



Draft—Not Yet Approved
**Minutes of the Maine Hospital Association
 State Uniform Bill Committee**
 June 3, 2005
 11:00 a.m. – 3:00 p.m.
 Maine Hospital Association

Chair: Suzanne Menard*

Members:

Gini Anderson
 Richard Bean
 Jeannine Bouchard*
 Sandra Bovard*
 David Carrier
 Benton Cash
 Paul Collins
 Cathy Conroy
 Vicki Cunningham*
 Vickie Domingue*
 Donna Esterline
 Stacy Forcier
 Maggie Fortin*

Tony Fournier
 Jean Fredette
 Rebecca Genest (via phone)*
 Kim Gray
 Barbara Hayden
 Elizabeth Inman
 Judi Kieltyka*
 Kristin Larkin
 Carol Male*
 Melody Morin*
 Shellie Nichols
 Rhonda Obie*
 Cheryl Pelletier*

Linda Quintal*
 Michelle Quintal
 Joanne Rawlings-Sekunda*
 Cheryl Rood*
 Cristina Ruecker McBreairty*
 Pat Schnable*
 Ann Stengelsen*
 Don Wacome
 Teri Lee Wade (ad hoc)
 Mark Warren
 Christine Wescott

MHA Staff:

Tamara Butts*

Guests:

Glenn Griswold*

**Indicates attendance*

Recorded by: Tamara Butts

TOPIC	DISCUSSION	ACTION/FOLLOW-UP
Call to Order		Suzanne Menard, chair, called the meeting to order at 11:00 a.m.
Minutes of the April 1, 2005 Meeting		MOTION: To approve the minutes from the April 1, 2005 meeting. <u>CARRIED.</u>
Membership Update	Michelle Quintal has left MaineCare and is now working at the Augusta central offices of Maine Veteran’s Home. She will remain on the committee to represent nursing homes. Barbara Hayden of Aetna in Pennsylvania has asked to be put on the list to get mailings.	Add Barbara Hayden to

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	<p>She may attend when in Maine or connect via phone.</p> <p>CIGNA has downsized to a few people so Suzanne Menard will call Mark Still to see if Ron Pelton or Mark will attend the meetings.</p>	<p>mailing list.</p> <p>Suzanne Menard will contact Mark Still about a CIGNA representative.</p>
NUBC Updates	<p>May 11-12, 2005 Tentative Agenda:</p> <ul style="list-style-type: none"> • Inpatient psych PPS – no adjustment to PPS rate if admitted to psych upon transfer from PPS hospital. If not coming from PPS can get upward adjustment for transfer. Need new source code to identify PPS vs. non PPS provider. SUBC supports assignment of this code – Source of Admission Code X. • Change in definition for value codes 48 and 49 – likely preparing for future changes. • New bill type for Non-Patient Lab Specimens requested by CMS. Maggie Fortin will call CMS to get additional information because this does not make sense. • Condition Code requested for item provided without cost to provider which applies to recalled or failed equipment that may be reimbursable to Medicare. Also, want to exclude from cost-base for determining PPS. Providers would have difficulty determining what CMS needs and which claims to identify. Likely would be a Medicare as Secondary Payer situation (product liability). Also, how can one account for increased cost of replacement parts. 	<p>Maggie Fortin to contact CMS about new bill type for non-patient lab specimens. Suzanne Menard will provide feedback to NUBC that the new bill type is not needed.</p> <p>Regarding condition code request, respond to NUBC that providers are limited in determining what CMS needs and claims to identify</p>
UB Implementation Issues	<p>Partial Hospitalization Issues White Paper – Maggie Fortin has distributed a grid to payers and will follow up in two weeks with each of them.</p> <p>Anthem Issues:</p> <ul style="list-style-type: none"> • Use of 77X category revenue code – Anthem system has changed to accept preventive codes and pay correctly. Providers can use 300 series revenue codes. • New billing policy for hospital based physicians, copay concerns – Anthem has provided guidance to providers regarding how to bill for various services. (See attached handout). Emergency department visits require a split bill, and Anthem claims this will not result in 2 copayments for patient. Anthem indicated that commonly used CPT codes for ER do not take copay on the CMS 1500 billing form. The same is true for inpatient services. When asked about procedures, cardiologist readings, etc. Anthem indicated that there is still no copay. These changes will require new contracts with hospitals. 	

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	<p>For practitioners that are already credentialed, hospital should provide Medical Provider Application for Participation Request and w-9 to record payment correctly. Hospitals won't be asked to recredential.</p> <p>Medicare crossovers – checks may go directly to provider.</p> <p>Special instructions for site of service will be provided – includes site of service reduction. This is a problem for hospitals since the service was provided in a department of the hospital.</p> <p>Does not include CRNAs or psychiatrists.</p> <p>Must do a separate 1500 for each practitioner.</p> <p>There are some alternatives and hospitals must negotiate during contracting. Becky Genest and Cathy Conroy are visiting every hospital with the contracting team.</p> <p>MaineCare Issues – Problems with the claims processing system continue.</p> <ul style="list-style-type: none"> • Previously billed and adjustment denials – claims are in system • Looking at week of June 13 for remits to come off the system • Cheryl Rood agreed to send updated problem list with examples and timeframes to Tammy Butts to share with the Committee. • The Committee stressed the need for MaineCare to communicate timely to providers about changes and corrections. • IVR - taking eligibility from old system, as of 6/13 it should be capturing info from the new system. • Providers asked for an inventory of claims in the system because MaineCare inquiry staff is instructing providers to rebill when some claims are likely already in the system. <p>If hospital representatives have denials for reasons that are not already on Cheryl Rood's list, give narrative description of the problem to Cheryl and send examples to Linda Quintal and Cheryl Pelletier at MaineCare.</p>	

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Old Business	<p>MHDO Update – Currently the MHDO is wrapping up the details of the claims data and are getting ready to release it.</p> <p>Hospital-based billing issues – Glenn Griswold reported that LD 416 had passed during the recent legislative session addressing hospital based billing. He noted that the goal of the Bureau of Insurance was to fix the copay issue (eliminate double copays) for hospital based primary care providers. Hospitals must review contracts with payer regarding facility fee payments. Hospitals cannot balance bill the patient if carrier won't pay facility fee. The Bureau of Insurance will go after the hospital and the carrier if consumer is not held harmless. Hospital representatives reminded the group the hospital charges did not change when physicians moved to hospital based. The charge was just separated into two components.</p>	
New Business	SUBC Website – part of the AAHAM site – link is working but some edits are necessary and the Committee would like to have more info available on the site.	
Subcommittee Updates	<p>Attachment – Tabled</p> <p>Electronic – notified of Anthem maintenance updates in June and July. The Committee asked Cristina Ruecker McBreaity to look into the problem of limitation to the number of lines on a claim.</p>	
Adjournment		The meeting was adjourned at 3:25 p.m.