Testimony for LD 1317
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Thank you for reading our testimony on this important issue that affects healthcare practices across Maine. My wife and I opened Jade Integrated Health 20 years ago. We are an independent, small practice employing 20 people. As a small practice, our focus is on evidence based, highest quality care. In other words, we are experts in our field and build relationships with our patients to ensure that we understand and treat the whole person. As a result, our patients get better faster and stay well longer. This costs the patients and health insurance companies less because of the care that we provide and our staff has the satisfaction of watching patients achieve their goals. All around it is a win-win. This is typical for small family practices where we do not see our patients as simply a business proposition. However, it also means that our margins are thin compared to larger corporate practices and hospital systems.

When insurers like Anthem put practices like ours on PPR and then set arbitrary standards throughout the process, we are not able to stand up against the unfair practice. For example, while on PPR for 10 months, we were not getting paid for any of the care that we were providing to Anthem patients. This represents 45-55% of our business. At the same time, we continued to pay our employees, including employees that schedule the patient, providers giving care, and billers billing out services. Therefore, we had no financial or staffing resources to go up against Anthem to dispute their unfair withholding of payment for services rendered.

While on prepayment review, we had to hire an additional full-time billing specialist. The process of PPR literally added more than 40 hours/week of administrative burden. Over the course of PPR it cost our company approximately $1500 in printing and mailing expenses and over $80,000 in billing employee wages-to date. Through this whole process we had 781 claims total on PPR and only 441 have been paid to date. We continue to have 266 claims that we are trying to get paid from the PPR process. We have submitted 209 to an appeals process. To date 135 have been paid. We went from being paid on average within 5-7 days with electronically filing to a minimum of 30 days after submission in the rare event that we did get paid for services rendered.

In the State of Maine we often talk about the importance of job creation. Process like PPR puts jobs at risk. Not only were we at risk of needing to cut staff due to lack of income, but it also forced us to delay plans to open an additional office which would, ultimately, create more jobs. On the flip side, one of our valued employees that worked for us for 4 years in billing and was spearheading our attempts with Anthem to get paid, left our practice simply out of frustration and burnout. She expressed to us her sadness at leaving a company she loved, but could no longer put up with the tactics Anthem was employing making her job impossible.

I would like to point out communication that one of our patients had with Anthem and our practice about PPR.

This first email was sent by the patient to Anthem through her portal in March 2020: “I am writing in regards to 3 denied claims for care that is covered by my policy and provided by an in-network provider. Claims before and after the dates denied have been approved and paid. I called November 1, 2020 and was assured by a representative, named Sam, that it was being taken care of. At this time only 2 claims are denied. I called again on January 24th 2020. I spoke with a very helpful representative named Kristin who checked into now 3 denied claims- August 27, 2019, October 8, 2019 and January 2, 2020. She agreed that codes, dates, provider numbers and tax id’s were sent correctly and she was sending them back for reprocessing. I was told it would take 3-4 weeks. I have heard nothing and my excellent

provider has still not been paid. I am wondering what my next step needs to be. I pay my bills on time and do not understand why a covered service, performed by an in-network provider, from which care has been covered and paid before and after the dates in question, has not been approved and reimbursed. I look forward to a solution to this unacceptable situation"

This second email from the same patient was sent to our billing specialist: "Here is a copy of my latest attempt to help solve the Anthem denial problem! I'm glad they reached out to you and hope it does not drag out any longer. Honestly, this would be criminal behavior on their part in any other industry. I took that sentence out of my communication to them, but it is true. They seem to pit patient vs provider. Just deny and then tell the patient that it's not the patients problem. Disgraceful when excellent care has been provided by an IN NETWORK PROVIDER!" Thank you for your patience and trying to work with them.

The following are details of PPR highlighting the specific practices that Anthem employed for the purpose to not pay legitimate, medically necessary claims.

The administrative burdens Anthem imposed are that impacted out ability to receive payment include:
-Requiring all documentation on a patient claim be mailed, whereas we typically submitted electronically
-Not accepting certified packages to track receipt giving them leverage to state that they had not received claims
-There was no way to prove what was in the envelope we sent to them, even though we catalogued every item sent
-Depending on who we spoke to in Anthem, we would get different answers on whether claims were received or not
-Because Anthem took our mailed paper claims and scanned them into an electronic system, critical pieces of pt medical records did not appear in their systems because of their scanning errors. What ultimately ended up in Anthem's patient medical record was out of our hands. We had to re-send some paper claims by mail up to 3 times.
-Anthem gave conflicting information stating we should not staple or paperclip claims and then telling us to do so when it was clear that they were losing pieces of documentation we sent
-Anthem telling us that we needed to number each page in claims submitted on paper, for example 1/10., 2/10….
-Anthem stating that there is "no claim on file" and we need to resend the entire file again
-Anthem giving us the wrong address to send appeals to
-Requesting the entire medical record after is has already been furnished to them at least once

Anthem reasons for not paying claims that are technical and do not have anything to do with medical necessity or deficiencies in charting which included:
-Time in/out not documented
-"Face to face" not written in the note
-Stating "flowsheet missing" when there was no flow sheet necessary in the medical record
-Provider did not sign HICFA form (providers do not sign this form)
-Anthem representative not understanding medical abbreviations or not being able to tell us what was wrong with the claim
- Stating "attachment required" when none was needed
-Refusing references to an attached document in the medical chart
-Stating a service is not covered under the pt benefit plan when it actually is a covered service
-Stating insured ID missing or invalid when we submitted the correct ID
- Provider credentials were only with the providers signature, not in their typed name directly underneath their signature

-Stating incorrect NPI when correct NPI was given
-Not meeting APTA guidelines when these are guidelines and Anthem misinterpreted these guidelines and frequently called them standards in order to deny claims
-Needing to put line spaces between codes billed to make it easier for the coder to read
-Anthem stating that we are using “too many” abbreviations
-Ordering physician signature is not legible (we have no control over the physician signature)
-Wanting providers to hand type in the note a patients written home exercise program even though it is a separate document in that patients medical chart that was submitted to Anthem.

When in PPR, Anthem does not deny the claims you are submitting, but will only reconsider them. This prevents practices from having the contractual option of an appeal. This drags the process out for months and they are in no hurry to pay out the claims. They point out perceived deficiencies in the note and then we send an addended note in order to resolve the perceived shortcoming in order to get paid. However, claims are not reviewed by the same Anthem representative, so after addending one claim, another reviewer might site a technical issue with the same claim and refuse payment. We would then start the same process to “correct” the claim again. This made it impossible to satisfy Anthem documentation demands and did not allow us to enter an appeals process.

Additionally, in PPR, they require you to research all the claims through customer service. Yet, we are in PPR with a separate set of Anthem employees and it is impossible to accurately review claims with customer service because they claim that they do not have access to PPR information.

While working with Anthem to correct their perceived deficiencies we had to addend hundreds of notes for items not related to the patients care or medical necessity. When we addend a note in an EMR, the original note remains unchanged. There is no way in an EMR to confuse an addended note with an original note. However, Anthem insisted that we were changing the original note and they could not tell what had been changed. This while they are in possession of the original note that we first submitted. Therefore, they would continue to hold back payment until we wrote, on the addend note, what information had been addended.

Anthem started a process that they could not manage. They created PPR, but were unprepared to handle communications with the practices that they targeted.

- They had no process to confirm claims received other than making our billers call Anthem, wait on hold 50-60 minutes to ask if specific claims had been received.
- Anthem limited the number of claims we could ask about to 3 patient claims per call and then we would have to start over with a new call and hold time.
- Claims that had not been paid, we would have to call and deal with the same process of being on hold to find out why a patients claim had not been paid. Depending on who you spoke with depended on the answer you received. Different departments had different answers. So Anthem was unable to track claims, claim information and claim perceived deficiencies for the purposes of us getting accurate information and ultimately payment.
- We sent a spreadsheet of unpaid claims to our PPR rep requesting status of the claims and she would not update at our request

-On more than one occasion, Anthem reps reported that our documentation had not even been read and they knew that because the information needed already existed in the note.
-Our staff having to point out in the note where to find the information that they were saying is missing
-Anthem was unable to follow documented timelines to provide feedback or a decision. For example, many of our appeals are well past the 90 day mark and we have not had any response from the Anthem appeals department.

-Once getting to the desirable action of being able to send claims appeals to their appeals department we faced new hurdles.

On November 24, we sent a box of 67 appeals at one time. Apparently, Anthem did not like that. They had the quickest turnaround time ever. Within a week we received the box of claims back. Each claim was stamped December 2 with another stamp stating "Reviewed by FHPS Appeals, not a formal appeal. Please work at customer service level". It was a formal appeal, but apparently their appeals department was not prepared to deal with the level of incompetence of the prior Anthem process that handled these claims or not willing to review all 67 appeals. Additionally, the appeals department did not even log the appeals which they are required to do. What is more interesting and telling is that when we sent the same appeals back, individually, some of them were paid and now some are still being reviewed in appeals. Some are being denied for timely filing as the appeals department did not log them when they should have.

The only way Anthem states that you can be removed from PPR is to achieve 75% correct claims on first submission. There is absolutely no transparency on how they come to that 75%. Because claims were being sent back to us when they actually had the information that Anthem claimed was missing, we suspect those still counted against us. It is very possible that 75% of our claims were written to the demands Anthem was making, but no-one at Anthem actually read the note and just decided it would be marked as deficient.

For example, many notes they were sent back for reconsideration because Anthem stated that "pt response "was not documented. However, when actually reading these notes with Anthem PPR reps, we pointed out where it literally stated the pt response to treatment. On another note that counted against us with Anthem's arbitrary 75% goal, they would only say that there was not enough detail in the note to reconsider it. One one particular note, I was not the rendering provider, but I read the note and spoke directly with the Anthem rep. There was so much detail in the note that I, not having ever seen this patient, knew their diagnosis, medical history, the treatment provided that day and the patients response that, if needed, I could reproduce that treatment exactly. When I asked the rep for exactly what type of detail was missing, he simply said not enough detail and the claim would not be paid. On another instance, our billing specialist was going over a claim with a rep where the Anthem rep exclaimed that "they did not even read this note!" because everything that the claim was being held back for was actually in the note.

Most recently, we are now engaged with Anthem as they are sending us notices to "take back" money on claims from PPR that they have not even paid to us.

Finally, due to the copious amounts of claims that we needed to follow up with and the time that it took due to Anthem's inefficiencies, we were unable to get paid for many claims because they are incorrectly applying "timely filing" limits.

Please vote to Pass LD 1317.