



MEDICARE
Part B Carrier
Part A Intermediary

Pinnacle Medicare Services Arkansas Hospital Provider Outreach and Education Advisory Group (POE AG) Minutes		
Meeting Date, Time & Place:	Wednesday, October 17, 2007 ♦ 10:30 a.m. Arkansas Hospital Association 419 Natural Resources Drive Little Rock, AR 72205 (501)224-7878	
Facilitator:	Tanya Brooks	Pinnacle Medicare Services
Medicare Representatives:	David Bailey Tanya Brooks Amanda Crosby Gary Eads * Greg Hart Linda Lewis* Sara Phillips * Sandy Tribble *	Pinnacle Medicare Services Pinnacle Medicare Services Pinnacle Medicare Services Pinnacle Medicare Services Pinnacle Medicare Services Pinnacle Medicare Services Pinnacle Medicare Services Pinnacle Medicare Services
PCOMAG Members in attendance: * Teleconference	Paula Archer Julie Carpenter Paul Cunningham Brian Drummond Carol Gray Martha Hall Sharon Martin Tom Stickel Michaëlle Wilkins	BKD St. Vincent Medical Center Arkansas Hospital Association St. Bernards Medical Center UAMS UAMS Department of Health & Human Services Stuttgart Regional Medical Center Chambers Memorial Health Center

New PCOMAG Members this meeting:		Roy Nichols	Conway Regional Medical Center	
Agenda Item	Discussion/Conclusion	Action Required	Status	
Welcome/ Introduction			Closed	
Purpose	The primary focus of the Provider Outreach and Education Advisory Group (POE AG) is the development and implementation of effective provider/supplier communication materials and strategies. Input and feedback are welcome regarding the best methods to utilize to accomplish these goals.	None	Closed	
Old Business:				
Agenda Item	Discussion/Conclusion	Action Required	Status	
Introductions	Meeting called to order at 10:34 a.m. Paul Cunningham welcomed everyone and opened the meeting with introductions. The meeting was then turned over to Tanya Brooks and Greg Hart.		Closed	
Review of Minutes from April 18, 2007	Our meeting minutes web site link: www.arkmedicare.com/provider/pcomag/default.htm		Closed	
"Present on Admission" (POA) Indicator	POE will obtain clarification on how claims will be reviewed with more than 8 diagnoses when more are needed to prove medical necessity. AI: Members asked POE to obtain guidelines on how the claims department will handle the POA indicator. Beginning for discharges on or after October 1, 2007, hospitals should begin reporting the POA code for acute care inpatient PPS discharges. There is one exception, i.e., claims submitted via direct data entry (DDE) should not	The Part A Claims department will accept the POA indicator on all FISS DDE claims as of January 1, 2008.	Closed	

	<p>report the POA codes until January 1, 2008, as the DDE screens will not be able to accommodate the codes until that date. – Refer to CR 5499 for additional information.</p>		
<p>UB-04 CMS-1500 (08/05)</p>	<p>UB-04 Members had a concern of capturing the reason for visit on the claim.</p> <p>AI: Members wanted to know if our Claims department was looking at this when processing their claims.</p>	<p>Linda Lewis from PBSI Claims Department stated they would not be looking for this on the claim.</p>	<p>Closed</p>
<p>New Business:</p>			
<p>Workshops</p>	<p>PBSI partnered with AHA and presented the 2007 Hospital General Update workshop, as well as, the Rural Health Clinic workshop on June 7, 2007.</p> <p>Workshops Conducted</p> <ul style="list-style-type: none"> • Hospital General Update Webinar - June 29, 2007 • Part A Medicare Secondary Payer (MSP) Webinar – May 16, 2007 • Inpatient/Outpatient Acute Care Hospital Workshop - September 5, 2007 • Hospital Based Ambulance Webinar - August 29, 2007 <p>The group was updated on how well the attendance was at most workshops but they were asked how we can do a better job in notifying the provider.</p> <p>The group stated we were doing a good job in notifying the provider community concerning upcoming events. They asked that we continue to publish the announcements and send all associations notification as well. Members indicated that a separate list serv message would highlight</p>		<p>Closed</p>

	<p>the event.</p>		
<p>Medicare Contractor Provider Satisfaction Survey (MCPSS)</p>	<p>PBSI has received the results of the 2007 Medicare Contactor Provider Satisfaction Survey (MCPSS). The results will be posted on our web site soon.</p> <p>An "Ask the Contractor" teleconference will be held on August 1, 2007 @ 12:00 p.m.</p> <p>Selected providers will receive invitations to our upcoming Provider Satisfaction Survey Focus Group scheduled for August 21, 2007. Providers will be given the opportunity to discuss the results and share their suggestions on how we can improve as a contractor as well as share the positive things we are currently doing.</p> <p>Greg Hart shared background information on the MCPSS. He explained each category and PBSI's grade.</p> <p>The total number of attendees, for the call, was very low and this included providers from Arkansas and Rhode Island. We asked the group how we could improve participation.</p> <ul style="list-style-type: none"> • One member suggested we send an email notification out reminding providers of an upcoming meeting. <p>We encouraged the group to go out on CMS's website and view the 2007 MCPSS results.</p>		<p>Closed</p>
<p>Issue with the National Provider</p>	<p>Effective September 17, 2007, claims will reject if the NPI/PIN combination is not on the crosswalk. If you are</p>		<p>Closed</p>

<p>Identifier (NPI)</p>	<p>receiving rejections because you're NPI/PIN combination is not on the crosswalk it is because of one of the reasons listed below:</p> <ol style="list-style-type: none">1. There was a system problem with the crosswalk file and some NPI/PIN combinations were deleted. This problem has been resolved and deleted combinations have been replaced. <p>OR</p> <ol style="list-style-type: none">2. If you are still receiving rejections, you may not have been on the crosswalk file to begin with. If this is the case, please follow the instructions below:<ul style="list-style-type: none">• Verify the NPI file information on NPPES matches the information Medicare has on your PIN file.• Make sure that NPPES contains ALL of your active Medicare legacy PINs.• If NPPES is correct, check with Provider Enrollment to ensure that your Medicare enrollment information is up to date and matches NPPES.• If incorrect, you will need to submit a completed CMS-855 Medicare Provider Enrollment Application. When completing the CMS-855, list all the NPIs that will be used in place of your legacy PINs that should be matched with their NPI. <p>Remember: The only way to get on the crosswalk is to put your PINs on your NPPES file. If the information in your NPPES file and your PIN file are different, there is a very good chance that no one to one match will be made. Without a match claims will reject.</p> <p>Amanda Crosby informed the group that the</p>		
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Revalidation process had started. When CMS changed to the new PECOS system they realized all providers were not in the system. Some providers had never completed a CMS-855 form. Therefore it has been mandated that all providers must be entered into the PECOS system.

Letters were mailed in September 2007. The letters were mailed to the Top 100 Billers and this was determined by the Tax ID number with the highest volume.

Important:

- **The authorized delegate listed on the Provider Enrollment file will be the one who receives the notice. If this has changed over the years then providers will need to make sure Provider Enrollment has the most current information.**
- **All forms must be downloaded from www.arkmedicare.com or www.cms.hhs.gov**
- **If providers do not submit the application within 60 days, your Medicare number will be revoked.**
- **The forms can be completed online but you must print and sign. An original signature is required by the authorized official.**
- **Submit the application as though you have never enrolled in Medicare before. You will have to submit all required documentation along with the application as well.**

Identified Problems:

- **Provider should make sure they understand the definition of what an authorized official is.**

- **Your Tax ID information should match your Provider Enrollment file and the NPPES file must match as well.**

Revalidations will be done every 5 years.

We asked the group what more could be done to get the word about the revalidation process. Most members agreed that a notice should be placed on the web site and a message should be sent through the listserv.

Amanda Crosby announced that she is over Part A Enrollment and Part B Enrollment is under David Couvillon out of the Louisiana office.

Part B Provider Enrollment experienced a 40% increase of applications which caused a backlog. With the addition of new staff we are processing more timely.

Part A Provider Enrollment are processing 100% of applications within 60 days.

David Bailey stated that as of September 24, 2007 the NPI bypass edit was lifted. A notice has been on all reports since July 2007 instructing providers to use their NPIs. The bypass allowed the NPIs to be processed even if there was no crosswalk. Now that the bypass has been lifted the system is now checking for a match. For those providers who have not confirmed their crosswalk they are experiencing rejections.

If you are having issues with your NPI you will need to contact NPPES to resolve this issue.

- **For Part A the system is checking for the “billing” and “pay to” NPI.**
- **For Part B the system is checking for the “billing”, “pay to” and “rendering” NPI.**

As of January 2008 you must use your NPI on your claims for the “billing” and “pay to” providers. You may still use your legacy number for attending and referring physician.

There have been two issues identified:

- **Provider Related** – Providers are sending the individual number when they should send the group number. They are submitting claims with the “rendering” NPI when they should send the “pay to” NPI.
- **System Related** – The new data center, CDC, is who we receive our NPI crosswalks from and also our remits. A crosswalk file was accidentally deleted which caused numerous rejects.

On 10/5/07, 76% of all files Med A sent were kicked out. EDI is instructing them to resubmit. It is imperative that providers check their H99 reports. This report will tell you how many claims you submitted made it into the system and how many were rejected. This report is downloaded through the Gateway system which is used for batch

	<p>submission.</p> <p>As of 10/1/07 any application submitted for any EDI transactions must include the providers NPI.</p> <p>HIPAA 2 – 5010A reports will be adopted around the 1st quarter of 2008. They will replace the 837 4010A report. The reason for the change is to be able to handle the ICD-10 code set.</p>		
<p>Clarification for Ambulance Services Rendered During Inpatient Care</p>	<p>Ambulance services are separately reimbursable only under Part B. Once a beneficiary is admitted to a hospital, Critical Access Hospitals (CAH), or Skilled Nursing Facility (SNF), it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider.</p> <p>Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B.</p> <p>Members agreed this was a problem but the educational efforts made by PBSI have been great and we have experienced a decrease in the number of Claim Submission Errors.</p>		<p>Closed</p>
<p>Comprehensive Error Rate Testing (CERT)</p>	<p>The CERT error rates are used by CMS to measure progress toward performance goals (paid claims error rate less than 4.3% by 2008. Because of this, it is vital that you respond to any and all requests for medical records from the CERT Documentation Contractor.</p> <p>We have found that there are questions providers still</p>		<p>Closed</p>

<p>have concerning the CERT program.</p> <p>Medical Record Location Problems are occurring when attempting to locate medical records. Here are some potential root causes:</p> <ul style="list-style-type: none">• Location of Care may be incorrectly submitted on the bill• Accuracy of input of the performing provider field on the bill• Medical records not stored at the location of the billing provider• Physician Office provider may not have copies of the medical record when the services he/she provided were at the hospital or clinic setting <p>The CDC states they need the providers help in ensuring the patient name, date of service, and other information provided on the claim are accurate and that the medical record documentation is available a the provider's office or through their billing service.</p> <p>Here are some very important facts to know concerning documentation submission.</p> <ul style="list-style-type: none">• CERT Documentation Contractor (CDC prefers documentation to be faxed. Please make sure the original document will fax in high quality.• CDC can accommodate imaged legal sized paper.• CDC will contact providers to obtain legible documents. <p>POE would like to know if there are any other obstacles they may be experiencing when it comes to complying with CERT requests.</p>		
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**Part A CERT Reports
Gross Paid Claims Error Rate,
Including Non-Response**

Fiscal Intermediary	May 2006 Report (Claims submitted from 4/1/05 to 3/31/06)	Nov 2006 Report (Claims submitted from 4/1/05 to 3/31/06)	May 2007 Report (Claims submitted from 10/1/05 to 9/30/06)
RI	1.8%	1.2%	1.0%
AR	2.8%	2.6%	1.5%
All FI Clusters (Average)	3.5%	2.3%	1.4%

Members were surprised to hear that facilities were receiving CERT errors due to incorrect documentation submission. They agreed that these results are important during presentations with as much detail as possible for providers.

2008 Health Professional Shortage Area (HPSA) Bonus Payment and Physician Scarcity Area (PSA) Bonus Payment

The 2008 HPSA bonus payment file will be used for the automated bonus payment for claims with dates of service on or after January 1, 2008 through December 31, 2008. Physicians and providers should review the CMS website to determine whether a HPSA bonus will automatically be paid for services provided in their ZIP code area or whether a modifier must be submitted.

Physician scarcity designations are based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in every country or the

Closed

	<p>lowest primary care and specialty ratios of Medicare beneficiaries to active physicians in each identified rural census tract. The bonus payment is based on the amount actually paid, not the amount Medicare approved for each service. PSA termination date is December 31, 2007 and is not payable for dates of service after that date.</p> <p>Members asked that we make of note of this in our educational material.</p>		
Workshops	<p><u>2008 Workshops</u> Hospital Based Ambulance Webinar Inpatient/Outpatient Webinar Claim Adjustments Webinar Observation Webinar Medicare Secondary Payor (MSP) Webinar Hospital General Update Workshop Evaluation/Management Webinar Navigating the Web Webinar</p> <p>A listing of the 2008 workshop schedule was discussed with the group and they all felt these were very beneficial topics.</p> <p>Paul Cunningham suggested we add a topic concerning Recovery Audit Contracts. Greg insured the group that we would be including it in our educational material, it is one of the sources reviewed by our Medical Review area when considering their plans for the upcoming year.</p>		Closed
"Ask The Contractor" Teleconference	<p><u>2008 ACT Teleconferences</u> Consultation Provider Enrollment & Revalidation Intravenous Infusion of Immunoglobulins (IVIG) Medicare Overpayments</p>		Closed

	<p>The members felt the list of upcoming topics were a good selection.</p> <p>Paul Cunningham suggested we create an educational guide on the new DRG system and also the Medicare Advantage Plans and the No Pay Bills</p>		
<p>Open Discussion: PAG Member</p>			
<p>Claim Solution Open Door Day</p>	<p>Michaelle Wilkins suggests that PBSI host a Claim Solution Open Door Day on a quarterly basis. She stated that the workshops are great with keeping us current on updates but there are so many different claims issues that they are hard to address at a workshop. She states that her billers have over 15 years of billing experience and they know how to bill. They need more complex issue resolutions. They want to come and sit with a Claim Specialist to work through some of their more complex issues. Members were in agreement to this idea.</p> <p>Gary Eads felt it was good idea but due to budget constraints this could not be accomplished at this time.</p> <p>Members felt that PBSI should make the effort to develop this suggestion.</p> <p>Another member suggested if an email box could be set up to send their questions directly to the claims department.</p> <p>Greg reminded everyone of the processes we currently have in place and he encouraged them to utilize these processes. He reminded them of the</p>	<p>POE will work with Claims and Customer Service to explore options.</p>	<p>Open</p>

	<p>45-day response CMS guidelines for all written correspondence.</p> <p>Gary Eads instructed members to contact him directly if they were having complex issues and were unable to resolve them through our current processes.</p>		
Meeting Location	<p>AHA will begin their remodeling process in November. Therefore, the Hospital POE AG meetings for 2008 will be held at:</p> <p>Pinnacle Business Solutions, Inc. 515 West Pershing Blvd North Little Rock, AR</p>		
Adjournment	<p>The meeting was adjourned at 12:35 p.m.</p>		
	<p>The next POE Advisory Group Meeting:</p> <p>Place: PBSI – North Little Rock, AR Date: January 16, 2008 Time: 10:30 a.m. – 12:30 p.m.</p>	None	Closed