**HUMANA MINUTES**
**November 7, 2016 RIC/RAC Meeting**

**HUMANA REPRESENTATIVES PRESENT:**
**Mr. Scott Clark**
**Mr. Kevin Byerley**
**Ms. Suzy Hansen**
**Ms. Melinda Hubbard**

**FACILITATORS PRESENT:**
**Mr. Wesley Ashmore**
**Ms. Karen Northcutt**

MR. ASHMORE: I want to introduce you to Scott Clark with Humana, who will do an introduction and then introduce his team.

MR. CLARK: Good afternoon. My name is Scott Clark. I'm the vice president of Network Development for our Mid-South region, which is Tennessee and Alabama. Thank you for giving us the opportunity to come and address some of your questions.

To my left is Suzy Hansen. Suzy is our director of Health Services, clinical overview for the Mid-South region.

To her left is Kevin Byerley. He is responsible for our Provider Payment Integrity (PPI) processes. And a lot of questions you had were related to his department, so he should be able to address some of those.

And then on the end is Melinda Hubbard. Melinda works with me on our Network Development, so she helps support the contracting, the network score card, and things like that.

So happy to be here.

MR. ASHMORE: We're going to do this one slightly different from the other payors. I'm not going to read the questions. They're going to talk about each category. As you can see in your packet, it's broken up into different sections.

So with that, I'll just turn it over to you.

## Front End Review Process

1. On the front-end reviews, how can hospitals comply with federal guidelines to issue timely IMM and MOON notification when the level of care determination is delayed?

   **Response:** **The MOON notice is required to be submitted from the hospital to the patient for MA plans and traditional Medicare. Our Front End Review Process turns the majority of cases in the same day and usually within a couple of hours. If there is additional Clinical data required Humana allows for 72 hours to receive and properly assess the additional information.**

2. We have confirmation from other regions of Humana where they do peer-to-peer reviews with PAs and people other than the attending. Why is the Mid-South region subject to a different set of rules?

   **Response:** **It is Humana policy that peer-to-peer discussions occur with the treating physicians only because of the knowledge and insight provided in those discussions. There have been exceptions based on unique relationships to allow for Physician Advisors but Humana is following policy.**

## Provider Payment Integrity (PPI) and Audit Process

3. Please provide update on where you are on the development of the Claim Information Exchange (CIE) tool you referenced at the July 18, 2016 RIC/RAC meeting.

   **Response:** **The CIE Tool is available but Humana is rolling out one provider at a time. So if the provider would be interested in a demonstration of the tool they can contact:**

   **Melinda Hulon (mhulon@humana.com) or**
   **Kevin Byerley (Kbyerley@humana.com )**

4. Please provide the list of dedicated provider representatives by region for Humana and Humana PPI.

   **Response:** **The attachment describes the path into Humana for issues relating to:**
   - **i. Medical Record Requests**
   - **ii. Clinical Audit Disputes**
   - **iii. Grievance and Appeals**
   - **iv. And Claims Issues**

5. We are unable to get timely response to medical reviews that have been completed and a determination made. We must request for the determination on multiple occasions. Determination made 08/08/2016 – determination letter received 09/21/2016. How can we obtain medical review determination response in a timely manner?

   **Response:**

   a. **The contact channels for Humana are listed in detail in the attached document which includes the escalation path for issues not resolved in a timely basis. If these reviews are related to our Provider Payment Integrity process, the PPI resolver team would be able to assist.**

   b. **PPI Resolver team through the contacts listed in the attachment or through:**

**Melinda Hulon (mhulon@humana.com) or**
**Kevin Byerley (Kbyerley@humana.com )**

6. When submitting medical records, we submit an invoice and MR in same package. When this is received by Humana, only the invoice is logged and the MR is misplaced. This results in second and final notice request received by our office. Why are the medical records not logged at the time of receipt when the invoice is logged? How can we improve submission practice to ensure that our medical record submission is not misplaced upon receipt? Are there quality measures that Humana can put into place to ensure medical records received are disbursed to the appropriate department area?

   **Response:**

   a. **The contact channels for Humana are listed in detail in the attached document which includes the escalation path for issues not resolved in a timely basis. If these reviews are related to our Provider Payment Integrity process, the PPI resolver team would be able to assist.**

   b. **PPI Resolver team through the contacts listed in the attachment or through:**

      **Melinda Hulon (mhulon@humana.com) or**
      **Kevin Byerley (Kbyerley@humana.com )**

7. What does Humana recommend a provider to do if info is being submitted but Humana is not showing received?

   **Response:** **Escalate to the PPI Resolver team through the contacts listed in the attachment or through:**

      **Melinda Hulon (mhulon@humana.com) or**
      **Kevin Byerley (Kbyerley@humana.com )**

8. When is Humana going to start keeping the Medicare payment rates updated in their system so they can pay the correct amounts initially and not request so many refunds? Example: Payment reason on letter: 070-Paid in excess of the Medicare allowable.

   **Response:** **We are researching this issue and are not able to answer your question at this time. We will need to understand the context and have examples to research.**

9. When is Humana going to start keeping the Florida Medicaid out-of-state payment rates updated in their system so they will pay the correct amounts and not request so many refunds? Example: Payment Reason on letter: 082-paid in excess of the Medicaid allowable. [Example attached.]

   **Response:** **We are researching this issue and are not able to answer your question at this time. We will use the information provided understand the context and research.**

## Grievance & Appeals Process

10. Please explain your appeals process for inpatient medical necessity denials where a member directed denial has been issued.

    **Response:**

    a. **Our Grievance & Appeals Process is described in our Provider Manuals published on the Humana Web Site. This can be found on page 22 of the Provider Manual for Physicians, Hospitals, and Health Care providers document. https://www.humana.com/provider/support/publications/**

11. How do we go about getting appeal reviews escalated if they have exceeded the allotted 60 day review time frame?

    **Response:** **Escalate to the PPI Resolver team through the contacts listed in the attachment or through:**

    **Melinda Hulon (mhulon@humana.com) or**
    **Kevin Byerley (Kbyerley@humana.com )**

**Policy and Procedure Web Sites:**

**General Provider Education**
**https://www.humana.com/provider/medical-providers/education/**

**Provider Manuals & Related Documents**
**https://www.humana.com/provider/support/publications/**

**Website link to all PPI information**
**https://www.humana.com/provider/medical-providers/education/claims/financial-recovery/**

**Appeals Policy**
**http://www.humana.com/providers/claims/related_resources/financial_recovery/hospital_audits.aspx**

**Audit Policy**
**http://www.humana.com/providers/claims/financial_recovery/hospital_audits.aspx**

**Claims Code Editing Policy**
**https://www.humana.com/provider/medical-providers/education/claims/financial-recovery/**

**Approved list of "routine not separately billable" items published separately to re-enforce Humana Code Editing Policy (see page 8 of Policy)**
**http://apps.humana.com/marketing/documents.asp?file=1879176**

**Additional Discussion at Meeting**

MR. CLARK: We took the questions that you had, and I broke them up by what we call our processes, our internal process. First is the front-end review process. And that's primarily some of the clinical questions that you addressed. So what I thought we might do is let Suzy walk you through the process, and if that does not address the specific questions, then we can take some follow-up questions on that. But it seemed a little more logical to us in how we manage the process to break it up like that.

So with that, I'll turn it over to Suzy, and we'll go through the front-end review.

MS. HANSEN: Good afternoon. I'm Suzy Hansen. I'm the Health Services director for the Mid-South. I cover all of Tennessee and Alabama in my market for coverage. I have the clinical operations area, which is the utilization management, case management, and analytics area. So all of those teams, I report up to them. And I consider that true. I didn't get even a chuckle.

Most of you know what front-end review is. It's just medical necessity review for a case when we get a request.

We do inpatient reviews, acute and post-acute only, and some outpatient, but it doesn't impact Alabama. Most of the outpatient reviews go to a clinical intake team.

So any inpatient requests for an inpatient acute or post-acute comes to my team if it is a case that has not already discharged. So if it's a member that's either pre-service, hasn't been admitted yet, or is already in the bed concurrent, then we review that on my team.

If it's a case that's retrospective, the notification we get about the admission is after the discharge date, that actually goes to a retrospective review team, because it's a separate process.

And I say all of that just because I think one of the questions submitted was related to a retrospective.

So front-end review, just real high level, is when we get a request, it comes to my team. We look at the clinical. If the nurse can approve the case based on the clinical information received, she (or he) is going to issue the authorization and give the facility the authorization number and move forward. If she can't approve it based on the clinical received, then we try really hard to get the rest of the information we need to make the coverage determination a positive one for you as an approval.

Most of the time, probably 50, 60 percent of the time, the patient is already in the bed when we get the notification. They've come to the ER or whatever. That's considered concurrent. By our standards, we have 24 hours, or one day, to make that determination. The majority of our cases we turn around we get a notification to you within just a couple of hours. We have time studies where we track all of that.

The exception is going to be a case that we keep trying to get additional information to get an approval, the nurse can't get that information. They request additional, and that allows us two more days, or 48 more hours, in addition to the 24 to make a determination. But we always try and get that decision to you as quickly as we can.

Because, say that the case doesn't really meet an inpatient but we want to go ahead and approve an observation, if the facility will agree to that. We'll ask for them to consider changing the orders to an observation until additional clinical can be received. We can always convert it to an inpatient after that if needed or if it's appropriate.

If the conversion isn't accepted and if the facility can't get us any more information, we have to then route it to our medical directors, because none of our nurses can make a noncoverage determination; it has to go to the physician. The physician is then going to review it. They're under the same time frames that we are. They have to get us a decision back, and then we notify of an approval or a nonauthorization determination.

If it's noncovered, if it's a denial decision, then our staff will advise the facilities that they have a peer-to-peer opportunity if the treating physician wants to discuss the case with our medical director. And we offer that, and we encourage that if there is more information that the staff at the hospitals couldn't get us and there's maybe a late lab result or an imaging study, something came in that we couldn't get.

So that's kind of, high level, how that process works. And then we send the member the CMS required IDN notice, and we always CC the physician and the facility on those so that they get the same letter so they can see what the member got.

I'll go ahead and address the two questions I had as part of this, and then I'll open it to other questions.

There was a question about peer-to-peer reviews. Our policy states that we do a peer-to-peer review with a treating or a physician that has credentials at the hospital that has seen the member and can write orders on that member.

The reason we do that is because, in the past, we used to have peer-to-peer conversations with some of the external vendor organizations. And what we kept finding out was happening was, first off, a lot of times those physicians had access to no more information than we did. They were looking at clinical information that we got that they also got, and they couldn't impact the decision on that order in a timely way. Because sometimes they might tell us we agree observation is more appropriate. We would wait to get a change to an observation. The member would get discharged. The observation order never got written, so it didn't ever have really a big impact.

So Humana has a corporate policy that says our physicians will discuss the case with someone that can impact the order; that can write that order, that has seen the patient, has some kind of way that they're treating that member or have credentialed and an order is an opportunity for that facility.

There are a few markets that have some exceptions to that because of direct language or processes within a contractual arrangement with a facility. Those are very limited, but there are a couple that I'm aware of. But for the majority of Humana, the corporate policy applies.

The other question was on the MOON notification, if the MA plan submitted the MOON notice and the response was it doesn't apply to us as an MA plan. And I'm going to apologize, the answer that was originally sent was an interpretation of everything. But the interpretation was taken as do we submit the notice, and that was what that answer was for. The MOON notice is required to be submitted from the hospital to the patient for MA plans and traditional Medicare. So we don't issue that notice, but our members for MA plans do receive it.

So questions?

(No response)

MS. HANSEN: Well, if there are any later, I'll be happy to have questions submitted, and then Scott can get them to me, and I'll do my best to answer any questions if you think of some afterwards. Thank you.

MR. CLARK: So the next process had to do with our Provider Payment Integrity (PPI) processes. And I'll turn it over to Kevin, who can do an overview and then answer some of the questions.

MR. BYERLEY: My name is Kevin Byerley. I am part of our Provider Payment Integrity team, which pretty much just stands for anything that's overpayment, our team deals with. So it could be coordination of benefits, it could be down to clinical, it could be anything that you see overpayments, which usually my team is not the one who's the most liked.

My team ranges all the way from Pennsylvania all the way down to Georgia and now to Alabama. We just reorganized, and with that reorganization came some new people to different aspects of the teams. So yes, now I am part of Alabama, Tennessee also.

MR. CLARK: By the way, his email address is in question number 3 and 5. If you need him directly, you can get him that way.

MR. BYERLEY: I'll give a brief walk-through of what our teams do.

Most of you probably have some questions around clinical, medical records, and so on and so forth. What our clinical teams actually do is they select claims for audit. When they select claims for audit, they send out a medical records request to the facility. Unlike Medicare, we send up to the three.

So we'll send the first one to the facility, whatever address we currently have in the system. So if that address is not correct or you're not receiving those, that's when you need to reach out to our team, or you can reach out to our customer service team because they can also have those addresses updated. We'll send a second request out in 30 more days. And then if we don't receive a response in 30 days, we'll send another one out.

So we give a total of 90 days in order to receive medical records. If we don't receive those medical records, of course, we'll set up a technical denial on that, and a lot of times that gets people's attention, especially if they look at it and they're saying to us we never received that medical records request, how can you take money back on us. And we honestly get it.

If you contact our team or the customer service team, they should be either extending out that date for you, totally writing it off, or whatever is needed in order to help that. Because it's not anybody's fault if we have the incorrect address in the system.

If you contact the Provider Payment Integrity customer service at any time, and you're not getting an answer based off of what you're asking, you can definitely reach out to our team. So yes, again, my address is here, and so is my manager's. If you do that, please have a reference number.

The reason I'm stating that specifically is because we can look in our system, based off that reference number we can listen to phone calls, we can listen to that team, we can work with that team. They actually work one floor above me, and we can go there and talk to them, listen to the phone calls and everything else and try to work that out. Because sometimes it takes coaching; sometimes maybe the question that's being asked is not the appropriate question, and that's a learning opportunity on both sides.

I believe out on our website, humana.com, on the provider portal, that you can go out there and see key questions that if you call our customer service department that they want you to answer while on that phone call and actually leave, such as a secure voice mail. That's one of the biggest issues that they have that there's not a secure voice mail when they try to contact back. And due to HIPAA and our legal department, they state there has to actually be a voice mail that's secure.

One other thing that they ask for is a time that you are going to usually be at your desk. Now, I know you guys are very busy, but at the same point, if you're usually at your desk at eleven o'clock Central Standard time, then leave that on there because they're supposed to be calling you back at times that you say is appropriate for them to contact you.

Now, after the medical records are actually reviewed and if we can verify that everything is there that's needed in order to complete that audit, we'll actually complete that audit. They should be sending a letter out stating what the findings are specific to that completed audit. And if they're not sending those to you, again, that's when you come to us. Because that address may not be correct in our system or somebody might have worked in the past with your department or hospital, and they might be looking at it and we just had the wrong address.

We have implemented something new into that system. We have to put our specific email in there, and we also have to put contact information for the person who contacted us. So, for instance, if Suzy was the one who contacted us from the facility and said we want to change to 123 Bird Street, then we will literally say Kevin asked for this to be changed due to Suzy contacted us. And we put a phone number and an email in there. Because in the past somebody else from the facility was contacting us, and what they were doing was asking for it to be changed to another address. So there's conflicting information within the facilities, that's why we said let's put that in there; then we reach back out to both parties and say let's communicate here and let's get a mutual address.

We also have our medical records online. And this might answer the question that was submitted. When you're submitting medical records online through our provider portal, this will be going to just Availity. If you're submitting those online, that's the best way you can submit medical records to Humana. And I truly, really, actually mean that. We're coming up with other processes that would help identify better ways for the provider to communicate with Humana, but we're not quite there yet, so please bear with us.

Another question was medical records are being sent in and an invoice is also being submitted with that and we're only putting one of those in the system. If you see that, please tell us. And I really

do mean that. Again, my contact information is there because I work with our medical records team very closely.

And the reason I'm saying that is because if our scanning team is not scanning that correctly, then we need to know that. And they can also go pull that information that was sent in from the provider or the facility, and they can actually pull all that information and then send it back to us and say here's everything that was sent in. And that's when we can pretty much come down on them and say why are you not doing your job correctly. Because, yes, I have seen that as an issue, and, again, that's what I'm trying to work through within my department is to try to fix those issues.

Another question was about our CIE tool. It stands for Claims Information Exchange. That's a great communication tool within Humana - and I actually sit right across from these folks. That's also on Humana's provider portal. And the only things that are going to be on there are specific to overpayments that's currently set up in this system. Now, if the money has ever been recouped or the provider paid us back or anything like that, those will not be in the system, in that specific system.

But we can do trainings for you. I'm definitely not an expert on that, but again, I work very close to that team. We can set up a training for whoever needs it. So it could either be onsite or it could be over the phone, and then you have a dedicated person working with you. Again, they are more of experts. I don't want to go through the processes, I'd rather them communicate that piece to you.

So after an audit is completed, we'll, again, send a findings or a no findings letter out. So if the provider feels like what we have found on our findings is incorrect, then they have every right to dispute that with Humana.

It can go up to a year for the provider to actually submit any kind of documentation back to us. Usually, when we see disputes being sent in and it's being overturned with Humana is when additional information is being submitted to Humana. Not by any means am I saying anybody here is not doing this, but usually when we ask for medical records it might be sent 300 pages to Humana, but then, when a provider disputes, they might send an additional eight pages in. And those eight pages make a huge difference.

I'm not clinical by any piece, so you don't want me looking at your medical records because no telling what could come out of that; but at that same point, that's usually when it's actually overturned. I've seen some of the questions here based off of that. The provider does have a right for three levels of dispute on that. And when they send that dispute, we do have specific addresses that's actually out there on our website, humana.com. And they can actually look at all of that.

A lot of stuff that we ask for and look at in types of audits is out there on humana.com. Our processes are out on humana.com. And if anybody has any questions on where to find that, because I know it's sometimes not the easiest workflow to go through on our site, please, again, reach out to myself or my manager. And we'll send you direct links to where you can find that information.

Usually what my team does is we work highly escalated things. It comes down from Scott, for instance, or Suzy, or, again, even higher up than those two, and we work directly with providers. So, again, we want to make the process as good as we possibly can. And we listen to the providers as much as we can.

So I believe I answered all the questions on here.

MR. CLARK: One of the things I included for the packet was an escalation process with all the contact information. It has the links and some of the key department names. And I also listed links to our humana.com site in the answers to your questions.

AUDIENCE: We are continuing to see denials that were approved concurrently by a clinician at Humana, received the inpatient authorization, and then on the back-end are getting denied. I think that you may have addressed that in the previous meeting and that it was supposed to be getting resolved, but we're still seeing those.

MS. HANSEN: Okay. I can take that one because that's more on my side than on Kevin's.

On the front-end review process, from my market, we do a couple of things on my side that are just because we try really hard to prevent back-end issues.

Can I ask, is your facility that you're representing, do they have coverage for UM and physicians over the weekends?

AUDIENCE: Yes.

MS. HANSEN: Okay. Because that's one of the challenges we've run into.

On weekends, Friday after five or six o'clock at night, or on Saturdays, the challenge we've run into sometimes is we get a request, we have staff on the weekends that review those requests to see if we've got clinical or enough to meet a coverage to give it approval and, if not, we'll go ahead and outreach to see if we can get additional clinical or a clinical because sometimes we don't get anything with weekend requests.

On Sunday, we can get that request and we can make a determination on Monday and we're still within our time frames and usually we can have all the stuff reviewed. But on that Friday night to Saturday, what happens on occasion is if we have enough information, the nurse looks at it, and then she doesn't really have everything she needs, and she tries to go ahead to make a coverage determination; they may say we're going to tentatively approve, we don't really have everything we need but there's a potential it could be reviewed on the back-end. And normally that's going to be a short-stay situation. The member is in and out within that one day; they get admitted on Friday night, they're discharged on Saturday.

We are looking at ways to do process improvement for that because those are the cases that may hit Kevin's area on a short-stay back-end review.

AUDIENCE: These are like three-day stays.

AUDIENCE: You know, we have InterQual. I mean, I'll use MCG. They're meeting InterQual. They look good on my end. I do the appeals for our five facilities, and these look good to me. These are good cases. I'm not appealing these. So I'm just not sure why they're hitting on the back-end.

MS. HANSEN: Okay. Well, if it's a three-day stay, if someone can get me some examples of those, I'd really like to look at it. Because normally, in my market, there's several things we do. When a nurse reviews a case in our systems and determines it's appropriate for an inpatient admission, we actually have a special place in our system that we check as an inpatient appropriate. That checkbox is supposed to prevent that case from being pulled for a short-stay review on the back-end.

Now, it's a manual process, so sometimes there's human error and they forgot to check it and then it got pulled. And if we identify that's the case, we let PPI know and we say reprocess that, don't do anything with that because we feel like it's an error, it's our mistake, we forgot to check it. If we didn't check it because they weren't 100 percent sure of medical necessity on our end, it can be audited on the back-end.

And I want to address the MCG InterQual issue as well. Those are just guidelines. You know, all of them are nationally accepted. A lot of them are aligning together. There are very much a lot of similarities; there are still some differences. That's just review guidelines for the front-end review person on the nurse side.

When it gets to a medical director decision, they have Milliman and other guidelines they use. But they look at, clinically, the whole picture because the patient has a lot of comorbidities. The guidelines are more diagnosis driven. A severity of illness for InterQual, intensity of service level for InterQual. They're going to look more at the complete clinical picture. They're just guidelines for the nurse on the front-end to use.

But if there are cases that are three- and four- day stays, and I actually was on a call before I got here about some people saying it was during the week cases, like Monday through Friday, I would like to see those because it may be an education issue. It could be a process breakdown within a certain region or market. And we really want to look at that as an educational opportunity because there shouldn't be ones during the week or three- or four-day stays.

AUDIENCE: Okay, for our nurses in case management, from my understanding, all that they're getting is this patient has been approved for inpatient on these claims.

MS. HANSEN: Okay.

AUDIENCE: I think if that is the case, that it is a soft approval, that there needs to be some education on that side as well because they're directing their status based on that direction as well.

MS. HANSEN: All right. Well, my team will say we don't have enough for medical necessity. They will let you know there's a potential for a retrospective review for a case. And then maybe sometimes the nurse on your side will say let me see if I can get you what you're needing or whatever.

So sometimes you can prevent it. But I don't know in other markets how they handle it, so that's why I want to make sure, because some of the patients that come to your facilities are outside of Tennessee and Alabama. You've got Florida; you've got all your contiguous states that can come as well. But I'll be happy to try and look at it for you.

AUDIENCE: So just send those to you in an email? Would that be okay?

MS. HANSEN: Yeah. If you've got Scott's, or however you're going to put questions together, will get it to me, and we'll open it up. I can see all other markets' cases, so we can see what happened.

AUDIENCE: Thank you.

MR. CLARK: And just one point of clarification. And this is where good communication comes into play. Because the system will automatically send a response when you send it in through the system. And a lot of folks interpret that as an authorization response. But it's not really; it's an acknowledgement.

AUDIENCE: These are phone calls.

MR. CLARK: Okay. Well, then forget what I just said.

MS. HANSEN: They should all come as a pended status. So even if it had something, it would be pended.

Something else we do in my market, because we're really customer oriented believe it or not, I know you guys think a big, bad payor, but we really do try, we also do a report about a couple times a month where we pull all cases that don't have that inpatient-only box checked and then we make sure it was not an oversight on our part because we're trying to prevent a back-end situation where we should have checked that box and then you guys get it pulled to a short-stay and then that vicious cycle happens.

So we do a lot of things where we're trying to prevent problems for the facilities on the back-end. But I would like to see those examples. I would appreciate that.

MR. CLARK: Yeah. And we'll be happy to work through that. I think one of the things we found when we looked through the data is most of the cases where we found errors generally have been after Friday night at six o'clock or five o'clock and before the Saturday piece. From your facility, that may not be the case. But when we look at aggregating everything that's coming in to us, that seems to be where we're having most of the breakdown.

Because it's that initial weekend coverage determination. Somebody comes in on a Sunday, we can typically cover it. But it's that Friday night to Saturday night piece that we're finding where there's a gap in that check in the box.

MS. HANSEN: And we've got on-call teams and people that may not be as well versed. There are staff, but they may not be used to handling your facility and things like that. So that's why we've put some back-end audits in place within my team to try to make sure we catch those.

AUDIENCE: Who is your external reviewer? Do you have Maximus looking at your reviews if we wanted to appeal outside of Humana? And I say that because we've exhausted our efforts to try to get claims that we know meet inpatient criteria or that qualifies for inpatient to be certified.

MS. HANSEN: No.

AUDIENCE: This can be during the week, so it's not like a weekend situation that we're experiencing. We're having four- and five-day observation for patients that meet medical necessity.

And back to the peer-to-peer issue, when our physicians are calling, they're being quoted Maximus criteria, and there's no room for them to invoke their medical opinion and judgment into the case. So we need another alternative for someone to hear us.

MS. HANSEN: Can I ask a question just for clarity for the process piece? Are these cases truly a front-end UM side type decision, or have they been through a retro-review recovery system?

AUDIENCE: These are front-end.

MS. HANSEN: Okay. And I'm not from the disputer appeal area. But some of the confusion that we see frequently and, to be totally honest, has been confusing for me at times, an appeal is generated traditionally, the true meaning of an appeal, like what a member has, follows the process that's outlined in that IDN, that integrated denial notice, that the member gets. And we cc the facility or provider on that so they'll be aware of what the member was given.

Most of the time, when a facility is "appealing", it's a dispute reconsideration process, and it goes through our clinical claims review team. So it's a little bit different because it's not the same like levels of an appeal that a member themselves would have. The only way it goes to the appeal process is if it's a pre-service expedited, it's a nonpar provider, or if the facility is acting on behalf of the member and has followed all the CMS process for an AOR, where you're actually the authorized representative for the member. But if it's straight from the facility because the facility doesn't agree, it's handled as a dispute reconsideration process.

So currently, I think that the facility has 18 months to submit that from the date of the processing of a claim or the request. I don't even know if there is a number at this point in time in the number of dispute review cases. Those now come to the market.

So say it was my market that did the denial determination, the clinical claims review team gets that dispute request; but then it will come back to my market for another medical director that did not make the initial determination to re-review. Because we're trying very much to be fair to the facility, so we'll have another physician review it within our team.

And that's consistent across other markets. It goes back to their medical directors, and another medical director should review it.

AUDIENCE: But who is on the outside looking in?

MS. HANSEN: There isn't an external process for the dispute reconsiderations. It just comes back to the internal team. On the PPI side, they do have other processes, and they go outside. On an appeal, it would go to Maximus for an appeal process.

AUDIENCE: So if we feel that you didn't approve it and you turn around and deny it, then we can appeal it to Maximus?

MS. HANSEN: Not in the dispute process. And what would probably be best is for us to get information for you on the dispute process, their guidelines. Like I said, I am not part of that team, so I'd hate to misstate something that they've got within theirs. But I'm not aware of it going beyond them. But I could be wrong.

MR. CLARK: Just to add something from a nonclinical perspective. I understand your frustration. And I have a little bit of an issue with this on our internal side, is if you submit a claim for

reconsideration, the first thing that that clinical person is going to look at is is there any new information. If there's not any new information, they really don't review it; they just kick out another denial letter and send it out.

I've been working with some facilities that have gotten really upset and said, look, I just disagree with your opinion. When it's gotten to that point, then there is, through the contractual process, an arbitration process that we can get to. But typically we've found that before it goes to that point, if it gets escalated, we get the medical directors together and have a verbal conversation. Because typically there's just emails and stuff going back and forth. We resolve 99 percent of the cases in that situation before it ever it goes to that.

So in this case, I would say just let me know what cases. I'll give you my card, and you can send those to me, and I'll make sure that somebody is having a conversation with you.

But just to reiterate what Suzy said, there's really two paths you can take. If you're disputing the claim or the clinical, it's called, in our internal vernacular, a claim reconsideration process, and it's reviewed by our internal folks. And they typically go through that cycle three times. If it's a member appeal, it goes through an entirely different process.

And a lot of times there's confusion about those two paths because people call that an appeal. An appeal actually has to be member-directed and has to have the AOR signed by the member, and it goes through an entirely different path. And a lot of times facilities think that they're going to an appeal process, and they're really getting channeled back through the claims reconsideration process. And that's where some of the confusion comes in. So if we can make sure it's on the right path, you can go through the right cycle and get to the right people.

But ultimately, I would say if you get to the point where you're terribly frustrated and you're not getting the conversations, we're your contacts, and we'll help you resolve that internally. Because somewhere along the line it's gotten into a cycle, and it's just not getting resolved. And we don't want that to happen.

AUDIENCE: I just wanted to jump back to PPI for a second, back to the medical records portion, where we were talking about the multiple requests that Humana sends. We talked about this a little bit at the last meeting when there was a different panel here, Andrew Winkler.

What we brought up at that time was that the medical records are being submitted directly into your portal. But then you will get a duplicative request that's dated after the upload date on the portal. And so what we would ask is maybe what can Humana PPI do to audit those requests that have already been uploaded prior to sending out that second request? Because that is an issue.

We dealt with Teresa Bell for the longest time before; you know she's moved, gone on. And she had given a number of reasons, but we really still haven't seen that resolved yet. So that is still an issue with the duplicative request.

But also on the lines of the portal, if you are in the concurrent side and you're reporting a case and my case manager uploads documentation, you can go pull the PDF, you can see what the case manager uploaded.

I brought this up with Teresa sometime back, that on the medical records portal, if my ROI person goes and uploads, it only shows you that there was an upload done. And so with regard to transparency, we've been asking for Humana to show us the PDF of what we uploaded like all the other payors do.

Because until Humana does that, it's your word against ours as far as what was uploaded, but yet we can see it on the concurrent side. So we'd like to see some transparency there and like to see some movement of that needle. But we are still getting duplicative requests on the date of the post when that record was uploaded.

MR. BYERLEY: Okay. Can I ask a couple of questions on that?

MR. CLARK: Sure.

MR. BYERLEY: Okay. So when you're uploading the medical records, is it close to that 30-day time frame?

AUDIENCE: No. It can be within days of receiving the first request.

MR. BYERLEY: Okay. I've seen that before, so that's the only reason I wanted to ask that.

And to go along with that, is it a request stating that certain information was not received by Humana?

AUDIENCE: No. Just regular requests.

MR. BYERLEY: Okay. If you could actually work with me on that.

AUDIENCE: Sure, I would be happy to.

And then back to the young lady back here talking, Suzy, about the up-front. We have been receiving these. We have done the checkmark off. It is the during the week cases.

And what I was going to ask you, in light of what we were just talking about, is, for the sake of the room, we have actually been directing those back to Melinda Hulon, and she has gotten some of those turned around. So I don't know if you want to provide that to the room if it does fall in that bucket, because that's just extra work you're not going to have to do.

MS. HANSEN: Well, she's sending them, usually, to me.

AUDIENCE: Okay.

MS. HANSEN: So it's getting back to me to review.

AUDIENCE: Right. So we can speak to that.

MR. CLARK: Kevin, it seems like last time we had this issue, there was another group within Humana that was requesting medical records that didn't have anything to do with PPI. And that's where some of the overlap comes from. It was a Medicare audit.

MR. BYERLEY: Correct. So we have a team inside Humana called MRA. It stands for Medical Risk Adjustment. We have so many acronyms at Humana it's not funny. But to go even further with

that, they might ask for the medical records, and then we'll also ask for the medical records on the post-payment side to audit.

That is one thing that we are really trying to work with. Myself and Melinda have been working with that Medicare Risk Adjustment team. They kind of notch us, I guess you could say, on who gets it first.

So one thing we're trying to really work with them on is to say, hey, when you get the medical records, if you get it first and we want them, can you please go out there and see if there's a second request out there for them by our team so we don't have to come to you and actually ask for those medical records.

I guess humana.com is what you're uploading on provider uploader? Has anybody from our E Business team talked to you or anything like that before?

AUDIENCE: We've had multiple conversations over the years. So I think that it's just an actual true bottom line duplicative request. We brought them up before. They just still happen.

We do compare what those requests are. And we have noticed where now PPI is lumping other requests such as itemized bills into the request for true medical records. So now providers are having to just differentiate all of that as well. But we have truly looked at all of these, and they are just flatout duplicate.

MR. BYERLEY: Okay. Yeah. And I want to work with you on that piece. I want to work with you on both pieces, to be honest with you. But the second part that you were discussing of seeing what's actually uploaded online, I didn't know if anybody from our E Business team, when you actually upload that, if you had any discussions with them.

I have honestly never seen the provider side, so I cannot say yea or nay on that. And I don't want to give a false answer to any of that. But we have an E Business team at Humana, and what they do is they do trainings on information such as that.

I'm not sure if anybody has ever brought it up to them before. I know you said you were working with several people on our team already in the past such as Teresa. I think it's James in Alabama, isn't it?

MS. HANSEN: Bonita Fields.

MR. BYERLEY: And she is on our E Business team. And she's the expert on how to upload medical records, how to look at medical records, how to pull anything like that off of there. And we'd be happy to get her on a call with you. And a lot of times if we have your contact information, I can send it over to you, and she will contact you directly and try to take information off that. They're more the IT piece, while we're more of the operational piece.

So, yeah, I have never been asked that before, to be honest with you.

MR. CLARK: So in other words, it's kbyerley@humana.com, he's the guy you contact.

But I just want to let you know that we recognize we have a communication issue within Humana on the two groups asking for medical records. And so when you get that, if we can just get back to Kevin and let us know that, then we'll work internally to resolve that for you.

But we've seen that in the past. And I've come across that, and I've really tried to get communication to the facility. But because they're Medicare Risk Adjustment, they're supposed to be independent internally so that we don't influence them, and that's the reason why there's, a lot of times, a lack. It's not your fault; it's our fault, but we're trying to work through that.

AUDIENCE: And the only other thing I had was if you could give a general update on the whole Aetna-Humana issue.

MR. CLARK: Sure. I don't know anything, but I'll tell you what my perspective is. And this is just Scott Clark's perspective. So if anybody is here from the New York Times or whatever, you can write this down.

My understanding is that the judge has the case and is scheduled to hear the case right after the first of the year. The big issue that is on the table, I understand, is really down to one core piece; and that is, does Medicare Advantage compete with only other Medicare Advantage or does it compete with Medicare. That's the issue that the judge is trying to resolve.

Are we competing with Medicare? We believe we do, because if we didn't, most everybody would be on the Medicare Advantage plan, but they're not; most of the people are on fee-for-service Medicare with a supplemental plan.

So we believe very strongly that that is the reason for the case and that's what the issue is. We think the ruling is probably going to come the first part of next year. And that's really what we're waiting on. It's going through the courts.

I think there's a different judge hearing the Anthem-Cigna deal. If I were willing to put $100 on the table, I'd say that deal is probably not going to go through, because I don't think they like each other very much and they're not cooperating; where, on our side, I think that we are cooperating. And I believe personally that it's the right thing to do.

There's a great deal of synergistic overlap. Aetna is mostly a commercial opportunity, whereas, Humana is mostly Medicare. If you overlay the two lines of businesses, it helps us really do a lifetime value customer to where we're helping them when they're pre-65 and we're helping them when they're post-65.

But that's really where I think it is. Internally, I think we're enthusiastic about it. But I really couldn't tell you anything more than that. That's a very different swim lane than I'm in and a very different comp package than I'm in. But personally, from where I sit, that's what I see.

AUDIENCE: Thank you.

AUDIENCE: I understand that I've got to talk to you out in the hall, so let's get out in the hall. But I did want to invite Kevin and his lady friend to come to Mobile in February for Mardi Gras, and we will show you how to upload medical records.

But I have two questions, and it was the ones about the Florida rates and Medicare rates and claims. We get hundreds of requests from Humana wanting refunds based on the rates.

And so my question is can you keep the rates updated in your system so we don't have all these requests? And we don't always agree that the request is actually valid, so it makes a lot of work for everybody. And I have a box full of correspondence from Humana, just lots and lots of it wanting money back.

MR. CLARK: And when I saw those questions come in, I'm sorry, I really started digging into it, and I couldn't answer it by the time this meeting is going on. But I am going to continue to research it and figure it out.

I do know that sometimes your rates get updated faster than the government notifies us of the rate tables, and sometimes that's where that conflict comes in, believe it or not. But I don't know the answer to that question. But I'll take that information, and I'm researching it, and I'll get an answer back for you.

AUDIENCE: That will be great. It's a lot of work.

MR. CLARK: And I will look for any reason to go to the panhandle of Florida or Mobile. Is there anything else I can answer for you quickly?

AUDIENCE: Yes. Going back to medical records, if the medical record is submitted to you in a PDF file, I need clarification as to why there's any conflict between who gets what first. Because a PDF file could be opened simultaneously. I don't understand the problem.

MR. CLARK: Neither do I.

MR. BYERLEY: And that's something we're trying to work through, yeah.

MR. CLARK: All I can say is our bad. We're working on it.

MR. BYERLEY: So clinical actually started the MRM database. Okay? So no other departments were really using the MRM database that you could actually upload medical records or anything else. MRA was using something totally different, subrogation was using something totally different, everybody was using something totally different.

So the piece that is coming together now is the clinical piece is the owners of it. But we're trying to get everybody else within Humana on board, which takes IT dollars, of course, because you have to convert everything over. So we're trying to get everybody on board with MRM where you can upload the medical records.

So that's one reason we're working with MRA specifically at this current time to actually say, you know, if you have these medical records and you see all this out there and we have a request, so on and so forth, then they just upload it and not cause you more harm and not cause you more work at the same point.

Because again, we're paying you every single time you have to submit those. You know, when you send us an invoice, we have to pay that for so many pages or up to a certain amount. And so, again, that's costing us money. At the same point, it's causing you a lot of grief and harm.

So, yeah, I totally agree with you. I've been fighting it for a while now.

MR. CLARK: So we agree it's a problem. We're really trying to work on it. And we'll work with you on that. And the only thing I can say is we're sorry. I don't know what else to tell you. You're right. Mia culpa.

So I guess I'll just conclude, but I'll answer any other questions you have out in the hallway.

But I did want to say, first of all, we welcome the opportunity to come to this meeting and talk to you. It's always a little bit of a concern by our management whether the torches and the pitchforks are going to come out and run us out of town on a rail, but we do see this as an opportunity to share with you what we're working on and what our struggles are and what we're trying to do.

The last thing we really want is Humana to be difficult to work with. And I know sometimes that may seem like I can't believe you're saying this, but we do look at ourselves as being sort of an innovator in terms of payor methodology and things that we work on and try to take care of our members, especially when we look at opportunities to share savings back to payors in terms of getting aligned on medical scores, the risk scores, our model practice agreement.

And unfortunately, as we move to getting those engagement programs in place, a lot of times they're more complex, and sometimes our systems drag behind. And if that's the case, then it causes some confusion. But it's one of the prices we pay for trying to be innovative on the other side. So I would just ask that you bear with us as we work through that. We are listening to you, and we are trying to do what we can to address your issues.

We want to come here. I'll give you my email address, my name, my phone number, whatever. I would ask that you try to go through those channels I gave you first before you call me and call me when you're frustrated because I can't handle everybody all at one time, I'm sorry to say. But I'm happy to try to help and work through your issues because I do believe we want to work with you. We want an engaged partnership.

And unfortunately, from a system's perspective, we're not where we need to be. But we're working to get there. And we're going to do everything we can to improve those systems.

So I just wanted to end on that note, that we really want to work with you and that, hopefully, as we continue to come to these meetings, we'll continue to resolve some of these issues so you don't have as many of those and we're just back to taking care of the patients, which is what we really want to focus on.

Thank you for having us. We appreciate it.

MR. ASHMORE: And just be sure, if you still have questions, send them to Peggy, and we can get them on the agenda for future meetings. Thank you, Scott.