Medical Markets

What to do when an insurer downcodes your claims

AT A GLANCE

Physicians who believe their claims have been unfairly downcoded can try filing an appeal or even taking the insurer to small claims court.

Julie A. Jacob
AMNEWS STAFF

IT'S HAPPENED TO PHYSICIANS IN FLORIDA, TEXAS, Ohio, Kentucky and elsewhere: They open a letter from an insurer and discover that a level 4 or 5 claim has been downcoded to a level 3.

In other cases, such as what happened recently to some physicians in Dayton, Ohio, doctors learn that a claim is still coded at the same level but that the amount of reimbursement has been cut.

Claims adjustment has become a contentious issue between doctors and insurers. Insurers argue they have to review claims to ensure that they're coded correctly and, if necessary, adjust them; but doctors counter that insurers are just trying to squeeze more cost savings from them.

Disagreements between doctors and insurers over coding have occurred around the country. Last summer Humana began reviewing the level 4 and 5 claims of all 40,000 physicians in its networks across the country. After a flurry of protests from doctors, Humana modified that policy to focus only on doctors with unusual coding patterns.

UnitedHealth Group likewise scaled back on its claims review program in Florida after protests from doctors. Last fall, about 20 doctors in Dayton, Ohio, complained to the Ohio State Medical Assn. after Anthem Blue Cross Blue Shield said reimbursement for level 4 and 5 claims was be-

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FIGHTING YOUR DOWNCODE

Here's what experts say you should do to protect yourself from insurers downcoding your claims. In all of these steps, it's important to keep thorough records.

- Review any contract before you sign it. Most contracts spell out reasons for downcoding and what the physician can expect during an appeal.
- Make sure you've filled out the claim correctly. If a claim comes back, call claims administration and check to see if more documentation is necessary.
- If you've done everything right and the claim is still downcoded, contact the insurer's medical director or regional director. Avoid fighting with low-level administrators.
- If informal discussions with a director don't work, file an internal appeal.
- While discussions with the insurer are going on, call your local medical society. It may be able to tell you if a particular insurer has a habit of downcoding claims, and it may also be talking to the insurer on other physicians' behalf.
- Contact your state insurance department. There's not much it can do, but it may be an action worth adding to your file.
- If all else fails, take the insurer to small claims court. Do this only if you're supremely confident you have done everything right.

Harvard Pilgrim rescue plans being studied

AT A GLANCE

Massachusetts regulators are reviewing a variety of proposals for the insurer's bailout. A deal involving a for-profit plan is possible.

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THE FATE OF HARVARD PILGRIM Health Care came one step closer to a resolution on Feb. 11, the date by which potential buyers or investors had to submit their proposals for salvaging the ailing health plan.

But whether Harvard Pilgrim will be able to continue functioning as a nonprofit remains the unanswered question. The health plan, which covers 1.1 million people in Massachusetts and another 100,000 in Maine and New Hampshire, was placed into state receivership Jan. 4 after revealing that its 1999 losses would reach $177 million, a number that has now ballooned to $198 million.

State regulators are reviewing the proposals, said insurance spokesman Christopher Goetcheus. No deadline has been set for deciding which proposal to present to the Massachusetts Supreme Judicial Court, which must approve any bailout plan, he said.

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Lenders down on health care but are still best hope

Scott Gottlieb
AMNEWS CONTRIBUTOR

ONLY A FEW YEARS AGO, HEALTH care was the darling of Wall Street, physician practice management companies were flush with cash, and many doctors shared the boom as they sold their practices to the highest bidder.

Of course, none of that is true anymore. Even the friendly, neighborhood bank — or, more likely, the local branch of a humongous, nationwide bank — may not be of much help, if one survey is to be believed.

GOTTLIEB

But commercial lenders may still be the best hope for doctors, especially because lenders are more willing than Wall Street to consider funding a long-term growth plan.

Convincing a commercial lender won't be easy. The health care industry has sunk to a new low in the eyes of most commercial lenders, with 85% saying that they would not lend to a health care concern, including physician practices, according to the latest Phoenix Lending Survey. Since the popular survey's inception in 1995, no single industry has ever been so resoundingly rejected.

In the lending survey, respondents were asked whether they expected certain key indicators to be up, down or remain the same. In all types of lending — large commercial, middle-market, small-business and international — lenders believe activity in the health care sector will drop. Tightening appears to be most prominent at the larger-sized loan level.

The bad news has been developing over time.

Last quarter, more than half of the

Street Smarts
How Wall Street sees health care

95 lenders participating in the survey named health care as the least attractive industry among a list of 16 to which they lend.

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What to do when claims are downcoded

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ing cut to about $37 because they submitted too many high-level claims.

What doctors can do

ALTHOUGH THERE'S NO GUARANTEE that an insurer will stop adjusting claims if a doctor complains, physicians can take steps to increase their chances of satisfactorily resolving a claims coding dispute, according to managed care experts.

The key is reviewing the contract carefully before signing it, said Alice C. Gosfield, a Philadelphia attorney who specializes in health care issues. "The first place to win the battle is before you sign up."

Many contracts include clauses that allow the insurer to adjust reimbursement at will and make the final decision about which procedures are bundled together as one service, Gosfield said. Before signing the contract, doctors should find out what the insurer's appeals process is, she added.

It's also important to make sure that claims are submitted correctly in the first place, along with supporting documentation, said Laura Diamond, a spokeswoman for the American Assn. of Health Plans, a managed care trade group in Washington, D.C.

If the claim comes back with an adjusted code, doctors should first call the claims administration office and ask if they need to submit more documentation, Diamond said.

If a claim is submitted correctly with appropriate documentation and is still downcoded, doctors should contact the company's medical director, said John Knight, general counsel for the Florida Medical Assn.

"Bypass the lower-level administrative employees," Knight advised. "The best person to talk to is the regional HMO director."

Moving up the ladder

IF AN INFORMAL DISCUSSION WITH the medical director doesn't resolve the issue, Knight said, doctors should then file an internal appeal.

Throughout the process, it's important for doctors to keep thorough records of the steps they have taken to settle the coding dispute, Gosfield said, including copies of letters and logs of telephone calls.

At the same time that the physician is discussing the matter with the insurer, he or she should also call the local medical society to report the problem. That way, the physician can learn whether the downcoding is an isolated incident or whether other physicians have been downcoded, too.

Medical society representatives can walk physicians through the steps they need to take to try to resolve the issue, Knight said.

Medical societies may also contact the insurer on the doctor's behalf. State medical societies in Texas and Florida met with Humana officials last fall to discuss the claims review issue, and the Ohio State Medical Assn. wrote letters to Anthem after hearing from doctors in Dayton.

The OSMA encouraged Anthem to work with physicians on a case-by-case basis, said Todd Baker, director of medical economics and advocacy.

In fact, that's what Anthem is doing, said company spokesman Joe Bobbey, who encourages physicians to work with the insurer's medical director to settle the matter. Insurer representatives visited the offices of several Dayton doctors whose level 4 and 5 reimbursements had been cut. In some cases, Anthem restored the doctors' reimbursement back to the original amount after discovering that the large number of high-level claims was due to office coding errors.

However, Patrick Jonas, MD, a family physician in Beaver Creek, Ohio, said he wishes that Anthem officials had visited his office before cutting his reimbursement. He said he had a large number of high-level claims because he had just started a private practice after years in academic medicine and was seeing new patients who visited him with several different medical problems at once.

"If they had called me and said they wanted to audit, I would have said fine, come on over," Dr. Jonas said.

If the issue isn't resolved after talking with the medical director, doctors can also try contacting the state insurance department. However, there isn't much that such departments can do, Knight said, because state insurance regulators are reluctant to get involved in contractual disputes.

Finally, if all other steps have failed, physicians can turn to small claims court, said James Wieland, a health care attorney in Baltimore. "I have had good luck with doctor groups taking, or threatening to take, a carrier to arbitration or small claims court," he said.

However, doctors should take HMOs to small claims court only if they are confident that the claims are documented correctly and that the patient records can substantiate the claim, Knight said.

"If all else fails, that would be the last remedy," Knight said. ◆