Private Payer Roundtable
October 11, 2018

Anthem

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Issues submitted prior to roundtable

1. *(All Payer Question) What are the top 5 support calls or questions that you receive from providers?*

Response:

i. *Credentialing (status, process, termination)*
ii. *AIM - Prior Authorizations specific to different plans*
iii. *Availity – not showing specific eligibility details, ERA/EFT issues*
iv. *Reimbursement Policies and Clinical Guidelines (BlueCard plans)*
v. *Claim denials and appeals*

2. *(All Payer Question) What are the top 5 claim denial reasons that you currently see?*

Response:

1. *Providers not participating with a specific network*
2. *Incorrect billing; modifier usage*
3. *AIM – prior authorization issues*
   - *Some BlueCard plans don't use AIM for PA*
4. *Providers not aware of Medical Policy and Clinical Guidelines*
5. *Availity – detailed eligibility, ERA/EFT*

3. *(All Payer Question)* What major changes or initiatives can providers expect to see in 2019?

Response:

i. *Merging of Provider Relations teams – Medicaid and Commercial teams will become one in Kentucky and Indiana. Claims processing will remain the same.*
ii. *Coming Soon – 4/1/19: Availity – the ability to dispute a claim payment/denial online*
iii. *Currently live: Availity – the ability to upload "solicited" medical records to attach directly to the claim; to have the ability to upload "unsolicited medical records and additional documentation to attach directly to a claim.*
iv. *EDI Availity Gateway – claim clearinghouses*
v. *Upcoming Provider Workshop webinars –*
   - *3 hour webinars on Oct. 23 and Oct 25*
vi. *Virtual Credit Cards for providers who are not signed up for EFT.*
   - *ERAs will be on Availity only. Providers can opt out of virtual credit cards but will still have access ERA on availity.com.*

4. Please provide information on Anthem individual plans that will be offered on Healthcare.gov for 2019 including network details

Response:

KY - Pathway Transitions HMO and Pathway X Transitions HMO. The alpha prefixes are: VXZ, XTV and VTY. The Transitions network is very limited. This is an ACA Health plan. It is not to be confused with Pathway/Pathway X

(Gold, Silver, Bronze) PPO and HMO plans. "Transitions" is the key word in identifying these policies. There are no updates for any additional plans to be offered on or off the exchange for Indiana

- *Transitions Network includes the following hospital system and providers; UofL, Hardin County Hospital, Carrol County Hospital and UofK.*

5. Well exam/preventative visits; Why are CBC's and urine not considered preventative thus not being paid and considered non-covered charges?
(*Practice Name: Brownsboro Park Pediatrics)*

Response:
I received 3 claim examples to review. All 3 examples are Blue Card plans. CBC's (85025) and urine dipsticks (81000) are denying due to the submitted diagnosis of "routine physical diagnosis".

Blue Card plans are out-of-state plans that instruct Anthem KY as how to process the claims according to their member's policy. I requested the provider review the diagnosis codes on these claims and resubmit a corrected claim if possible.

Roundtable Discussion:

A. ACA Pathway Transitions Plan
   - What will pediatric anesthesia providers at Norton need to do to be able to provide services to Transitions members since only UofL will be in-network? Anthem will follow-up
   - Does the Pathway Transitions plan include hospice benefits? Anthem will follow-up
   - Since the Transitions plan was already available in 2018 for Hardin County residents, some providers have already encountered issues with confusion from members

B. When Anthem mails notices to providers of changes to contract, network, etc, do they mail those to the provider or to the group?
   - Notices are mailed to each provider individually and to the group addresses.

C. When dealing with a mass quantity of claims denied for timely filing, what is the best method to appeal this and get the claims reprocessed?
   - Submit a letter to Anthem stating the reason they were not filed timely

D. Kristin at Anthem will send an updated Administrative Directory to GLMS for distribution to attendees. This Directory is updated regularly and may be found at Anthem.com

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Humana

Cathy Kraemer, Director, Provider Contracting ckraemer@humana.com
Melinda Hulon, Regional Manager, CCM Service Experience & Quality mhulon@humana.com
Aaron Brashear

Issues submitted prior to roundtable

1. *(All Payer Question) What are the top 5 support calls or questions that you receive from providers?*

Response:

I. *Eligibility and Benefits*
II. *Financial Recovery*
III. *Grievance and Appeals*
IV. *Claims processing*
V. *Others are around demographic inquiries.*

2. *(All Payer Question) What are the top 5 claim denial reasons that you currently see?*

Response:

I. Charges for services received after your coverage has ended are not covered. Refer to your Benefit Plan Document.
II. No payment is allowed for this service. This service is part of a primary procedure and is never separately payable.
III. This charge is a duplicate. Please refer to the original explanation of benefits for payment information.
IV. The service being billed is not supported by the diagnoses billed and is not considered separate and distinct from other services billed on the same date of service. No additional payment will be made
V. Charges for dependent maternity not covered. Please refer to your Benefit Plan Document for more information.

3. *(All Payer Question)* What major changes or initiatives can providers expect to see in 2019?

Response:

I. For Customer Service calls, IBM Watson interactive call technology.
II. For Providers, new info in directories called Care Highlight (was Care Value).
III. **Quality & Cost Efficiency Ratings**
- Beginning in 2019, Humana will begin rating physicians on quality and efficiency using ***hearts*** and ***ribbons*** on the provider directories.
- Letters about the quality rating program will be sent to providers this fall and there will be an opportunity at the beginning of 2019 to dispute the current rating and/or request additional details.
- Ratings will go live on Humana.com in the Spring of 2019.

4. When uploading documents to website in response to record requests, only 1 record can be uploaded at a time. Can this be changed to allow more than one to be uploaded? *(Practice Name: Gastroenterology Health Partners)*

Response:

I think the upload needs to be tied to the inquiry to make it actionable and meaningful.

- *Front End Record Requests – If claim is pended for records, upload at availity.com (up to 300 mb)*
- *PPI or Post Pay Record Requests – MRM barcode included with request and unique to each patient.*
- *If practice has an EMR connection with Humana, there should be a lot of information that is able to be accessed directly. They are working on improving this process and technology.*

5. We [ENT Group] merged with an allergist group this year and Humana is using the ENT edits to process their claims. This is resulting in denied claims for same day as an OV with allergy testing. Our understanding is that allergy edits will allow testing and OV on the same day. We bill 99204 with a 25 modifier and the appropriate allergy test, 95004. Humana is paying the office visit and denying the allergy testing. Before the merger, this group billed the same way and was reimbursed consistently for both. Why would merging these group cause a difference in claim edits? *(Practice Name: Advanced ENT & Allergy)*

Response:

- *Humana will follow-up after Roundtable*

Roundtable Discussion:

A. Humana continues to make changes to the way they provide support to practices. In addition to calling the provider services number where a reference number will be given, providers also have the option of sending an email to contactppi@humana.com or helpppi@humana.com. Be sure to provide the reference number in your email.

B. Humana has done away with referral requirements on all plans, including HMO products

- Bennett & Bloom is still experiencing denials for no referral. Send examples of these to Cathy Kraemer to research. The Community HMO plan has a narrow network and not all physicians are in-network so this may be causing these denials instead of missing referrals.

C. Are COB requests sent to patients every year?
- Humana's COB department sends these requests out regularly on every plan and member in order to collect the most up-to-date information
- COBs must be completed for each individual member and not per family

D. When Humana sends out notices to providers of changes to contract, network, etc, do they mail those to the provider or to the group?
- If material changes are made, Humana has to give proper notice and will follow the requirements.
- Other notices are mailed to each provider to give them information on upcoming changes, etc.

E. What is the most efficient way to address incorrect payments being made contrary to the contract?
- Since this is a contractual issue, reach out to Cathy Kraemer for assistance

F. When dealing with a mass quantity of claims denied for timely filing, what is the best method to appeal this and get the claims reprocessed and will Humana override timely filing?
- Melinda and Cathy will be able to help with this on a case-by-case basis and Humana may approve overriding timely filing denials depending on the circumstances of each case.

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United Healthcare

Molly Mills-Kidd, Senior Hospital/Physician Advocate molly_f_mills@uhc.com

Billy McCord, Manager, Network Contracting william_d_mccord@uhc.com

Issues submitted prior to roundtable

1. *(All Payer Question) What are the top 5 support calls or questions that you receive from providers?*
Response:
   - *This varies from provider to provider, however the most support calls or questions I receive are claims related*
   - *Policy interpretation questions*

2. *(All Payer Question) What are the top 5 claim denial reasons that you currently see?*
Response:

The top five denial reason codes again vary from provider to provider but mostly are;
   - *Not separately reimbursable*
   - *Modifier usage*
   - *No prior auth/notification*
   - *Maximum frequency per day*
   - *Non-covered item.*

6. (All Payer Question) What major changes or initiatives can providers expect to see in 2019?
Response:

A. *New Medicare Advantage Plans becoming effective 01/01/2019*
   - *Will expand into 9 additional counties in and around Jefferson County for a total of 17 counties*
   - *United Healthcare brought handouts listing the highlights of this plan with sample of member card*
   - *Will this plan have a hospice benefit? Yes*

B. Dual Special Needs Plan (DSNP) plan effective 01/01/2019
   - Same 17 county footprint as Medicare Advantage Plan

C. Medicaid Contract
   - Sent out at least 2 mailings to establish a Medicaid network in preparation for the state rebidding for Medicaid MCOs in 2019 or 2020
   - United healthcare has Medicaid plans in other states.
   - Behavioral Health will go through Optum for Medicaid plan just like commercial plans currently.

Roundtable Discussion:

A. Patients presenting with AARP card with “Passport logo”. This allows the patients that are commonly referred to as snow birds to obtain services outside of their home area.
   - The patient must call to activate this coverage prior to being seen outside of their home area each time.
   - Claims will not be paid if the patient does not call prior to being seen.
   - Denials for no-referral on these plans?
     Bennett & Bloom experiencing denials for no referral when the member card states no referral needed.
     Contact Molly when denials are rec will follow-up after Roundtable

- If provider is contracted with United Healthcare, are they automatically contracted with the AARP Passport plan? If contracted with United Healthcare Medicare products, should be par for this plan as well as new Medicare Advantage plan in 2019.

B. When United Healthcare sends out notices to providers of changes to contract, network, etc, do they mail those to the provider or to the group?
   - This depends on the communication notices are primarily mailed to the correspondence address on file. Policy changes are communicated in the Network Bulletins posted online

C. When dealing with a mass quantity of claims denied for timely filing, what is the best method to appeal this and get the claims reprocessed and will they override timely filing?
   - Send to Molly and she will assist