

Provider Communication Advisory Committee Minutes (PCOM)

1:30pm – 3:30pm
September 20, 2005
Bloomington, Minnesota

Attending Members: Allina Medical Clinic, CentraCare Clinic, Columbia Park Medical Group, HealthPartners, Institute for Athletic Medicine, Mankato Clinic, Park Nicollet Clinic Therapy Partners, Inc/OSI Physical Therapy, University of MN Physicians

WPS Staff: Rita Hobot, MN Provider Education and Outreach; Mary Muchow, WI Provider Education and Outreach; Bonnie LaPanta, RN, MN Policy Development; Emily Drewitz, Administration

Agenda Item	Discussion	Outcome/Action
I. Welcome and Introductions	<p>Members were welcomed to the meeting. Rita introduced the new co-chairperson for PCOM, Mary Muchow, from the WPS Provider Education and Outreach department in Madison, WI. Members were asked to introduce themselves and to update their information as needed on the Members' List.</p> <p>Rita and Mary informed the members of their new email addresses. rita.hobot@wpsic.com, mary.muchow@wpsic.com</p>	Members can contact their chairpersons with concerns/comments
II. Review of Minutes – March 15, 2005 Action items/Responses	<p>Minutes from June 14, 2005 meeting were approved.</p> <p><u>ACTION:</u> Members were asked to submit For future topics for ACT (Ask-The-Contractor) teleconferences</p> <p>Members were asked to email of denials on modifiers 76, 91 and 25</p>	Members were asked to submit Suggestions to their chairpersons

	<p>Members were reminded to review the minutes when they are received and to email Rita with their responses to the Action Items and issues within their office prior to the next meeting.</p> <p>Chairperson reiterated the intent of this Committee is to identify and address issues that are the concern to a large number of providers. Committee members act as a liaison between Medicare and the larger provider community. The primary focus of the PCOM committee is to assist the carrier in implementing and reviewing provider education strategies and efforts.</p>	
<p>III. 2006 PCOM Calendar</p>	<p>PCOM meeting dates for 2006 have been set. The meetings are scheduled from 1:30pm – 3:30pm on:</p> <ul style="list-style-type: none"> • Tuesday, March 28, 2006 • Tuesday, June 13, 2006 • Monday, September 18, 2006 • Tuesday, December 12, 2006 <p>The meetings will be held at the same location: Holiday Inn 101 West 94th Street Bloomington, MN</p> <p>With the beginning of 2006, WPS will provide a 1-800 number for members to call in on if they are unable to attend the meeting in person. Members are encouraged to use the number when it is not possible for them to be there in-person.</p>	<p>Members will be made aware of the call in number prior to the meeting.</p>
<p>IV. Beneficiary Education Activity</p>	<p>A. Part D – update</p> <p>Beneficiaries may seek information and answers to their questions from providers on the new drug program and ask for assistance in choosing a drug plan. There is a “provider tool kit” that can be downloaded from the CMS website, www.cms.hhs.gov/medicare with information and brochures for providers on the Medicare Part D</p>	

	<p>program or by calling 1-800-MEDICARE. Providers can also refer beneficiaries to the Senior LinkAge Line, 1-800-333-2433, which can answer their questions and assist them in choosing a drug plan. Beneficiaries who currently have drug coverage will be receiving a letter in October from their drug plan to let them know if their current coverage is considered “credible” by Medicare. Credible drug plans are those plans which offer at least as much coverage or more than the Medicare Part D plans. Rita provided handouts for members to have available for beneficiaries.</p> <p>B. New premiums and deductibles for 2006 Medicare Part B</p> <ol style="list-style-type: none"> 1. The premium will go from \$78.20 to \$88.50 2. The deductible will go from \$110 to \$124. 	<p>Rita will contact the MN Board of Aging and State Ship to see if a representative would be available to do a presentation at the December meeting. on the new Medicare Part D drug program.</p>
<p>Provider Education</p>	<p>A. ACT (Ask-The-Contractor) teleconference The next ACT teleconference is scheduled for Wednesday, September 21, 2005, 9am – 10:30am. The topics will include on Modifiers and NPI. Providers who are unable to attend the call may listen to a recording of the call until September 28.</p> <p>Providers do not need to register for ACT teleconferences. ACT teleconferences will have updates that will be discussed, then the call will be opened for providers to discuss any issues or questions they may have on any topic.</p> <p>iLink iLink is a new computer based technology that WPS is using as an educational tool. Providers are able to listen to presentation via phone and to participate in an interactive presentation on their computers. Internet access is needed to participate.</p> <p>C: Member stated that in the iLink presentation that she participated in it was difficult to hear due to background noises from phones that was not muted.</p>	<p>Members are encouraged to listen to these calls and forward this information to anyone who can benefit from these calls.</p> <p>ILink offers a function that allows the presenter to mute all telephones.</p>

	<p>B. Seminars Members were encouraged to submit commits or topics for seminars.</p> <p>C. General Medicare CD-ROM Comments and suggestions received from members on the new General Medicare CD-ROM were incorporated into the new CD-ROM. Copies of the CDs were given to members.</p> <p>D. Small Provider Education (PET) WPS is in the process of forming four Small Provider Educational Groups, Podiatric, Physical Therapy, Chiro, and General Practitioners, to work on educational needs and issues. These groups will meet 2 times per year on a rotating basis through the four states. Providers can attend in person or through teleconference.</p> <p>C: Member suggested asking the societies to help illicit members to Join the groups.</p> <p>E. Listserv: Members were encouraged to signup for the Listserv. Facilities are not limited to the number of people they can signup. CMS set a goal of 25% of providers registered on the Listserv by the end of September.</p> <p>Members were informed that most of the Listserv messages sent are jurisdictional. Those who signed up for state specific messages may be missing a majority of information sent out and are encourage to change their selections.</p>	<p>Per a suggestion from this committee, provider enrollment information was incorporated in the new General Medicare book</p> <p>WPS will be contacting societies.</p> <p>Again, members were asked to sign up and continue to encouraged other providers to sign up</p> <p>.</p>
VI. Updates/Other Issues	<p>A. Medicare 2006 Physician Fee Schedule – CD ROM WPS has sent out the Physician Fee Schedule in the past on CD ROM as part of a CMS pilot project. This year CMS has made it mandatory for all carriers to send it out on CD ROM. Included on the 2006 CD ROM will be supplementary educational tools, Communiqué archive, HIPAA updates, Frequently Asked Questions (FAQ's), information about the Medicare Part D program, helpful hints for using the CD ROM, some of the handbooks and guidebooks</p>	<p>Members received survey And were asked to Forward completed Surveys to the chairs</p>

	<p>from seminars, etc. The targeted date for distribution of the CD ROM is early November. For those providers who are unable to use CD ROM, paper copies are available. Members were asked to complete the survey on the CD ROM to assist WPS in determining what should be on next years CD ROM.</p> <p>B. Medicare Preventive Service – CD ROM The Medicare Preventive Services book is available on the CMS website that can be downloaded along with brochures. Members received a copy of this CD and were informed that CD can be ordered on CMS’ website.</p> <p>CMS is conducting a pilot program on Medicare Preventive Services and are looking for volunteers (physicians, nurses, and other health care professionals including billers and front office staff) to test the newest web-based training course, “Expanded Benefits,” which educates users on the new preventive services available under Medicare. Those interested in volunteering with this pilot testing can send an e-mail that includes their name, profession and contact information to CMS medlearn@cms.hhs.gov with a subject line of ‘pilot tester’.</p> <p>C. Electronic Remit (ERA) WPS is encouraging all providers to receive their remits electronically instead of paper and providers receiving both electronic and paper are asked to drop the paper copies. CMS is currently testing new software with volunteer providers that will allow providers to receive the emits electronically and post payments to their accounts.</p> <p>D. Electronic Funds (EFT) Providers are encourage to begin receiving their Medicare payments electronically.</p> <p>E. National Provider Identifier (NPI) A portion of the ACT call that is scheduled for September 21, 2005 will be devoted to NPI. Provider should be aware that the NPI will not take the place of enrolling with the local contractors. Compliance</p>	<p>Members received a copy of the preventive services CD</p> <p>Questions on ERA may be directed to our EDI department 952-885-2881 (2882) (2811)</p> <p>Questions on EFT may be directed to our EDI department 952-885-2881 (2882) (2811)</p>
--	---	--

	<p>date for all covered entities is May 23, 2007. WPS will be able to process claims with the NPI using either the providers' legacy number or the NPI number at this time, but will eventually be using only the NPI number.</p> <p>F. Toll-Free Numbers for the new Administrative Law Judge (ALJ) Effective July 1, 2005, toll-free numbers were available for the Administrative Law Judge offices of the Health and Human Service Office of Medicare Hearings and Appeals. For providers in Minnesota the office to contact is Cleveland, Ohio.</p> <p>Q: Member questioned the statement on page 8 of the September issue of the Communiqué, under the Partial Rescission of Provision Concerning Decision Letters Resulting from Contractor Fair Hearings, that states: Note: WPS Medicare is no longer required to issue an acknowledgment letter in response to a request for an ALJ Hearing. Is this really referring to ALJ Hearings or from Fair Hearings? A: It refers to the ALJ Hearings. The acknowledgement letter will be issued by the office of Medicare Hearings Appeals (OMHA)</p> <p>G. Interactive Voice Response (IVR) WPS is currently in the process of developing a speech enabled Interactive Voice Response Unit and hope to have that available late this year or early next year.</p> <p>H. Treatment of Hurricane refugees Providers treating hurricane refugees may not have all the information needed to determine Medicare eligibility and meet the privacy requirements. Contractor's customer service representatives are permitted to waive some of the privacy issues regarding release of information. CMS also has a website with questions and answers posted for providers treating hurricane refugees.</p>	<p>CMS has website with questions & answers posted for providers treating hurricane refugees</p>
--	--	--

	<p>I. Anniversary This year marks the 70th anniversary of Social Security Administration and the 40th anniversary of the Medicare program.</p>	
<p>VII. Round Robin (Discussion Questions)</p>	<p>The purpose of this section is to discuss issues that are occurring and to work together to find solutions for those issues.</p> <p>A. Determine why high volume of duplicate denials are occurring: Duplicate denials have been slightly reduced in the last quarter; however they remain the highest denials. The goal is to significantly reduce duplicate denials.</p> <p>Rita is working on complying a list of how many denials each member has. She requested again that members go back to their offices and discuss duplicate denials with their staff and email her as to:</p> <ol style="list-style-type: none"> a. Who is submitting the duplicate claims? If it's the vendor that resubmits the claims determine when and why they resubmit. b. Why the duplicate claims are being submitted? c. The costs and time involved in duplicate denials? <p>Q: Member stated that they are receiving duplicate claims as a result of billing separate claims for PT services that are performed on the same beneficiary, by the same Physical Therapist on the same day, but were ordered by different physicians for different body parts. These claims cannot be billed on the same claim because they have different start of care dates.</p> <p>A: Rita asked member to email her examples that she can research for a possible solution.</p> <p>Rita stated that the second highest denials are unprocessable claims due to incomplete or invalid information. These claims have no appeals rights and must be resubmitted. In many cases only one line on the claim is unprocessable, but providers resubmit the entire claim causing the remaining lines to deny as duplicates. This is very costly for carriers and providers. Providers should check into setting up their systems so they can resubmit just one line.</p>	<p>Members were asked to investigate in their offices – who is submitting duplicate claims, why are they being submitted and at what cost and email Rita with the results.</p> <p>Member should email Chairpersons with examples of duplicate denials for PT services that are done on the same day, by the same therapists, but were ordered by different physicians on different body part with different dates of care. Rita will research for a possible solution</p>

	<p>B. Ansi/Remark codes that do not contain enough information to determine why a claims was denied: Rita stated that CMS has a resource on their website called “Understanding the Provider Remit Notice”, which provides good information on understanding their remit notices. CMS also has a MedLearn Matters article on Remark Codes.</p> <p>Example: CO109 - Claim not covered by this payer contractor claim. This code is used for HMO beneficiaries, Railroad Beneficiaries, could be missing Modifier 26 or could be SNF. Members would like to see this broken out more to state the specific reason.</p> <p>Q: C-SNAP allows providers to determine if the beneficiary is on an HMO, but is there a way to determine which HMO the beneficiary is on. A: A list of all HMO’s is on the CMS website – www.cms.hhs.gov/healthplans/reportfilesdata/claimsaddrs.asp</p> <p>Q: Could a link be created from C-SNAP to the CMS website A: Rita will research this suggestion.</p> <p>Example: COB20 – Payment adjusted because service partially or fully furnished. The example given was denied because an independent lab was paid on the same lab that was being billed by the provider.</p> <p>Q: Member questioned the difference between a COB20 and a COB6 denial code. They both appear to be on independent labs. A: Rita asked for examples so that she can research the issue.</p> <p>Example: CO54 – Multi physicians not covered in this case. The example given shows the same code and date of service being billed by the Radiologists and by a general surgeon, which is why it denied.</p>	<p>Chairpersons will research suggestion to have a link added from C-SNAP to the HMO site on the CMS website.</p> <p>Member will send examples of COB20 and COB6 denial codes to chairpersons</p>
--	---	---

C. Preservative free Tetanus –
Providers have been using code 90714 for Preservative free Tetanus. This code is no longer a valid code for Medicare. The AMA reinstated this code and is being used by other payers. The correct code to bill is 90718. Providers should not be using 90749, which is an unlisted code, as there is a valid code.

Open Discussion:

Q: Member stated that her facility continually bills Medicare for code 36416 – finger prick even though they are aware that Medicare will not pay for this service. She has discussed this process several times with her co-workers, but they state that they need Medicare’s denials so that they can bill supplemental insurances even though most claims are denied by the supplemental insurance as well. She questioned if there anything in writing stating specifically that providers are not allowed to bill for this procedure that she could give to her co-workers.

A: Rita and Mary will research the CO and the Program Integrity Manual that they can put into a Communiqué article or on the Listserv.

Q: Member stated that providers feel that they should be able to bill a separate office visit if they see a beneficiary on two separate times for the Welcome to Medicare Physical

A: The providers must do all seven components of the IPPE in order to bill for the IPPE.

Q: Member stated that providers do not want to do the Visual Acuties when the beneficiaries have just been seen by his eye doctor.

A: Providers must perform all seven components of the IPPE in order to bill for the IPPE. Visual acuties are a component of the IPPE. Providers need to contact CMS with their complaints regarding the required components of IPPE.

Q: Member questioned if there was any new information on Incident

Rita and Mary will research issue of providers billing code 36416 for finger pricks

	<p>Too policy and why it was rescinded.</p> <p>A: No new information has been received on this issue.</p> <p>Q: Member questioned the denials they are receiving for beneficiaries with eating disorders. According to the CPT book it is acceptable to use inpatient CPT codes when a beneficiary is seen in a partial hospital setting, but they are receiving denials.</p> <p>A: Rita asked member to send her an email regarding this issue and she will research it.</p> <p>Q: Member questioned if it would be possible to increase the number of fields for the unit fields. Presently there are only 3 fields which limits the number of units to 999 and many times the have number of units over 1000.</p> <p>A: This is a systems limitation of the MCS system.</p>	<p>Member will email Rita with the question of denials for using the inpatient CPT codes for beneficiaries seen in a partial hospital setting</p>
<p>VIII. MEDPUB – Medlearn Matters Articles</p>	<p>Members were sent the following Medlearn Matters articles to review and discuss at the meeting. No questions on these articles at this time.</p> <p>MM3608 – Initial Preventive Physical Examination</p> <p>MM3902 – Low Osmolar Contrast Media (LOCM): Payment criteria and payment level.</p> <p>MM3883 – Access process for beneficiary Eligibility/Replies (HIPPA 270/271 Transactions) (Extranet Only)</p> <p>MM3956 – Medicare Announces End of HIPAA Contingency Plan for claims submissions</p> <p>MM3935 – New Health Professional Shortage Area</p> <p>MM3648 – revisions to the Medicare Benefit Policy Manual (PUB 100-0), Chapter 15, Sections 220 and 230 Regarding Therapy Services.</p>	<p>If members come up with any questions concerns regarding the Medlearn Matters articles addressed they can send their questions/ concerns to the chairpersons</p>