Greater Louisville MEDICAL SOCIETY est. 1892

GLMS Private Payer Roundtable October 26, 2017

ANTHEM		
Anthem Question 1 Submitted prior to roundtable	Our practice is having claims conflicts with Prolia injections. We called to see if a PA/Pre certification was required for Prolia injections and were told no. When the claim was processed it was denied for no PA. We have documentation of the date, time, and who we spoke with, but the representative would not take that information to pay the claim. They are reviewing their records.	Connie Lefler, Clark Phys Group Just for Women Health Solutions
Anthem Response:	*Although this issue was submitted to Anthem in advance, the practice was unable to respond to Anthem's request for further details prior to the roundtable in order to address this concern. Connie was present at the meeting and will provide details to Anthem following this meeting. Kelly Tindle responded that as a general rule, it is suggested to document the number called and the name of the representative you speak to when calling about a pre-authorization. If you are told none is needed, contact your Anthem provider rep and provide that representatives's name and the call details to get the issue resolved.*	

ADDITIONAL ANTHEM ISSUES DISCUSSED DURING ROUNDTABLE	
Further Pre-Auth Info	***What procedures require a preauthorization; what is Anthem's process for preauthorizations?*** *Preauthorizations for Anthem members may be obtained at availity.com. Availity will direct the provider to the appropriate place to request a preauth depending on the type of service needed and will also confirm whether a not a preauth is needed for the requested service. Turn around time for non-emergent preauth requests is within 72 hours.*
Formularies	***In regards to tiers for Pharmacy benefit management; does Anthem have a method to determine which medications are placed in which tier?*** *The tiering process is determined by the Pharmacy Manager. Generally, the tiering can depend on factors such as the cost of the drug, its purpose, and how long it has been on the market. Kelly Tindle will speak with the pharmacy manager for Anthem and find out how the tiers are determined and how frequently they change. She will follow up with GLMS on the information.*
25 Modifier Reductions	*Beginning with claims processed on or after January 1, 2018, evaluation and management services that are eligible for separate reimbursement when reported by the same provider on the same day as a minor surgery ("0" or "10" day global period) will be reduced by 50%. This change is expected to effect many specialities but especially Dermatologists. Concerns about this policy change may be emailed to Kelly.Tindle@anthem.com. Kelly Tindle will follow-up with GLMS with more information including how/when were providers were notified of this change.* ***FOLLOW-UP DETAILS FROM KELLY TINDLE ON 10/31/17*** *: A few offices asked about E&M with a flu shot or E&M with immunizations and this does not apply. The modifier 25 reduction is for E&M with a surgery CPT code starting with 10000 CPT code series.*
New Administrative Directory	*New Administrative Directory listing Anthem pre-fixes is expected to be available in the next couple of weeks.*
Exchange Plans	*In Kentucky, Anthem exchange plan members currently enrolled in the Pathway X PPO plans will be moved to the Anthem Pathway X HMO plan for 2018. In Indiana, Anthem is withdrawaling from the exchange marketplace altogether and will not offer plans on the exchange in 2018.*

GLMS Private Payer Roundtable October 27, 2017

HUMANA		
Humana Question 1:	Humana routinely will recommend a discharge from a facility contrary to the physician's recommendation that the patient needs to stay longer. The physician recommends continuation of skilled therapy until the patient is no longer at risk for falls, heart or high/low blood pressure issues, etc. This early discharge from the SNF often results in readmittance to the hospital from home which is more costly to the insurance company than continuing therapy. It would be helpful if Humana could explain how they determine insurance discharges from SNF	Sara Melhorn, Norton Geriatrics
Humana Response:	*Dr. Slayton provided details on the review processes for discharging patients from a SNF. Continued stay reviews are performed by physicians. Providers may request a peer-to-peer review if they disagree with the results of the continued stay request. He noted that the average length of stay in skilled nursing facilities has increased over the years instead of decreasing and hospital admisstion rates following SNF discharge has decreased by 5%.*	
Humana Question 2 Submitted prior to roundtable	Humana **Gold** patients state they have a $40 copay for mental health. However, the copay processes at $45 for a psychiatrist which upsets the patient. They call Humana and Humana tells the patient the office is doing it wrong. The office charges the patient the amount stated on the explanation of benefits. For a therapy appointment, Humana processes at $40 copay.	Nancy Butler, Louisville Behavioral Health Systems, PLLC
Humana Response:	*Pam Trigilio responded to Nancy on this issue prior to the roundtable to say that this pertains to the member's benefits. Pam will be sending this issue for review and will work with Behavioral Health Systems on follow-up.*	
Humana Question 3 Submitted prior to roundtable	Not recognizing place of service. Humana recouping on OB patient that was seen in the office then sent to Baptist Health Floyd for observation. Claim was paid then recouped stating included.	Michelle Heintz, OBYGYN Associates of Southern IN
Humana Response:	*Michelle added that she has communicated with the PPI Dept with no resolution after 1.5 years dealing with this same issue. Cathy Kraemer will follow-up on this concern.*	
Humana Questions 4 Submitted prior to roundtable	A continuing issue with Humana is a claim will be recouped 24 months after it has been paid, without any explanation, or knowing what patient it is for. How long does Humana have to recoup a claim?	Lisa Dischinger, Sensible Psychiatric Services
Humana Response:	*Cathy responded that she was under the impression that Humana followed an 18 month recoupment timeline. The response from the audience was that many have received recoupments up to 24 months following payment. Further discussion revealed that recoupment requests do not include details needed by the practice and they are not able to obtain this information by calling because they cannot speak to a person and have to leave a message.*	

GLMS Private Payer Roundtable October 27, 2017

ADDITIONAL HUMANA ISSUES DISCUSSED DURING ROUNDTABLE	
Pre-Auth Info	***What procedures require a preauthorization; what is Humana's process for preauthorizations?*** *H umana preauthorization requirements are based on national guidelines. They have different review expectations for different procedures and/or speciality services. Dr. Slayton explained Humana's philosphy on preauthorization requirements and noted that they are taking an approach of backing way from adding more requirements as opposed to adding to the list of services that require preauthorization.Turn around time for non-emergent preauth requests is 14 days; emergency cases 72 hours. Preauthorizations may be submitted online.*
Formularies	***In regards to tiers for Pharmacy benefit management; does Humana have a method to determine which medications are placed in which tier?*** *Factors which determine what medications are in which tier include agents in the class and published information of quality efficacy. These are reviewed on a regular basis.*
Oral Surgery Preauth	*A concern was raised regarding preauthorizations for oral-surgery requirements and reviews not being performed by "peers". The concern is that the reviewer may not understand the surgery in question, resulting in an inaccurate denial. Dr. Slayton suggested that there may need to be more education provided to the pre-auth team specific to oral surgeries that are being requested and denied. He will follow-up with the practice for additional details and specifics.*
UNITED HEALTHCARE ISSUES DISCUSSED DURING ROUNDTABLE	
Pre-Auth Info	***What procedures require a preauthorization; what is UnitedHealthCare's process for preauthorizations?*** *United Healthcare has a committee that decides which services require preauthorization. Molly will send more detailed information to GLMS to share with members. Preauths may be requested at UHCprovider.com at the Advanced Notification/Prior Authorization link.* ***FOLLOW-UP DETAILS FROM MOLLY ON 11/08/17:*** *Providers can locate the Advance Notification/Prior Authorization Requirements by going to our provider portal at uhcprovider.com/advance. The requirements list the codes that require Advance Notification/Prior Authorization. Housed here are also FAQ's for Physicians and a Quick Reference Guide for submitting the request online via Link. I stated in the roundtable session that there was a committee/board that decides what codes are placed on the advance notification/prior authorization list ... the committee is composed of physician and nursing leadership. They perform reviews of utilization to decide what codes go on the list. The Medical Director stated that the process is most stringent with Medicaid processes due to state rules and Medicare due to federal guidelines. For the Commercial plans the choice of codes are or can be impacted by the private payor or company and how the plan for management is set up.*
Formularies	***In regards to tiers for Pharmacy benefit management; does UnitedHealthCare have a method to determine which medications are placed in which tier?*** *Molly will send more detailed information to GLMS to share with attendees.* ***FOLLOW-UP DETAILS FROM MOLLY ON 11/08/17:*** *From UHC PDL Decision Making Process document - UnitedHealthcare takes a comprehensive approach to determine a drug's value, including impact to overall healthcare costs and outcomes. The evaluation of any medication and/or clinical program are completed by the UHC Pharmacy & Therapeutics (P&T) committee.*

GLMS Private Payer Roundtable October 27, 2017

Web Updates	*Unitedhealthcareonline.com is moving to UHCprovider.com. News, policy information and Link will be located at this new site. UHC On Air for provider education and My Practice Profile for demographic updates will also be at UHCprovider.com*
Contracting Representative	*Mark Bronke has joined United Healthcare as the new Physician Network Contractor.*
Pre-Check My Script	*"Pre-check my Script" is a provider tool where you can view formularies, check coverage and benefits for a patient and also see if a preauth is needed for a prescription medication.*
Claims Reconsiderations	*Corrected claims may be uploaded at the Claims Reconsideration box in the Link self service tools at UHCprovider.com*