PRIVATE INSURANCE ADVISORY COMMITTEE REPORT

OHFAMA HOD 2016

BRUCE G. BLANK, DPM

PIAC REPRESENTATIVE

UPDATE ON HUMANA MEDICARE

- ISSUE OF HUMANA MEDICARE ADVANTAGE PLANS' BLANKET DENIAL OF AT RISK FOOT CARE CLAIMS WITH -59 MODIFIER
- APMA IN DISCUSSIONS WITH HUMANA
- ONE POSSIBLE TEMPORARY SOLUTION IS A PREPAYMENT AUDIT
- APMA WORKING OUT MECHANICS OF AUDIT SO IT'S IMPLEMENTED IN MANNER NOT TOO BURDENSOME ON PODIATRISTS

CRITICAL INFORMATION CONCERNING HUMANA MEDICARE PRE-PAYMENT AUDIT

- PRE-PAYMENT AUDIT IS NO ONE'S 1ST CHOICE
- OPPORTUNITY TO PEND THE CLAIM PRIOR TO SUBMISSION OF SUPPORTING DOCUMENTATION IN LIEU OF CURRENT FREQUENT DENIALS
- GIVES DPMS THE ABILITY TO UNDERSTAND EXACT INFORMATION HUMANA IS REQUESTING AND REQUIRES MORE IN DEPTH CLAIM REVIEW ON HUMANA'S PART- **AS OPPOSED TO CURRENT PRACTICE OF DENIALS WITHOUT REVIEWING ANY SUPPORTING DOCUMENTS.**
- APMA FEELS ABOVE WILL FAVOR OUR MEMBERS BECAUSE CURRENT OVERTURN RATE ON APPEALED CLAIMS IS HIGH IN FAVOR OF DPMS

HUMANA MEDICARE APPEALS OF DENIED CLAIMS

- ENCOURAGE YOUR ACADEMY MEMBERS TO APPEAL DENIED CLAIMS FOR AT-RISK-FOOT-CARE THAT INCLUDE THE -59 MODIFIER

OTHER AVENUES OF FIGHTING UNFAIR DENIALS OF CLAIMS TO HUMANA MEDICARE

- APMA REVIEWED MEMBER CONTRACTS BUT THEY INCLUDE PROVISIONS THAT REQUIRE GRIEVANCES TO GO THROUGH ARBITRATION RATHER THAN LITIGATION, INCLUDING CLASS ACTION LAWSUITS.
- APMA IN CONTACT WITH LEGISLATORS AND CMS TRYING TO GET PROBLEM SOLVED
- OHIO CONGRESSMAN BILL JOHNSON'S (NEW REPUBLICAN SPONSOR OF HELLLP ACT) STAFF WAS IN CONTACT WITH APMA AS RECENTLY AS LAST WEEK CONCERNING PROGRESS IN NEGOTIATIONS WITH HUMANA.

PRIVATE INSURANCE ADVOCACY

RECENTLY PRESENTED BY KELLI BACK, ATTORNEY AND APMA CONSULTANT
CAC-PIAC MEETING 11-2016

- **BEST PRACTICES: APPEALS**
  - NUMBER 1 RULE: IF YOU FEEL YOUR CLAIM WAS IMPROPERLY DENIED/DOWN CODED: **DO IT.**
  - **FAILURE TO APPEAL CAN:**
    - RESULT IN A LOST OPPORTUNITY TO GET A SYSTEMS ISSUE FIXED IN A TIMELY MANNER.
    - REINFORCE A PAYOR'S BELIEF THAT THE PRACTICE IS ACCEPTABLE.
    - DEPRIVE APMA OF EVIDENCE TO IDENTIFY SYSTEMIC PRACTICES AND BRING THEM TO THE ATTENTION OF PAYERS ON OUR BEHALF.

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- **APPEALS: BEST PRACTICES**
  - EVALUATE THE DENIAL: TAKE A CLOSE LOOK AND MAKE SURE CLAIM WAS SUBMITTED CORRECTLY/APPROPRIATELY
    - IF NOT, ASK FOR A REOPENING OR OTHERWISE FILE A CORRECTED CLAIM.

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SUBMITTING YOUR APPEAL

- SEND IT TO THE APPEALS DEPARTMENT AS DIRECTED
- DO NOT INCLUDE LEGAL ACCUSATIONS
- INCLUDE A STRAIGHT FORWARD EXPLANATION
  - APPEALS REVIEWERS ARE OFTEN NURSES
  - IN ORDER TO DENY, THE LAWS OFTEN REQUIRES REVIEW BY A PHYSICIAN

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SUBMITTING YOUR APPEAL

- INCLUDE RELEVANT EVIDENCE:
  - FOR MEDICARE ADVANTAGE APPEALS, INCLUDE FFS EOBS THAT SHOW THAT THE CLAIM WAS PAID/SERVICE WAS COVERED.
  - INCLUDE EOBS SHOWING THE CLAIM HAS BEEN PAID IN THE PAST
  - INCLUDE ANY PAST APPEAL OVERTURNS ON THE SAME ISSUE
  - INCLUDE ANY RELEVANT PORTIONS OF THE MEDICAL RECORD.

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KEEP APPEALING !!!

- **IF YOUR APPEAL IS DENIED, DETERMINE WHETHER THERE ARE ADDITIONAL LEVELS OF APPEAL.**
  - UNDER THE ACA (MEMBER PROCESS), MEDICARE FFS, MEDICARE ADVANTAGE (NON-CONTRACTING PROVIDERS) AND MEDICAID, THERE ARE ADDITIONAL LEVELS
  - UNDER THESE PROGRAMS, YOU CAN OBTAIN REVIEW BY AN EXTERNAL, INDEPENDENT ENTITY.

THANK YOU FOR THE OPPORTUNITY TO SERVE

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