Provider Communication Advisory Committee Minutes (PCOM)

1:30pm – 3:30pm
Tuesday, December 14, 2004
Bloomington, Minnesota

Agenda Item	Discussion	Outcome/Action
I. Welcome and Introductions	Rita opened the meeting by welcoming members. She asked that members update the Members' List with their correct information, especially their email address as this is how she will be sending out information for each meeting. Rita also asked that each organization select 2 staff members to represent their organization at the PCOM. She stated that it is important to have the same 2 people at each meeting to resolve issues as a group on educational needs.	
II. Review of Minutes – September 21, 2004	Minutes were approved from the September 2004 meeting. **ACTION ITEM:** / **ANSWERS**: ✓ 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. — Rita contacted a representative from Social Security who has asked members to submit examples to Rita. Social Security will investigate and let Rita know what they find. Rita is is still trying to get a representative to attend an upcoming meeting. ✓ Member asked if the date of service for offsets could be added to the end of the remits. — Rita discussed this with the Financial department. Financial stated that this is a MCS Systems requirement. It would require all carriers on the MCS system to agree to the change. WPS will be putting in a systems Change request.	

	✓ Members had requested more Information listed on Denial Codes so they could determine why the claim was denied. Members stated that this could eliminate some calls. Many providers are only looking at the Ansi Codes and not the Remark Codes, which gives Additional information on why the claim denied. Rita asked members to investigate this issue and if there is not enough information between the two codes, members should bring examples with them to the next meeting.	Members should investigate with their offices if they are looking at both the Ansi and Remark codes on denied claims to determine if additional information is still needed to determine why the claim was denied. If there are still denial codes that need further explanation, members should bring examples to the next meeting or email them to Rita.
III. Updates	A. 2005 Fee Schedule CD ROM Rita stated that the 2005 Fee Schedules have been sent to providers. She brought copies for each member. The fees are correct on the CD ROM with the exception of: ♦ Clinical Social Workers ♦ Medical Nutrition Therapy Fees (MNT) However; the Clinical Social Workers and MNT fees are correct on the WPS website. Rita stated there would be a charge $13.89 for hard copies of the Fee Schedule. Hard copies will only be sent to providers who lack the equipment to use or view the CD ROMs. Providers will have to request a hard copy through the Freedom of Information. This year the following information was added to the CD ROMs: ♦ How to print ♦ How to use the Adobe AcroBat ♦ How to use the WPS website Rita asked all members to fill out a survey regarding the CDs. Members can send them to her by fax, mail or bring them to the next meeting.	Members should complete the Fee Schedule CD-ROM survey.

	Q: Member asked if RVU's are included on the CD ROM. A: *CORRECTED ANSWER:* NO: They are NOT on the CD-ROM. The RVUs can only be found on the CMS web site for the MPFSDB at http://www.cms.hhs.gov/physicians/mpfsapp/default.asp B. Flu Shots – Administered by non-enrolled providers. Rita stated that to increase access for beneficiaries to obtain a flu shot, CMS will now reimburse non-enrolled providers. Non-enrolled providers or the beneficiary will need to submit a copy of the receipt for the shot and a completed 1490S form. The forms are available through the CMS and WPS websites and beneficiaries can call the 1-800-MEDICARE number to obtain a copy of the 1490S form and information as to where to send the forms. C. Demonstration of improved Quality of Care for Cancer Patients undergoing Chemotherapy. Rita stated that this demonstration would begin in calendar year 2005. Medicare will initiate a 1year Demonstration Project for the Quality of Care of Cancer Care patients undergoing chemotherapy. Information on how to appropriately bill for these will be published by CMS by January 1. A fact sheet was attached to handouts given to members. There is information out on the Federal Registry and there have been physician open door forums on this project. D. Redetermination Notice Rita stated that the First Level of Appeals has a new name, Redetermination Notice, as of October 1, 2004. Physicians/Beneficiaries will now receive formal decision notification letters. These letters will now describe ♦ Redetermination process ♦ Results of the Medicare Appeal ♦ Providers info about how to file an appeal regarding Medicare's decision. Rita stated that there is a Medlearn Matters article, MM2620, on Redetermination Notices. The article explains background and gives additional information.	

E. MPFS National Abstract File for Purchased Diagnostic Tests and Interpretation.
Rita gave members the highlights of the Medlearn Matters article, MM3481, that she emailed them:

- ♦ Effective immediately.
- ♦ Providers should bill local Medicare Carriers for services purchased from outside suppliers in other jurisdictions and purchasing services from another provider within their jurisdiction, continue to bill as before.
- ♦ Providers are responsible for making sure the outside supplier is enrolled with Medicare.
- ♦ Bill using the zip code for the provider location rather than where the service was actually performed.

F. Physician Education for the Revisions to the HPSA Bonus Payment processes and Implementation of the Physician Scarcity Area (PSA) Bonus Payments.
Rita stated that there are 2 Medlearn Matters articles, SE00449, which she sent to members by email and a new article, SE0453. Both of the articles highlight upcoming changes to the Incentive Program, discusses the PCA (Physician Scarcity Area) Bonus Payment, discusses that the 5% bonus payment is based on the actual payment rather than the approved amount. The new article discusses the specialties that are excluded:

- ♦ Dentist
- ♦ Chiropractor
- ♦ Optometry
- ♦ Podiatry

The new article also discusses that some services will be eligible for both HSPA and the PSA.

G. HIPAA
Rita stated that MN compliance is at 99.94% for HIPAA and WPS is currently working on raising the percent of Electronic Remit Receivers, which is currently at 99.9%.

	Rita stated that members should be aware that NPI is coming. It will be effective May 23, 2005 and will effect everyone. WPS will be conducting education in early spring through the website, the Communiqué, the ListServ, etc H. Voluntary Refunds Rita emailed members a copy of the Voluntary Refund form and a copy of the instructions on how to use this form. She encouraged all providers to use the form and to complete it correctly to ensure that refunds will be posted correctly. I. Clinical Lab Fee Schedule Rita informed members that there is a Medlearn Matters article, MM3526, on the annual update for Clinical Lab Fee Schedule.	
IV. Beneficiary Education	A. Medicare & You 2005 Rita provided members present with copies of several handbooks: ♦ The Medicare & You 2005 handbook that is given to beneficiaries. This handbook discusses briefly the new Welcome to Medicare Physical. ♦ Guide to Choosing a Medicare Approved Drug Discount Card. ♦ How to Read you Medicare Summary Notice that is a good tool for explaining to beneficiaries. (Freda Terry, Stratis Health, provided this handbook). B. Rita distributed a copy of the 2005 Premiums and Deductibles, which is effective January 1, 2005.	
V. Provider Education	A. A Day with Medicare and Partners Rita stated that A Day with Medicare held in October was a success. MN had 176 attendees for the day and received excellent feedback from participants. Rita stated that several participants suggested having general sessions and fewer breakout sessions. The next "A Day with Medicare" will be held May 2005 in Michigan, which is the last in our jurisdiction. Rita stated that after the last event in May, WPS will look at all the surveys to determine if more events of this nature will be planned and what sessions will be held. B. 2005 PCOM Meeting Schedule	**Members should email Rita with suggestions for possible sessions**.

	Rita distributed the 2005 PCOM meeting schedule next year. The meeting will be held at the same place and time. C. 2005 Winter/Spring Schedule Rita stated that they are currently working on seminars and teleconferences for 2005 Winter/Spring and will be posted on the website as they are scheduled. She stated that the upcoming seminars in January on Modifiers and on Practical Solutions. Rita encouraged members to sign-up for seminars/teleconferences quickly as they have been filling up fast. D. New e-mail system. Rita informed members that WPS transitioned into a new email system on November 11. She stated that the old email, rhobot@wpsic.com, should still work; however if you are having difficulties please try rita.hobot@wpsic.com.	**Members should check WPS website for a listing of seminars/ teleconference**.
VI. Data Inquiry Analysis	Rita stated that she was unable to obtain the Data Inquiry Analysis and the information on the Duplicate Denials because the STARS program has been down.	**Chairperson will try to obtain this information for the next PCOM meeting in March.**
VII. Round Robin	A. Rita had asked members at the September meeting to discuss Duplicate Denials with their organizations to determine who receives the denials and why they are submitting duplicates. She stated that the top 10 providers for Duplicate Denials are being contacted by phone to determine why they have a large volume of duplicate denials. Rita stated that some providers stated that their vendor was re-submitting the claims, which is costing both providers and the Medicare program money. Some providers stated that they have their computers set to automatically re-submit a claim if they have not heard from Medicare in a certain amount of time. This procedure again costs both providers and the Medicare program money. She asked members for feedback from the organizations. Member stated that their vendor re-submits the entire claim even if its only 1 line that is unprocessable. Rita stated that she is aware that some systems do not allow only the 1 line to be re-submitted; however, re-submitting the entire claim creates duplicate denials. She	**Members will forward feedback from their organizations to chairperson**

	stated that if providers could eliminate the unprocessable denials it would also prevent several duplicate denials. Member stated that they would like a report showing how many duplicate denials their organization is receiving so she can show it to their vendors. She stated that she was also unaware that they only had to submit the lines that were denied as unprocessable. Rita stated that WPS would be willing to provide any educational material needed to help prevent unprocessable claims or duplicate denials. Member stated that they have been unable to convince their systems people to change their system to allow them to rebill only the unprocessable lines. Rita stated that members should give their systems people a copy of the Communiqué article that she emailed them discussing duplicate denials and that patterns of filing duplicate claims are consider a form of program abuse even if it does not result in a duplicate payment. Member stated that the new Medicare system denies a claim for the top denial and only lists the top denial; whereas the old system looked at the whole claim and listed the reasons for denial. It would save providers and the Medicare money if they reverted to the old systems way. Rita stated that it is the providers' responsibility to reexamine the entire claim that was denied to determine if there are other errors and should not simply fix the 1 error and resubmit. Rita stated that this was a training issue for providers within their offices. Member stated are receiving denials for global where the patient was seen by a different doctor in a different facility. Their facility is unaware that they were seen by a different doctor. Rita stated that modifiers need to be added to the claim and then resubmit the claim or appeal the claim.	**Chairperson is still checking to see if the information is available.**

	Member stated that in the past few months their facility has seen a sharp increase in a request for documentation for critical care and surgery. Rita stated if the policy states that documentation will be requested and the claim states additional information is available, then a letter is generated requesting this documentation. Q: Member asked for information regarding the new genetic testing modifiers. A: Rita stated that Medicare would not be using them. Members stated that sometimes they receive vague answers from "Contact Us". Rita stated that if members feel they have received a vague answer from the "Contact US" request, they should send copies of these emails and she will research it for them. Member stated that they are having difficulty getting beneficiaries to sign the "signature on file" form. They attempt to explain the form to beneficiaries, but they refuse to sign it. Rita stated that providers should tell beneficiaries that unless they sign the form, their claims cannot be submitted to Medicare and providers can refuse to see them. Member asked if they cannot get the beneficiary to sign the form, can they bill the beneficiary for the services without submitting the claim. Rita stated that providers must submit all potentially covered services to Medicare. Member asked if MSP claims could still be sent in by paper. Rita stated that all claims including MSP claims are to be sent in electronically. Rita stated that the goal of this committee is to discuss educational issue needs that are needed within their organizations and to come up with educational suggestions for	

	these issues. To accomplish this members need to determine what the issues are by questioning their co-workers and bringing the issues to the Round Robin for discussion. Rita asked members to start with these questions: ✓ What type of denials are the seeing the most ✓ What denials are they calling the Medicare office for the most ✓ Are they receiving a high volume of duplicate denials and if so determine why duplicate denials are occurring ✓ Are their Ansi and Remark codes that do not contain enough information to determine why a claim was denied? If so bring examples to the next meeting. ✓ What is their number 1 Appeal to Medicare	Members should be prepared to discuss the questions at the next meeting.
Next meeting	The next PCOM meeting will March 15, 2005.	