

Provider Outreach and Education Meeting Minutes
February 22, 2005

Attendees:

Dell Forrester- Maryland General Hospital; Kristi Pederson- Trans Healthcare; Barbara Cerbone- Centers for Medicare and Medicaid Services; Randy Zimmerman- Johns Hopkins Health System; Rhonda Tucker- Johns Hopkins Health System; Traci Phillips- Maryland Hospital Association; Carla Gardner- CareFirst of Maryland Medicare A; Cathy MacKenzie; CareFirst of Maryland Medicare A; Ella Glover-CareFirst of Maryland Medicare A; Kim Droboniku; CareFirst of Maryland Medicare A; Annette Watkins- Providence Hospital (via conference call); Yvette Morris-Young- Psychiatric Institute of Washington DC (via conference call); Cathy Callis-Garrett Memorial Hospital (via conference call); Kathleen Richardson-Anne Arundel Medical Center (via conference call); Christine Fontaine-Shore Health System (via conference call).

Welcome to the Provider Outreach and Education Advisory Group. The purpose is to provide advice and recommendations for the selection of provider education and training topics.

Upcoming training activities include ESRD Composite Rate training effective 4/1/05. We are still looking for a place to conduct this training.

Inpatient Psychiatric PPS will be held at Sheppard Pratt Hospital on March 14 from 10-3 p.m.

Our training schedule for 2005 is posted on our website; please encourage your staff to sign up on our web site for training.

We had our first "Ask the Contractor" conference call in January; we had staff from our audit area, medical review, EDI, claims and provider relations staff available to answer questions. We had 20 provider participants on the first call and hope to increase the participation for the next call. We had providers submit questions, and we answered those first, and followed up with open questions from the providers. This is similar to the CMS Open Door calls. Our next call will be on April 21st.

We are having a tremendous problem with the submission of credit balance reports. Providers are not completing them correctly. The group suggested we focus on this topic at seminars and send out a bulletin indicating the problems.

CMS Updates- Barbara Cerbone

Barbara announced the name of the group had changed from PCOM to POE.

CMS Part D effective 1/1/06. Barbara explained some highlights on the new Part D benefits. Best place to refer a beneficiary is www.medicare.gov or 1-800-MEDICARE

Medical Review Update- Janice Austin R.N.

MEDICAL REVIEW DENIALS DUE TO NONCOVERED DIAGNOSES

There are many LCDs and NCDs which provide coverage criteria as to the medical necessity of diagnostic services (i.e. laboratory, radiological, etc). Many of these services are evaluated for medical necessity by automated review. We frequently receive requests to adjust the claim by adding additional diagnoses which support coverage. However, claims that have been previously adjudicated by Medical Review can not be adjusted. Therefore, many providers will request an appeal and indicate that certain diagnoses were inadvertently left off of the claim. While this may be an appropriate reason for appeal, the added diagnosis(es) must be supported by medical records accompanying the appeal.

The key to avoiding claims denied due to non-covered diagnoses is insuring that all diagnoses applicable to the service(s) or item(s) are on the claim. Additionally, documentation in the beneficiary's medical record must support the medical necessity of any services or items provided.

Please note that it is very important that you submit all of the information in the Additional Development Request. These denials count toward your overall claims payment error rate and may result in a more intensive level of medical review.

Our web site is available for easy reference of LCDs and coding at www.marylandmedicare.com. The CMS web site is cms.hhs.gov/coverage/#lab for referencing NCDs. On the Main page of our web site is a section for Medical Review. Medical Review articles are listed under this section. New articles are posted monthly so it is important to frequently check this section for updates. Articles pertaining to PHP Claim Review and CERT Non-Responders were published on the web site in December. An article pertaining to Documentation and Coverage Requirements for Rehabilitation Services was published in January. CareFirst will address at least quarterly "Frequently Asked Questions" related to coverage and local medical review policy issues. A document pertaining to questions received during 1st Quarter FY 2005 was published as 2nd Quarter FY 2005 FAQs in January.

AVOIDING DENIALS IN MEDICAL REVIEW

There are two Medical Review concerns that have been identified as standing out:

- 56900 denials--Records not received within allotted 45 days. The date contained on the top left hand corner of the ADR begins the clock for the allowed forty-five days to submit these records to CareFirst. Facilities should standardize their procedures beginning with the receipt of their mail to insure proper routing for ADRs, as many providers deny receiving the original ADR in the appropriate department.

- 54018 denials--Services not documented. Submitting all requested documentation is the key to avoiding 54018 denials. Please note that facilities should submit all of the information in the ADR. The requested information is medically reviewed to insure that the claim is paid correctly in compliance with Medicare guidelines. If any information necessary to review the claim is not submitted, the claim will be partially or fully denied as indicated by the review.

Facilities should be familiar with all information resources available to them such as LCDs, NCDs, CMS Manuals, transmittals, change requests, etc. The CMS and CareFirst websites should be reviewed often and all information forwarded to applicable departmental personnel. Another focus in this area would be to implement a final audit process prior to records submission. An effective process might simply be to have qualified personnel review records to be sent as a final step prior to submitting the records. Not only could proper documentation be reviewed for accuracy, but it would also insure that correct dates of service, complete diagnoses lists, and other requested items contained on the ADR, are accurately reflected. This would help eliminate unnecessary denials that count toward your overall claims payment error rate and may result in a more intensive level of medical review.

Should you have any questions pertaining to Medical Review or LPET, please contact Janice Austin, RN at 410-561-4158 or janice.austin@carefirst.com.

Roundtable discussion-

How do we update a Local Coverage Decision if the diagnosis codes are not expanded enough? (Rhonda Tucker) Contact diane.zekoll@carefirst.com and she will review the requested changes.

Is there a way to determine if medical review denied a service or was is through your automated SuperOp program? (Rhonda Tucker) It does not matter which one placed the denial on the claim, both would need to be appealed.

[Non-Covered charges do not differentiate between beneficiary and provider liability. Is there any way that field can be expanded? \(Rhonda Tucker\) We will forward that on to our systems area.](#)

The short time period given to implement instructions from when we receive it, often programming changes need to occur. (Rhonda Tucker) Barbara Cerbone indicated that the FI is getting out the information as soon as they receive it; CMS is aware and works hard to avoid last minute instructions.

[A concern was brought up about MedLearn mater articles not including whether an effective date is for dates of service or claims submitted by dates. \(Rhonda Tucker\) Barbara Cerbone will forward that to CMS central office.](#)

An issue was brought up about clinic visits being denied for medical necessity. (Dell Forrester) Dell confirmed that it was not multiple units of clinic visits on the same day; she will forward examples to her provider representative.

An issue of bundle billing and hospitals and SNFs not paying for services when the patient was referred to their facility for a particular service was expressed by Dell Forrester. It was explained that when they can't get a facility to cooperate to contact their provider representative and we would contact the facility as long as we service both providers. If we don't we can get CMS regional office involved.

A request for an internet based HIQA/ELGA and mainframe as opposed to the current system. (Dell Forrester) Barbara Cerbone will look into this.

Kristi Pederson requested a cheat sheet with the condition codes for adjustments and the appropriate adjustment reason code.

Kristi Pederson also requested that enrollment forms and user access forms be added to our web site, as well as instructions as to whether they can be mailed or faxed. This would alleviate providers calling Kenya and Wayne when they need to add new users.

Kristi Pederson requested a description of the service be added to the CMS web site for SNF consolidated billing. Barbara Cerbone will look into this.

Traci Phillips expressed a concern providers are facing in that SNF patients are not disclosing that they are coming from a SNF. We could not think of a solution to this, other than asking good questions at the time of admission.

Randy Zimmerman brought up an issue of ELGA not including prior benefit information for MSP and HMO. Kristi Pederson also expressed a concern. Barbara Cerbone will look into this.

Randy Zimmerman advised that our customer service representatives are advising providers to send in hard copy claims of adjustments even though they are not touching the line that was denied. We will look into this.

The credit balance information on our website indicates it is from 1992. We will look into it; we did advise that some of it is more current.

Cathy Callis is having a problem with SNFs not obtaining an ABN because no authorized representative is available, and then the hospital is responsible. It was suggested to stop accepting specimens from this SNF until they can comply. The hospital is in an area where this is the only place that these can be sent.

Cathy Callis also has a problem with physicians not complying with our local coverage decisions and NCDs; they are ordering tests and not indicating appropriate diagnosis codes causing claims to deny. Who is responsible for educating the physicians if they

won't listen to the hospital? Cathy will forward her provider representative a listing of physicians that are not being compliant and we will forward it to Barbara Cerbone who will then refer it to the Part B carrier.

Kristi Pederson mentioned that they had a form that they use to make sure the hospital knows which services they are responsible for, she will check to make sure that she can share it with the group. The letter is attached to the e-mail with the minutes. This is a sample developed by a provider.

Randy Zimmerman asked about an updated HMO directory. We advised that it is located on our web site under provider links. He also asked for a listing of other FIs and carriers, we advised that this link is also on the same page as well as on the bottom of each MedLearn Matter article.

Rhonda Tucker also added that Medical Assistance is asking for denials from Medicare when a person is no longer entitled to Medicare. Barbara will look into this.

Our next meeting will be on Wednesday, April 20th.

(Blue Text indicates an open action item)