

2009 ISMA Commercial Payer Forum

The ISMA held this year's Commercial Payer Forum June 12 in Fishers, Ind. The event offers an opportunity for physicians' practice personnel to hear from the state's commercial health insurers directly and ask questions of company representatives. This year five health care insurers participated. The event includes a vendor fair that allows medical office staff to view and personally discuss an array of products and services important to their daily work.

INDIANA STATE MEDICAL ASSOCIATION

Speaker: Dan Kelsey MS, MBA, Director, Practice Advisory Group

How can you increase net revenue?

1. Don't write off as much
2. Negotiate higher rates
3. Look at your service lines
4. Increase your patient collection rates
5. Use the law to increase revenue

The law and payers prompt pay - Accident and sickness insurance companies and HMOs must notify physicians of any deficiencies in submitted claims within 30 days for electronic claims and 45 days for paper claims. If the insurer does not send notification in those time frames, the claims are considered "clean."

If claims are "clean," they must be paid within 30 days for electronic claims and 45 days for paper claims. Claims not timely paid are subject to interest. The interest rate varies each year; for 2008 and 2009 it was 5 percent.

"Clean claim" - A "clean claim" is defined as any claim submitted to an HMO or to an accident and sickness insurance carrier that has no defect, impropriety or particular circumstance requiring special treatment preventing payment.

The law and payers refund requests - Insurance companies must request any refunds of overpayments to physicians within two years of the date of the overpayment (not the date of service). The request must explain the reason for the adjustment, including identification of the claim on which the overpayment was made and, if ascertainable, the party financially responsible for the overpaid amount. Also, the request must include the amount of overpayment being reimbursed to the insurer through the adjusted subsequent claim.

However, Anthem/Wellpoint is restricted to 18 months (not two years) under the terms of a national class action settlement.

The law and payers' unfair claim settlement practices - Check your contract (where applicable) and follow the grievance and appeal procedures and file a complaint with the Indiana

Department of Insurance. Or, file an HMO class action lawsuit compliance dispute (for violation of the terms of a national class action settlement).

Cost summary - All of this information already tells you what you know: It costs money to get paid. Do you know what your costs are? Don't win the battle and lose the war. Cut what you can but don't sacrifice patient care.

Conclusion - Change is inevitable. You can accept it and adapt, or be left behind. Challenge yourself to make decisions based on data. Determine your costs. Is it worthwhile to spend 20 hours collecting \$50 for an account that is 180 days old?

Remember: The ISMA is on your side. Sometimes in joint efforts with the AMA, we are doing legislative lobbying, meeting with Medicaid, Medicare and commercial payer representatives, continuing medical Malpractice Act protections, and communicating regularly with the Indiana Department of Insurance.

The following information was provided by commercial payer representatives during the forum and is provided here by the ISMA as a resource for your practice.

ANTHEM/WELLPOINT

Pre-certification/pre-determination - Pre-certification authorization is required for a select set of services. If authorization is not obtained, services may be subject to pre-certification penalties. It is extremely important to provide all codes for a pre-certification. Some services are reviewed against a medical policy; all medical policies are available online at www.anthem.com and by mail upon request.

Outpatient Services - There is a 100 percent penalty for lack of pre-certification (excluding radiology program services). This is applied to both provider and facility, if applicable.

Inpatient - Penalties apply only to elective inpatient stays. If the site of care is considered an inappropriate setting, there is a 30 percent reduction in payment. If the service is considered not medically necessary, there is a 100 percent penalty. Find the complete list of 2009 pre-certifications at www.anthem.com.

Local Pre-cert Contacts – Contact Anjanita Phelps, manager of Ohio pre-certification at 1-513-770-7652 or anjanita.phelps@anthem.com.

Contact Karrie Weisbrodt, manager of Northern Ohio and Indiana pre-certification at 1-317-287-6224 or karrie.weisbrodt@anthem.com.

Here are some additional numbers: 1-877-814-4803

Fax: 1-317-287-8916 or 1-800-266-3504

National Pre-cert Contacts - Gina Butler, UMR manager, National Accounts, 317-287-6287 and Jason Tunnell, RN, manager, National Accounts, 317-287-6209

Some additional numbers are: Phone: 1-866-776-4793 and Fax: 1-800-773-7797.

Predetermination - Kelli Haberthier, director of Medical Management Predetermination and Specialties, and Tina Brogley, manager of Central Predetermination Services, Tina.brogley@anthem.com or 1-608-342-5382

What is predetermination? (front-end or pre-claim review) This is a process offered to providers prior to the procedure or service that determines the medical necessity, member eligibility and network status of providers involved, as well as coverage of service and benefit payment amounts (member responsibility). This process is available only for services or procedures not requiring pre-certification. It includes any service connected to a Corporate Medical Policy, Utilization Management Clinical Guideline, that requires medical review, as well as, any service identified in the member's benefits that indicate the service is a benefit – as long as it is considered medically necessary. Predetermination is not required, but claims may stop for review when submitted.

Medical policies are available at www.anthem.com or request a copy by mail.

Specialty pharmacy medical management - A phased implementation will occur for pre-certification of select specialty pharmacy prescription drugs, with support of an online tool for prior authorization. The provider portal to the online tool will be available for direct entry of the authorization as the last phase of implementation. The first roll out is scheduled for June 30 and includes the 18 medical policy drugs and the red/white blood cell drugs. The medical policy drugs have already been subject to medical necessity review. The new pre-certification process will give providers knowledge of coverage prior to submitting a claim. The red/white blood cell drugs will be an Radiology Quality Initiative program initially for education only until Oct. 1. Find specific information regarding products and drugs on the Network Rapid Update link www.anthem.com/provider/noapplication/f1/s0/t0/pw_b128391.pdf.

The review will involve looking at medical necessity, including dose, frequency and duration of each specialty pharmacy drug. The program scope applies to outpatient hospital, home infusion therapy, office, dialysis center, ambulatory infusion and ambulatory surgery. It applies to the HCPC (J and Q codes) and CPT codes that correspond with select drugs. Late call penalties are not part of this initiative. If a review cannot be obtained in advance, the drug will be reviewed retrospectively for medical necessity. Authorizations will be made based on the criteria for each specialty pharmacy drug. Some drugs, such as Epogen, will be authorized for eight weeks and others may be authorized for up to 52 weeks.

Provider clinical collection tools are posted on www.Anthem.com. If the tool is filled out completely, these provider tools will supply the necessary clinical information to complete the medical necessity review. Provider tools may be faxed or sent via e-review. The fax number is 866-993-5966 and E-Review address is specialtymeds@anthem.com.

Grandfathering of drugs - If a member is on a drug for a high risk life-threatening condition and the care does not meet medical necessity criteria, the drug will be “grandfathered” and

covered for six months, based on the enterprise policy. A new review will be conducted at six months with no intent to discontinue coverage during that course of treatment. Drugs for the treatment of chronic progressive disease also will be grandfathered for a period of time.

Timeline - Phase I, 18 medical policies (MP drugs under review), two new clinical guidelines CG-DRUG-05 (Erythropoiein products) and CG-DRUG-16 (white blood cell growth factors) are scheduled for June 30. Phase II, drugs for select Oncolytics are tentatively scheduled for Oct. 1. Phase III, drugs, timeline is yet to be determined. The IMASIS Web Portal for Providers is tentatively scheduled the first quarter of 2010.

ID Cards - Effective Jan. 1, 2009, at the request of the Blue Cross and Blue Shield Association, Anthem began transitioning to a new standardized format for members' ID cards. This mandate will affect all Blue Cross and Blue Shield member ID cards, including those issued by Anthem Blue Cross and Blue Shield (OH, IN, KY, MO and WI). Expect a consistent and uniform look and format.

NPI Reminder - To obtain information on National Provider Identifier (NPI), please visit www.cms.hhs.gov/hipaa or contact the CMS HIPAA Hotline at (866) 282-0659.

EDI - Providers can now submit and receive Anthem electronic transactions at no cost. Anthem has partnered with MD On-Line, Inc., a leading national clearinghouse, to offer professional provider practices submitting the CMS 1500 Claim Forms—particularly smaller offices—an innovative way to exchange secure transactions electronically, while complying with provisions of the Health Insurance Portability and Accountability Act (HIPAA). The only requirement is to have a personal computer with Internet access. No software purchase, set-up or monthly fees, or long-term commitment is required. Find information about MD On-Line at www.mdon-line.com.

E-Solutions - MyAnthem gives you access to a wide range of online tools and resources designed to make it easier for you to work with Anthem Blue Cross and Blue Shield. Services include eligibility inquiry and benefit detail. You can check claim status, do secure messaging and access Medicaid Eligibility Reports (Ind. only). To arrange training or get more information on eSolutions, get answers to questions or problems with MYAnthem, contact Michelle Carroll at 317-287-5138 or email michelle.carroll@anthem.com.

HUMANA

- **Humana Access Card** - This card serves as both a member ID card and a member's card to access their Health Savings Account (HSA) funds. Once a claim comes back adjudicated from Humana, a member can use this account to pay their portion of the balance.
- **Patient Consent Form** - To help providers keep accounts receivables low on high deductible health plans, Humana offers a Patient Consent Form they encourage providers to incorporate into their patient paperwork. When the member completes and signs the

form, it authorizes the office to draw funds from the patient's HSA account for the remaining member responsibility, after the claim is adjudicated by Humana.

- **Points of Contact:**
 1. Customer Service at (800) 448-6262 for benefits, eligibility and claims
 2. Centralized Provider Relations at (800) 448-6262 for select contracts and credentialing, contract questions, demographics, fee schedule questions, credentialing and recurring issues
 3. Availity.com – multi-payer Web solution (see below)
- **Silver Sneakers** –As a SilverSneakers member, patients receive a basic fitness center membership that entitles them to use any equipment at any participating SilverSneakers fitness center anywhere in the country — plus any amenities available with a basic membership, including steam and sauna rooms, where available. Members can take part in group exercise classes and work with trained advisors to develop their own exercise plan. Humana encourages physicians to discuss this free benefit with their Humana patients to help encourage and promote healthy activity.
- **HealthHelp** - The precertification program is a clinical review process for MRI, MRA, CT CTA and PET scans used by plans seeking to monitor quality and cost in radiology. The program follows URAC guidelines for utilization management. The program's toll-free telephone number is 1-866-825-1550 and TDD is 1-877-845-2224. Find the Web site at <http://healthhelp.com/humana>.
- **Availity.com** - Availity.com offers provider's access to e-tools, such as benefit checks, claims status inquiries, ref/auth submission, claim submission, fee schedules, and more – for multiple insurance payers. Currently, Humana, Cigna, Aetna and United Healthcare in Ky., Ind. and Ohio all participate on Availity.com, with Wellpoint expected to join later in 2009. There is no cost associated with registering and using Availity's online tools. Register for Availity.com on the Web site's home page using the "Easy as 1-2-3" link.
- **CareRead** - Otherwise known as card readers, CareRead works with Availity.com's eligibility/benefits check tool. The card reader, or wedge, is about the size of a computer mouse and is plugged directly into a computer's USB port. Once providers have access to Availity.com, they can plug in a card reader and "swipe" the new Humana or United member cards to populate the patient's information for accessing benefits/eligibility details. This will ultimately save time and decrease user error.

Card readers can also read financial information, such as debit cards or Humana access cards to collect payments from patients. Card transaction fees apply and providers must contact Availity for details on using the card reader for financial/payment collections. Obtain card readers free (limited time) by contacting James Graves at jgraves2@humana.com.

ADVANTAGE

Advantage uses a Web-based utilization reporting tool, www.Managedcare.com. Claims data are imported each month, and the goal is to add test results, other manual data as part of a member record.

Reporting includes Provider Dashboard, Member Dashboard and Stratification for Disease Management. Advantage has a goal to produce a member report card two times yearly, to be distributed to providers and members.

You may contact the Commercial Provider Relations Staff at 317-573-6644. Members of this staff include:

Sandy Thorne, Director of Provider Relations
Lisa Fening, Provider Relations Account Specialist
Rhonda Mims, Provider Relations Account Specialist
Lisa Poole, Provider Relations Account Specialist
Tenise Hill, Provider Relations Internal Coordinator
Candace Ervin, Provider Relations Internal Coordinator
Jackie Rosner, Credentialing Coordinator

Here is important contact information:

Prior Notification Line: Medical (800) 748-2544 8am-5pm
Prior Notification Line: Behavioral Health (866) 468-8257 8am-5pm
Prior Notification Fax: (317) 575-7532
Provider Line: (888) 445-8958
Member Services: (800) 523-7533
Advantage Medicare programs Web site: www.advantageplan.com

CIGNA HEALTH CARE/SAGAMORE HEALTH NETWORK

Cigna Health Care's Web site is at www.CIGNAforhcp.com. Call Provider Services at 1-800-88CIGNA or 1-800-882-4462. The claims mailing address is: P.O. Box 5200. Scranton, PA 18505.

Sagamore Health Network's Web site is www.sagamorehn.com; the interactive voice response (IVR) numbers are: 1-866-825-7154 or 1-317-580-8061. Call provider services at 1-800-320-0015. Send e-mail to mps@sagamorehn.com and/or fax to 1-317-573-2787. The claims mailing address is: P.O. Box 6051, Indpls, IN 46206.

Cost of Care Estimator - The CIGNA Cost of Care Estimator is an online tool that allows you to generate personalized estimates of the cost of a specific service, CIGNA's plan payment for the service, and/or a patient's out-of-pocket costs for the service.

The CIGNA Cost of Care Estimator is available for all professional and outpatient services in all care settings (inpatient estimates coming soon) as well as for covered individuals in CIGNA PPO, EPO and Open Access Plus health plans, including individuals with CIGNA Choice Fund. Future enhancements of the tool will include additional plan types. The estimates will include the anticipated payment from an individual's health reimbursement account (HRA) and flexible spending account (FSA) balances – coming soon. Estimated costs are specific to the health care professional or facility requesting the estimate and are based on applicable contract rates. These

benefits are available only for health care professionals who participate in the CIGNA network. Estimates are based on a real-time snapshot of a covered individual's benefits.

How does the CIGNA Cost of Care Estimator help the practice? It helps facilitate financial discussions between the practice and the patients, so payment arrangements can be made before treatment. It also helps educate your patients about the cost of treatment and shows what the plan pays. Estimates can be generated pre-care or while the patient is still in the office before registration or check out.

UNITED HEALTHCARE

Premium Designation Program - Supports physicians and hospitals in their practice of quality and cost efficient medical care, using nationally accepted quality standards and market level cost experience. Provides consumers information about the quality and cost efficiency of physicians and hospitals to help them reach an informed decision and take action. Supports employers in their efforts to manage health care costs by promoting quality and cost efficient health care.

Consumer-Purchaser Disclosure Project – This project has a standard set of principles for performance measurement and reporting assessed by an independent review organization and supported by physicians, consumers, labor, purchasers and payers including American College of Physicians, American Academy of Family Physicians, American Medical Association, American College of Cardiology, and American College of Surgeons.

Following the charter will mean consumers can make more informed decisions based on both quality and cost, with adequate guidance about how to use the information and any limitations in the data. Measurement is based on sound national standards and methodology. Both consumers and physicians have input into the measurement process and how results are reported. Measurement is a transparent process so both consumers and physicians can understand the basis upon which performance is being measured and reported. Physicians have adequate notice and opportunity to correct any errors, as well as information to help them improve the quality of care they provide.

United Healthcare was Awarded NCQA Physician and Hospital Quality Plus Distinction. Four Key principles served as the foundation for development of NCQA's Physician and Hospital Quality Standards: standardization, transparency, collaboration and action.

United Health Premium General Principles – For Quality First, only physicians who meet the quality threshold and achieve designations go on for cost efficiency analysis; this is measured at a national level. The metrics for quality come from established national guidelines and standards, published and readily available and/or developed by expert consensus. These are measured by evaluating paid claims data.

Cost efficiency is measured only at a specialty specific, local market level. The evaluation is done by specialty, comparing individual physicians to like-specialists in their own market. The data is a case-mix and severity-adjusted to reflect the individual physician's practice.

The physician has the opportunity to request reconsideration prior to and anytime after designation display.

Group Assessment Rules - To be eligible for this, the medical group must meet administrative conventions. The methodology rolls up all individuals in the medical group and compares specialists in a group with specialty specific rules. Even if the medical group meets designation criteria, if an individual physician does not meet the quality criteria, is not board certified, or is not monitoring or sanction disposition, that individual physician will not be designated.

Each specialty in a multi-specialty group is evaluated separately. Medical groups are evaluated **for quality** based on specialty-specific group average. If a group does not meet the quality benchmark, individuals can receive a quality designation independent of the group, based on individual score.

Medical groups are evaluated **for cost efficiency** based on specialty specific group average. If a group does not meet the cost efficiency benchmarks, individuals can receive a cost efficiency designation independent of the group based on individual score.

Credit is applied to cost efficiency at the medical group level if the qualifying group is a full-time academic practice.

Online detail reports are available through the physician Web site at www.UnitedHealthcareOnline.com. Physicians can submit a written request for reconsideration of their designation status via e-mail to unitedpremium@uhc.com.

Physician questions regarding designation status or practice rewards can be directed to 1-866-270-5588.