

Provider Communication Advisory Committee Minutes (PCOM)

9:00a.m.-12:00 noon

September 8, 2003

Madison, Wisconsin

Members: Mercy Health Systems, Medical College of Wisconsin, Cvikota Company, Marshfield Clinic, EBIX Billing Service, Advanced Healthcare SC, Wisconsin Medical Society and UW Health

Agenda Item	Discussion	Outcome/Action
1. Welcome and Introductions	<p>New Members</p> <p>The group welcomed two guests who are attending for the first time and are planning on becoming members</p>	N/A
2. CD ROM Initiative	<p>An analyst from the publications area told the group WPS's plans for sending out the 2004 fee schedules on a CD ROM</p> <ul style="list-style-type: none"> • It will be sent to all providers in November • It will contain instructions for searching the following content <p style="padding-left: 40px;">Fees for WPS's four state region Provider Education Information Provider Enrollment Information Provider Resources Publications</p>	Members will submit suggestions to the Chairperson for additional topics to be included.
3. Updates	<p>1. HIPAA</p> <p>Reemphasized the necessity for all physicians, clearinghouse and vendors to test. Members were given up to date information on testing and a handout out of all resources available to them.</p>	<p>1. Relay this message to all entities they are affiliated with. Members were told to watch for future</p>

	<p>2. Physical Therapy</p> <p>There was some confusion on whether or not the provider community needed to submit a modifier starting July 1, 2003 and which procedure codes needed the modifier. The group was advised to refer to a news article on our website date 9/5/03.</p> <p>3. Crossover</p> <p>We were happy to report to the group that all of our crossover partners have tested for HIPAA.</p> <p>An explanation was given as to why in some cases the crossover partners name appears on the provider remittance and sometimes it does not. It is the discretion of the crossover company whether or not they want their name printed on the remittance. In both situations the remittance states the claim crossed over.</p> <p>4. PCOM member suggestions</p> <p>The chairperson recognized the efforts of our members in the fact that they are continually submitting valuable suggestions relating to the many topics outlined on our suggestion form.</p>	<p>articles or list serv messages outlining the requirements of submitting electronically vs paper</p> <p>2. WPS conducted a mass adjustment on procedure code 25980. The members will let us know if there are any outstanding denials.</p> <p>4. Members will continue to submit suggestions to their chairperson</p>
<p>4. Claim analysis</p>	<p>1. Claim submission errors</p> <p>The group discussed the following four errors. Suggestions were made on how to reduce invalid procedure codes, provider numbers, purchased diagnostic tests and item 11 of the CMS 1500 claim form.</p> <p>2. Top reasons for telephone calls</p> <p>Ideas for reducing the following three reasons are:</p>	<p>1. Members will share this information with their contacts and offices to ensure the reduction of these errors</p>

	<p>Provider Customer Service call center receives calls was discussed. It was determined if we understand why the calls are being made, we can work on educating the provider community and reducing these calls. Eligibility Information, Claim Status and Provider Summary Status</p> <p>3. Appeals Workgroup An analyst that works with our Appeals Workgroup discussed two top reasons for a request for a review. Many providers request a review because they failed to submit the documentation requested and there appears to be confusion on when a modifier 76 can be added to a claim.</p> <p>4. Remark Codes The details of why a B15 is received and what the claims is lacking for correct processing was discussed. Either the claim was submitted with a code that is not payable separately and should not have been submitted based on the database or a modifier is needed because of a CCI situation.</p>	<p>2. Members shared situations on why these calls are being made.</p> <p>3. Based on these two reasons the members were asked to share this information with the appropriate entities in the provider community.</p> <p>4. Members were asked to continue to submit suggestions to WPS relating to confusion or changes regarding remark codes.</p>
<p>5. Benefits Safeguards</p>	<p>Information was shared with the group based on two Communiqué articles developed by our Medical Review area on two probes and their results.</p>	<p>Members were asked to share results with the</p>

	<p>Nail Debridement-Results show that many claims do not have supporting documentation for the service billed.</p> <p>Physical Therapy-Results showed that many providers are not returning the documentation requested in a timely manner.</p>	appropriate departments
6. Policy	A useful handout explaining the differences between an NCD, NCP or a LMRP was given out along with a current list of our retired policies.	Member can use the handouts for any training or as they see useful.
7. Financial	Information received from our financial area indicted that they have had an increase in providers calling because they do not understand refund requests based on the patient being in a skilled nursing facility.	Members were given the address for the CMS website that clearly explains all about SNF consolidated billing.
8. Provider Education Seminars	Details about the Madison Open House that will take place on October 7 th and 8 th was shared. Ideas for the fall series of workshops were discussed.	Members will share thoughts about topics ideas and where and when to hold them with the chairperson.

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6. Compliance of Medical Records		
7. Medicare Part A Update		
8. Open Forum		