Flash Back
Bounce Forward
Ongoing Denial Challenges with MA Plans:

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Harrisburg Medical Center, Inc.
Harrisburg, IL

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- Harrisburg, IL
- Population of Harrisburg: 9100
- Located in extreme Southern Illinois - 20 miles from Kentucky

Short-term Acute Care Hospital

- 80+ beds (includes Inpatient Behavioral Health unit in lower level of hospital)

OP Behavioral Health at one of our clinics (includes child psychologist)
Nine Clinics – Includes Orthopaedics, Pain Management, 3 Rural Health Clinics, 2 other OP Clinics, 2 Mine Clinics
Home Health Care

Harrisburg Medical Center, Inc.

Special Services: Oncology, Podiatry, PT, OT, Speech Therapy (OP therapy at 3 of the clinics), Respiratory Therapy, Sleep Diagnostic Center, Cardio/Pulmonary Rehab. Hospitalists program MRI's, Pediatrics

Surgeries Offered:

- Cataract excision and lens placement
- General Surgery,
- Orthopaedic : hip/knee replacement, joint scopes,
- Podiatry/Urology

Harrisburg Medical Center, Inc.

Medicare Advantage Plans:

Contracted With: Humana (Behavioral Health),
Health Alliance, Aetna
No Contract: United HealthCare, Blue Cross Blue Shield

Type of MA Reviews:

- DRG, Medical Necessity, No Prior Auth, 30-day Readmission
- OBV vs IP, Newest Record Requests are very broad – Med Necessity/Coding/Billing Review
- Want to admit most of our patients as OBV vs Inpatient

EXAMPLES OF PAYER ISSUES ENCOUNTERED:

Aetna – Issue of Waiver of Liability Form

Sent us the form 6 different times. Form was signed and sent back by certified mail after first request. Called reviewer and got voicemail. Left Message. No response. Called Customer Service. Got call back but no info on how to reach representative. After receiving 5th letter, wrote a letter detailing what was happening, if I didn't receive a response to my letter about my appeal by the following Monday, I would file a complaint with Medicare C rep. Received phone call within 24 hours, acknowledged they had the form, appeal was moved up to highest level of review, denial overturned within 5 days and payment received within 5 days.

EXAMPLES OF PAYER ISSUES ENCOUNTERED:

UHC – DRG Reviews

Medical record had already been requested and sent so that a “payment determination” could be made. In some cases, records had been requested more than once. Called Medicare C rep, told her what was happening. Complaint sent to UHC. UHC Advocate called me within 24 hours, after some research determined that I was correct and account could not be reviewed again for DRG. Record can only be reviewed once for payment purposes and cannot be requested for another review. Number of DRG reviews has been reduced dramatically.

Lessons Learned

DRG Reviews – If payment was determined based on receiving and reviewing medical record-cannot review the chart again for any other reason.

If you are not contracted with them, they count on the fact that you don't understand that they have to apply traditional Medicare guidelines when working with you.

Peer to Peer Calls – This has become very limited with MA plans. The process to get a Peer to Peer has become very complicated. Some payers won't even do them any more. Time frame has become very short to request one and often times it won't fit into our provider's time frame for when they can be here to do the PtP.

Lessons Learned (cont.)

Contacting, or threatening to contact, Medicare Part C Advocate. This has been a life line for me when all other options of getting them to pay are not getting me anywhere.

No MA plan contract-MA plans must use traditional Medicare rules when working with you.

Be persistent!!! Know the rules and push back. Get legal involved if you have to.

Send everything Certified Mail or use their e-submittal portal that will give you a date/time/auth #, so payer cannot say they didn't receive it.

Lessons Learned (cont.)

Only one record can be sent per Minimum Necessary Requirement for HIPAA Privacy. And them asking for the complete medical record doesn't mean you have to send it.

Pick apart denial letter or overpayment determination. Know how to read an EOB and what the denial codes mean.

Write strong appeal letters backed up by everything you need to overcome their rationale for denial. Send only the part of the medical record that back up you appeal.

FIGHTING BACK AGAINST MA PLAN

Amount of record requests for review are getting out of hand. In June alone we had 300 requests.

Latest requests from UHC/MA are very vague and overly broad.

No specific reason given for review – want to check for coding, billed correctly, medical necessity, etc. Any reason they can find to deny payment for all or part of the claim.

Also said they would keep the medical records for future reviews so “they wouldn’t have to bother us”. WOW

FIGHTING BACK AGAINST MA PLAN (cont.)

For each record requested, an authorization was obtained, no clinicals were requested, no denial of service before payment was received, and we have no contract with them.

Threatening to take payments back when we won't send them medical records. Reason for overpayment: no medical records received to back up DRG! Why didn't they review the medical record before they paid us???

Got our legal counsel involved.

FIGHTING BACK AGAINST MA PLAN (cont.)

She called, emailed UHC to inform them that they have no legal or contractual basis for denying us payment because we wouldn't send them the medical records

After second attempt to speak to someone with authority at UHC, sent another email. This time a person who had authority called our legal counsel and she presented her case to him

He agreed with her and sent us an email response that the denial was being withdrawn and apologized profusely. No further action would be required of us.

This email will come in handy in fighting future record requests.

PART C ADVOCATE COMPLAINTS

Had 2 MA accounts from Aetna and 2 from UHC – all four were a year or more old.

It was clear from reading the notes in the accounts that both payers were giving us the run around so they wouldn't have to pay us. Hoping we would give up and stop fighting them! Different reason for not paying us whenever we called them.

Filed a complaint with the Medicare Part C Advocate against Aetna and UHC.

Aetna claimed they only authorized an observation stay. We had proof that on one of the accounts, their Medical Director approved IP stay after a PtoP with our provider.

PART C ADVOCATE COMPLAINTS (cont.)

Aetna worked with us from the beginning after being contacted about our complaint.

One account was paid as an inpatient stay. Wouldn't budge on the other account so they said they would pay us for everything except the room charges. Charges were removed and rebilled.

IP payment was received quickly and the other payment was received within a few weeks.

Side Note: Aetna sent a post payment review request after we received both of these payments.

PART C ADVOCATE COMPLAINTS (cont.)

UHC – Two Behavioral Health accounts

We're told that we didn't need prior auth for behavioral health stays. Just send the billing after the patient is discharged. Case Manager called and spoke to more than one person about whether this was correct and was told that yes it was.

UHC kept telling us they needed the medical records before they would pay us.

I personally sent the medical records for both of these accounts via Certified Mail.

PART C ADVOCATE COMPLAINTS (cont.)

Filed appeals and both were denied, even after we proved to them that they had the medical records.

Since we have no contract with UHC they have to follow traditional Medicare guidelines-pay us within 60 days of receiving our billing.

Both of these accounts were over a year old.

Filed a complaint with Medicare Part C Advocate.

UHC was very cooperative at first and then suddenly wouldn't even return my phone calls.

PART C ADVOCATE COMPLAINTS (cont.)

Told them I need them to either pay us or tell me WHY they weren't paying us. If not, I would file a second complaint with Part C Advocate.

No response so I filed a second complaint. This time the UHC Director of Part C Complaints was personally working with me.

Both accounts were paid within three weeks-with interest-and they had to write me a letter explaining why they took so long to pay us. Said the medical records got misplaced but they have since been found and will be reviewed

Total recoupment for all 4 accounts was over $51K

PART C ADVOCATE COMPLAINTS (cont.)

Currently have over $60K that they owe us for two more behavioral health claims for this same patient. Both are over a year old.

UHC has just recently lost a law suit against them for how they evaluate patients for Inpatient Behavioral Health

BOTTOM LINE:

Never give up – Persistence will pay off in the end.

Just because they are BIG doesn't mean you can't fight them and win!