries contact WPS they will be instructed to call 1-800-MEDICARE. 			

- There has been a decrease in call volume by 15% in the Beneficiary Call Center. No complaints or problems have been received. Providers are encouraged to report any complaints or problems they receive from beneficiaries to Rita Hobot.
 - IVR – the IVR and Customer Service line was split into 2 lines as of June. Split allows for better access to IVR and Customer Service. If providers experience problems or have concerns, please contact Rita Hobot.
- B. Grace periods for HCPCS/ICD-9
- Effective October 1, 2004, grace periods for ICD-9 will be eliminated.
 - Effective January 5, 2004, grace periods for HCPCS will be eliminated.
- C. Correction for G0308 – G0327
- Reminder – these services may only be billed once per month. There are news articles regarding this issue and it is on both CMS/WPS websites.
- D. HIPAA
- All four states within the WPS jurisdiction have a high percent of providers that are submitting compliance claims. MN has a percent of 99.72.
 - Reminder that MSP and Chiro claims can be submitted electronically. Articles explaining submission are in the Communiqué.
 - ✓ MSP article was in the January 2003 edition
 - ✓ Chiro was in the June 2004 edition.
- Q: Member asked if a generic EOB would be excepted for the MSP claims when Submitting electronically.
- A: Providers are not required to submit an EOB when submitting electronically.
- E. SNAP (Secure Net Access Pilot)
- SNAP offers providers the ability to check eligibility and status online.
 - WPS began the pilot SNAP program last year. CMS has extended this pilot for 2 more years. SNAP is now open to all providers in the WPS jurisdiction to sign-up. Providers who are not signed up on SNAP can sign-up on WPS' website and there is information in the Communiqué.
 - This fall WPS is hoping to add enhancements such as claim copy denial reasons, deductible information.

Members were asked to contact Rita with any problems/concerns that they or the beneficiaries have with the new phone lines.

	<p>Q: Member stated that at the last meeting an enhancement was discussed that would allow providers to enter only 2 of the 3 required field when entering SNAP. They questioned if this is one of the enhancements that are being considered.</p> <p>A: Rita stated that Amanda is currently researching this possibility.</p> <p>Q: Member questioned if SNAP could provide the HMO name when it gives HMO information. They currently are able to access this information on a Medicaid system.</p> <p>A: Rita stated she thought this was a security issue that is currently being discussed with CMS. Providers will be notified of enhancements on WPS' website.</p>	
<p>IV. Beneficiary Education</p>	<p>A. 2004 WPS is trying to reach a large number of beneficiaries through fairs, newspaper articles, and partner events to educate and inform beneficiaries on Medicare.</p> <p>B. 2005 Focus</p> <ul style="list-style-type: none"> • Low literacy groups • Low income groups • Culturally diverse groups 	
<p>V. Provider Education</p>	<p>A. A Day with Medicare & Partners Minnesota's A Day with Medicare & Partners Open House will be held October 13, 2004, 8am – 4pm at the Sheraton Hotel in Bloomington. Registration is required and will be limited to 3-4 participants per organization due to space limitations. Providers may register through WPS' website.</p> <ul style="list-style-type: none"> • Partners participating: <ul style="list-style-type: none"> ➤ Social Security Administration (SSA) ➤ Quality Improvement Organization (QIO) ➤ State Health Insurance Program (SHIPS) ➤ DMERC ➤ Area Agency Aging (AAA) ➤ Trust Solutions • Sessions: <ul style="list-style-type: none"> ➤ Current Medicare Issues ➤ Drug Discount Card ➤ CMS Medicare Learning Network ➤ Medicare Medical Review ➤ Appeals/Hearings ➤ Financial ➤ Stratis Health (QIO) 	<p>Members were encouraged to register for "A Day with Medicare & Partners" open house on October 13, 2004. Limited space is available.</p>

	<ul style="list-style-type: none"> ➤ SHIPS ➤ Trust Solutions • Demos: <ul style="list-style-type: none"> ➤ Part B/CMS website demo ➤ CMS Online Manual demo ➤ SNAP demo • WPS and their partners will have tables setup with information and staff to answer provider questions. <p>B. 2005 Fee Schedule/Disclosure materials CMS is requiring all carriers to send the 2005 Fee Schedule on CD-ROM. WPS will be sending one CD-ROM to the group address. The CD ROMs will also include educational information and Communiqués. Rita will attempt to send one to each PCOM member. She also requested members complete a survey regarding the CD-ROM. She stated that last years suggested by providers were implemented this years version.</p> <p>C. LISTSERV changes Specialty LISTSERVs are now available. These LISTSERVs will provide information regarding just that specialty. CMS is requiring all carries to have 50% of their providers enrolled in LISTSERV by October 2005. Members were encouraged to send suggestions on how to get more providers to register for the LISTSERV to Rita.</p> <p>M: Member stated that putting information regarding the LISTSERV on remits would not be a good idea, as the people who receive the remits are not the ones who would be signing up for LISTSERV. Members suggested putting articles in the Communiqué, contacting provider associations and asking them to include it in their newsletters, development letters, bring up at seminars or to send the information directly to the office managers.</p> <p>D. Medlearn Matters – CMS’ Medlearn Matters contains excellent articles on what is happening, what it means to providers and the background of new Change Requests. New articles are listed on CMS’ LISTSERV. Providers are encouraged to access this information. Rita asked members to complete a survey regarding the Medlearn Matters.</p>	<p>Members were asked to complete a survey on the Fee Schedule CD-ROM to assist WPS with making changes to the CD-ROM that will benefit the provider.</p> <p>Rita asked members to send her suggestions on how to increase provider enrollment on LISTSERV.</p> <p>Rita asked members to complete a survey on the Medlearn Matters.</p>
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	<p>E. Acronyms Listings A listing of acronyms that WPS uses is included in the 2005 Fee Schedule CD-ROM. Members are encouraged to contact Rita with any additions or deletions to this list.</p> <p>F. Surveys – Members are encouraged to complete all surveys they receive. These surveys assist WPS in making improvements and enhancements that will benefit providers.</p>	<p>Members are encouraged to contact Rita with additions or deletions to the Acronym list.</p>
<p>VI. Data Inquiry Analysis</p>	<p>A. Phone calls</p> <ul style="list-style-type: none"> • The top phone calls are regarding unprocessable denials. Customer Service is stating that providers are unaware that the last page of remits contains descriptions of denials. Many providers divide up the remits; therefore, not all their staff is receiving a copy of the last page. Rita suggested that in these cases, providers make a copy of the last page for all staff. <p>Q: Members stated that many of the unprocessable denial codes only state more information is needed, but not what information is needed so providers have to call to determine exactly what is needed. Members asked if these codes could be made more specific.</p> <p>A: Rita stated that denial codes are CMS driven. WPS staff are involved in a workgroup with CMS to implement change in these denials.</p> <p>B. Appeals</p> <ul style="list-style-type: none"> • The most common reason for appeals was because of Diagnosis. Members were informed that providers do not have to appeal for a diagnosis. They can just resubmit the claim. <p>C. Duplicate Claim Denials</p> <ul style="list-style-type: none"> • The most common claim denials are for duplicate claims. In August, Minnesota had 43,236 line item denials. In Minnesota WPS is currently calling the top providers to determine the reasons for duplicate claims. The most common reasons received were: <ul style="list-style-type: none"> ➤ Providers have their system setup to automatically rebill a claim if they have not received a response. ➤ Vendors resubmit claims. ➤ Providers are not checking the status on whether a claim has been processed. 	<p>Members should discuss duplicate denials in the organization to determine why they are occurring and what can be done to prevent them.</p>

Members were encouraged to discuss this with staff in their offices that handle these claims and determine why they are resubmitting claims and bring these reasons back to the group.

Rita stated that duplicate claims hold up processing time and are bringing the cost of claims up. CMS is currently looking at the costs involved and may implement a fine on providers for every duplicate claim.

M: A member stated that when they receive a claim where 1 line was denied for medical necessity and they resubmit the claim electronically the entire claim is resubmitted not just the one line.

A: Rita stated that if this is the case, providers should be looking at the unprocessable line and determine the reason for them. This would eliminate unprocessables and duplicate claims.

Q: Member questioned if they could find out how many duplicate claims their Organization is submitting.

A: Rita stated that she would attempt to get these numbers for all PCOM members.

Q: Members questioned who was being contacted within their organization regarding this issue.

A: Rita thought they were contacting the business office, but she will investigate and let members know.

- Rita stated that another high reason for unprocessable claims was modifiers. In WPS' former system modifiers were excepted whether they went with the code or not. However, with the new MCS system, if the CPT code and an inappropriate modifier are used, the system will deny for unprocessable. Rita also stated that the first unprocessable edit a claim hits, the claim is denied as unprocessable. She reminded members that providers should look at the entire claim to ensure that the remaining claim is correct before resubmitting the claim.
- Other common denials were referring physician name and PIN number missing.

Rita will attempt to get the number of duplicate claims each PCOM members' organization has and who within the organization is being contacted.

VII. Round Robin	<p>A. Rita stated that at the next meeting she would like members to discuss:</p> <ul style="list-style-type: none"> • How they share information from these meeting with their peers • What methods are used to identify issues from their peers to bring to this forum? 	
VIII. Open Discussion	<p>Q: Members stated that they are receiving denial code MA130 and CO16 for unprocessables. These codes are generic and do not give a specific reasons why the claim was denied so providers need to call Customer Service to determine why it was unprocessable. If they were given more specific reasons it would eliminate several calls.</p> <p>A: Rita stated that the denial codes are CMS driven, but WPS is on a workgroup with other carriers and CMS to discuss these issues. Rita stated that she will take these concerns to her manager, Larinda Power, who is on this workgroup.</p> <p>Q: Member stated that they have received a lot of non-covered, CO109, for lab charges which in the past have been paid. Her office has contacted Customer Service and was told denials were due to the diagnosis code. In the past they would have been denied with CO16 with additional remark code that states diagnosis.</p> <p>A: Rita stated that she has reviewed a similar situation recently for a provider and found that denials were due to a recent change in coverage in certain policies. She suggested members reexamine policies to see if there have been changes. If none are presented. If they have further questions, providers can contact Rita Hobot.</p> <p>Q: Member questioned why the deductible and premium were increasing and requested a copy of the history of Medicare deductibles.</p> <p>A: Rita stated that increases could be due to changes in Medicare laws and the drug Benefit. She will send a copy of Medicare deductible history to members.</p> <p>Q: Member asked what constitutes the difference between CO96 and PR96.</p> <p>A: Rita stated that it is the difference between beneficiary liability and provider liability. It depends on whether something is denied as non-covered or it is denied as medical necessity.</p> <p>Q: Member questioned if it was medical necessity why isn't it denied with a CO50.</p> <p>A: Rita stated that it is because it is a not-covered service.</p>	<p>Rita will discuss possible changes with Larinda Power and relate her findings to the group at the next meeting.</p> <p>Rita will email a copy of Medicare's deductible history to members.</p>

Q: Member questioned if the date of service could be added to the offsets at the end of remits. This would eliminate a lot of phone calls between providers and Customer Service.

A: Rita will discuss this suggestion with the Financial Department.

Q: Member stated that they have been receiving denials due to global surgery. Charges are submitted on a lesion removal by the dermatologist and it is denied stating that the primary procedure was not billed even though they are billing the primary. She stated that after researching the situations, it was determine that another surgeon has a global period for something else, their claims are being denied. She questioned if a system fix could be done to prevent this.

A: Rita stated that at this time the only option for providers is to request an appeal.

Q: Member commented that it is at times very difficult to determine what the asterisk and pluses mean on a policy. She stated that they have questioned Customer Service on this issue and were told that it is explained better within the body of the policy.

A: Bonnie LaPanta stated that asterisks within a policy denotes the most recent change. She stated that at the end of all policy it explains the use of asterisks. Rita stated that members should contact her with the name of the Customer Service representative and she will discuss it with their manager.

Q: Member stated that when they enter a code to find a policy that the code does not always bring up a policy because the code is part of a range of codes within radiology policies.

A: Bonnie LaPanta stated that this must be a unique issue with radiology. She will discuss it with those responsible for maintaining the system to see if this can be corrected.

Rita stated that there has been a low attendance on seminars. She reminded members that upcoming seminars are listed on the WPS website under Education and that providers can register on-line for these seminars. She asked members to send her suggestions for ways to increase attendance or for suggested changes to seminars that would encourage more to sign-up or suggestions for new seminars.

Rita will discuss the addition of date of service with the Financial Department.

Bonnie will discuss this issue with the systems department.

Members are asked to send suggestions for improving attendance for seminars, improvement to seminars, or suggestions for new seminars to Rita.

	Rita reminded members that PCOM minutes are available on WPS' website under Provider Education/PCOM/Minutes.	
Next meeting	The next PCOM meeting is scheduled for Tuesday, December 14, 2004	