

# Provider Communication Advisory Committee Minutes (PCOM)

1:30pm – 3:30pm  
Tuesday, March 15, 2005  
Bloomington, Minnesota

Agenda Item	Discussion	Outcome/Action
Welcome	Members were welcomed and asked to update their information as needed on the Members' List.	
Review of Minutes – December 14, 2004	Minutes from December 14, 2004 meeting were approved.	
Provider Education Activities CR3376	<p>A. Ask-The-Contractor Teleconference WPS will be offering a series of “Ask-the-Contractor” Teleconferences (ACT) in response to requirements of the Medicare Modernization Act. We will model these teleconferences after the CMS Open Door Forums. Each call will be approximately 1-1/2 hours in length and will have 200 lines available for providers to call in. Teleconferences will be recorded for those providers who are unable to attend and will be available for 1-2 weeks after the call. The first call will be March 29 and the topic will be Place of Service. This topic was chosen because of a recent audit by OIG, which found 79 out of 100 claims had incorrect place of service listed. Members were asked to submit suggestions for future topics to Rita.</p> <p>B. Small provider training/survey Medicare contractors will focus on specialized training programs for small providers. A small provider is defined by CMS as a provider of service with fewer than 25 full time equivalent (FTE) employees. Members were asked to submit suggestions for training topics and how best to deliver the training to the small providers.</p>	<p style="color: red;">Members are asked to submit suggestions to Rita for future topics for Ask-The-Contractor teleconferences.</p> <p style="color: red;">Members were asked to submit suggestions for training topics and how best to deliver the training to the small providers.</p>

	<p>C. Provider Relations Research Specialists (PRRS) WPS' Customer Service representatives that are unable to answer providers inquiries will refer the inquiry to Tier 2 representative. If Tier 2 representative is unable to answer the inquiry, they will refer it to Tier 3, a PRRS Specialist.</p> <p>D. IVR Providers have requested written instructions for using the IVR system. Members received a handout on instructions for the IVR system and were informed that WPS is currently researching voice activated IVR systems.</p> <p>E. SNAP (Secure Net Access Program) This system allows providers to do claim status data and eligibility Verification. WPS has been approved by CMS to continue the pilot for 2 more years. WPS is currently working on an enhancement for MSP information.</p> <p>F. Provider Education Seminar Schedule Members were given a schedule of upcoming Provider Education Seminars. When providers register on line and the seminar is full, a copy of their registration is kept. If there is a cancellation, the provider will be contacted regarding the opening.</p>	
Beneficiary Education	<p>A. Medicare Prescription Drug Benefit Members were given the current information from CMS on the new Medicare Prescription Drug Benefit, Medicare Part D. Beneficiaries are not required to sign up for Medicare Part D; however, beneficiaries who do not sign up before May 6, 2006 will pay an additional 1% increase. Members were encouraged to check CMS' website frequently for updated information and printed brochures. In may SSA will be mailing notices to low-income beneficiaries informing them about available subsidies.</p> <p>B. Medical Advantage (Medicare Part C) Medicare Part C, formerly referred to as Medicare Plus Choice, will now be called Medical Advantage Plan.</p>	

	<p>C. Medicare Beneficiary Calendar Members were given a copy of the CMS 2005 Beneficiary Calendar of Events.</p>	
Preventative Services	<p>A. Diabetes Screening Test Members were given a copy of the MedLearn Matters article (MM3637) that outlines specific requirements for reimbursement of diabetes screening tests by the Medicare program. This document contains requirements for providers billing either the Medicare Part B program or those billing the fiscal intermediaries. Members were directed to <a href="http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp">www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp</a> for more information.</p> <p>B. Influenza Demonstration Members were given a copy of the MedLearn Matters article (MM3696). Through this demonstration Medicare will reimburse for antiviral medications for the treatment of a beneficiary with symptoms of influenza, or for preventive treatment for those exposed to a person with a diagnosis of influenza. Effective dates for the demonstration is December 1, 2004 – May 31, 2005 and covers only 4 different drugs. For additional information on this demonstration please see <a href="http://www.MEDICARE.gov">www.MEDICARE.gov</a> or <a href="http://www.cms.hhs.gov/researchers/demos/flu">www.cms.hhs.gov/researchers/demos/flu</a>.</p> <p>C. Preventative Services at a Glance Members were given charts showing CPT codes for billing Cardiovascular Screening Tests, ICD-9 CM Diagnosis Coding for billing Cardiovascular Screening tests, Procedure codes and descriptors for “Welcome to Medicare” Physical, and procedure codes and descriptors for Diabetes Screening tests.</p> <p>Members were encouraged to educate staff who make appointments as well As billers on the “Welcome to Medicare” Physical. Beneficiaries are only entitled to the physical within the first 6 months of enrolling in Medicare. Providers should have beneficiaries sign an ABN prior to exam if the provider thinks this six month period has passed.</p> <p>Q: Members questioned : (1) If EKGs had to be completed on the same day as</p>	

the physical. (2) How to bill the physical if they have to send beneficiaries to another facility to have the EKG performed.

A: Pub 100-3 Section 210.6

A new HCPCS code, G0344 will be used by physicians, qualified NPPs, and hospitals for billing the physical examination component of the IPPE. As required by statute, the IPPE benefit always includes a screening EKG, which should be billed using new HCPCS codes G0366, G0367, and G0368. These 3 codes represent the global, technical, and professional components of the screening EKG respectively. Therefore, if the primary physician or qualified NPP does not perform the EKG during the IPPE visit, another physician or entity may perform and/or interpret the EKG. The referring provider needs to ensure that the performing provider bills the appropriate G code for the screening EKG, and not a CPT code in the 93000 series. Physicians and NPPs should bill G0366 for the full EKG service (tracing, interpretation and report), or G0367 when only the tracing is performed, or G0368 when only the interpretation and report are performed. Hospitals can only perform the EKG tracing, so they should bill G0367 when they perform the tracing component of the EKG.

*Pub 100-4, Ch 12 Section 30.6.1*

*D – The EKG Component*

*If the physician or qualified NPP is not able to perform both the examination and the screening EKG, an arrangement may be made to ensure that another physician or entity performs the screening EKG and reports the EKG separately using the appropriate HCPCS G code. The primary physician or qualified NPP shall document the results of the screening EKG into the beneficiary's medical record to complete and bill for the IPPE benefit. Note: Both components of the IPPE (the examination and the screening EKG) must be performed before the claims can be submitted by the physician, qualified NPP and/or entity.*

	<p><i>E – Codes Used to Bill the IPPE</i>  <i>The physician or qualified NPP shall bill HCPCS code G0344 for the physical examination performed face-to-face and HCPCS code G0366 for performing a screening EKG that includes both the interpretation and report. If the primary physician or qualified NPP performs only the examination, he/she shall bill HCPCS code G0344 only. The physician or entity that performs the screening EKG that includes both the interpretation and report shall bill HCPCS code G0366. The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0367. The physician or entity that performs the interpretation and report only (without the EKG tracing) shall bill HCPCS code G0368. Medicare will pay for a screening EKG only as part of the IPPE. Note: For an IPPE performed during the global period of surgery refer to section 30.6.6, chapter 12, Pub 100-04 for reporting instructions.</i></p> <p><i>F – Documentation</i>  <i>The physician and qualified NPP shall use the appropriate screening tools typically used in routine physician practice. As for all E/M services, the 1995 and 1997 E/M documentation guidelines (<a href="http://www.cms.hhs.gov/medlearn/emdoc.asp">http://www.cms.hhs.gov/medlearn/emdoc.asp</a>) must be followed for recording the appropriate clinical information in the beneficiary’s medical record. All referrals and a medical plan must be included in this documentation.</i></p> <p>D. New Resource manual  Members were given a handout on CMS’ New Resources website. There are also brochures that can be printed for beneficiaries.</p>	
Publications	<p>A. ListServ  Members were informed that registration for the ListServ was not limited to one person per office.</p>	

	<p><b>B. CD-ROM Survey</b>  Approximately 135 surveys were returned to WPS regarding the CD-ROM. Overall comments were very favorable. Based on the results of the surveys, Medicare Publication submitted the findings in mid February to CMS and requested permission to do the CD-ROM next year and is awaiting a response from CMS. Members were asked to consider what they would like to see on next years CD-ROM, if permission is received.</p>	
<p>Round Robin  (Discussion questions)</p>	<p><b>A. Is your organization receiving a high volume of duplicate denials? If so, determine why duplicate denials are occurring.</b></p> <p>Member stated that they are receiving denials for modifier 76, 91, 25 usage. They stated that the information is on the original claim; however, it is denied as duplicate. Member will send examples to Rita to research.</p> <p>Member stated that they are receiving duplicate claims because Clearing House is submitting the claim twice.  Rita stated that providers should be contacting their Clearing Houses to work with them on this issue.</p> <p><b>B. Is your organization finding Ansi/Remark codes that do not contain enough information to determine why a claim was denied? If so, bring examples to meeting.</b></p> <p>Member stated that they would like to see some of the Remark codes reworded; such as, Reduced/Denied. It is difficult to determine if it is reduced or denied.</p> <p>Members stated that they are receiving unprocessable denials because of HPSA. Members are having difficult determining if they are in the HPSA area.  Rita stated that providers cannot bill globally. Claims must be split between professional and technical service or the services will be denied as unprocessable. Rita provided members a handout regarding HPSA</p>	<p>Rita will investigate examples of 76/91 modifier usage and send out findings to PCOM members.</p> <p>Members should discuss duplicate claims with their Clearing Houses</p> <p>Examples of ICNs with these Remark codes should be sent to Rita to research remark codes with Ansi codes to determine what information is lacking.</p>

	<p>Members stated that they are having difficulty with 57 – Level of Service denials. Members stated that it does not appear to be an E/M level of service issue. Member stated that they are having difficulty understanding M25, which states Level of Service, but often means frequency. Rita asked members to send examples of ICNs so she can investigate through the system to determine what the denial is saying.</p>	<p>Members should submit examples of ICNs to Rita who will research and bring findings back to the next meeting.</p>
<p>Updates</p>	<p>A. CR3440 ASCA Mandatory Electronic Claims Submission  Members were encouraged to read the revised MedLearns Matters article, MM33440, which highlights requirements of the Administrative Simplification Compliance Act (ASCA), which enforces mandatory electronic submission of Medicare claims including MSP claims. It also identifies exceptions to this requirement. Members can obtain more information by referencing this document online at:  <a href="http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp">www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp</a>  Members were also encouraged to read the Communiqué article in the March issue.</p> <p>Q: Member stated that they have had to drop to paper because the beneficiaries name on her Medicare card differs from the name they have in their office.  A: Providers should not be dropping to paper. The office records need to be updated to reflect the correct information.</p> <p>Q: Should providers submit MSP claims even though the primary insurance has paid in full.  A: Claims should be billed to Medicare.</p> <p>B. CR2457 Psychotherapy notes  Members were encouraged to read MedLearns Matters article, MM3457. This article discusses when providers are not expected to send notes.</p> <p>C. Place of Service  Members were encouraged to register for the “Ask-The-Contractor” teleconference, which will discuss Place of Service. Members should watch for articles in the Communiqué and on WPS’ website.</p>	

	<p>D. Chiropractic Demonstration Information regarding the Chiropractic Demonstration is available on CMS' website. This demonstration does not include Minnesota providers.</p> <p>E. Chemotherapy Demonstration (CR3670) Members were informed that supplemental insurances may not pay for this demonstration, so providers should educate beneficiaries to this if they are involved with this demonstration. Refer to CR3670 for further information.</p> <p>F. CR3694 Purchased Diagnostic Tests Members were informed that there is a MedLearn Matters article, MM3694, on Purchased Diagnostic Tests. If members would like more information, please reference this document online at: <a href="http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.aps">www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.aps</a>.</p> <p>G. "A Day With Medicare" The next "A Day with Medicare" will be held in Lansing, MI on May 12, 2005.</p> <p>H. Provider satisfaction Survey CMS has sent out satisfaction survey, which will measure the providers satisfaction with the Part B carriers. Members were encouraged to complete the surveys and return them to CMS.</p> <p>I. HPSA Members were informed that denial codes associated with HSPA are M73 or M78.</p> <p>Q: Member asked if the shortage area is changed, will there be an article in the Communiqué to inform providers. A: Rita will investigate and let members know.</p> <p>J. First update to the 2005 Fee Schedule Database, CR3726 Members were informed that there is a MedLearns Matter article regarding the 2005 Fee Schedule Database.</p>	<p>Rita will check to see if shortage area changes will be listed in the Communiqué.</p>
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Next Meeting	The next PCOM meeting will be Tuesday, June 14, 2005 and will be held in the same location.	