Greater Tompkins County Municipal Health Insurance Consortium

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"Individually and collectively we invest in realizing high quality, affordable, dependable health insurance."

Claims and Appeals Committee
Meeting Agenda
July 20, 2021 – 2:00 PM
Ithaca Town Hall/Satellites by Zoom

1. Call to Order (3:30) — Bud Shattuck
2. Changes to the Agenda
3. Approval of Minutes – May 24, 2021
4. Executive Director Report — Elin Dowd
5. Discussion on the following topics: — Elin Dowd
    a) BMI Excellus Claims Audit
    b) Appeal Process and Flow Charts
    c) PBM Audit Proposal
6. Set Next Meeting Date
    a) Proposed: September 20, 2021
7. Future agenda topics
8. Adjourn

Confidentiality: Committee membership will adhere to the Consortium's Conflict of Interest and Code of Ethics Policy when discussing any information specific to a subscriber.

Minutes – DRAFT
Claims and Appeals Committee
May 24, 2021 – 3:30 p.m.
Zoom

Present: Bud Shattuck, Don Fischer, Tanya DiGennaro, Donna Dawson (arrived at 3:38 p.m.), Tom Brown (arrived at 3:51 p.m.)
Staff/Guests: Elin Dowd, Executive Director; Michelle Cocco, Clerk of the Board; Steve Locey, Rob Spenard, Locey & Cahill

Call to Order

Mr. Shattuck, Chair, called the meeting to order at 3:35 p.m.

Changes to the Agenda

There were no changes to the agenda.

Approval of Minutes of May 10, 2021

It was MOVED by Mr. Shattuck, seconded by Mr. Fischer, and unanimously adopted by voice vote by members present to approve the minutes of May 10, 2021 as submitted. MINTUES APPROVED.

Ms. Dawson arrived at this time.

Medical Claims Audit Update

Mr. Locey said Excellus was contacted after the last meeting of this Committee and requested to provide a report of all of the denied claims for 2018 and 2019. He presented the Committee with a summary of a long list of denied claims that was received in response to that request.

Mr. Locey spoke to the audit and said there was a total of 14,482 claims that were denied in the sample; Excellus advised that the total adjudicated number of claims was 209,610 which leaves a denial rate of 6.9%. Some of these claims may have ultimately been paid upon the receipt of additional information. Members were asked to let Mr. Locey know if they would like further information. He said he hasn't looked into denied claims for other consortiums he works with but thinks this would be within a normal range; he will look into this further to see what the Medicare standard is.

In response to Mr. Shattuck, Mr. Locey will look into how many of the original number of denied claims were resubmitted and paid.

Mr. Brown arrived at this time.

Mr. Locey said they are continuing to go through the errors identified in the audit and will meet with Excellus in the next week to gather information relating why those claims were adjudicated the way they were. He will also be following up on the agreed-to errors to make sure Excellus follows through on corrections.

Mr. Locey said for those claims that were paid in error and the member didn't profit from the claim, they typically would not recommend that if the claim is adjusted to go back to the member for it. In situations where Excellus has agreed to errors and have said they paid the

claim in error but it is a member responsibility, Locey and Cahill would request Excellus pay it because it was their error. He said they have been successful in the past getting Excellus to reimburse a client for errors Excellus has made in terms of claim payment. In cases where a claim was paid twice, they will be following-up with Excellus to see if they can retract the payment from the medical provider. They don't typically recommend going after a member for payment unless they were paid twice for one service. If a member were to profit from a claim he would recommend asking the member to pay those funds back. Mr. Locey said communication about that would be sent to the member from Excellus, not the Consortium.

Ms. Dawson asked if there is a statutory limit on when claims have to be resolved. Mr. Locey said contract law states there is a six-year period for which claims have to be resolved.

Mr. Locey said he does not expect there to be many issues that will require the Committee to make a decision on coverage. He addressed one issue whereby Excellus will pay a claim where Medicare was primary and the claim was paid without questioning a denial by Medicare. He said this does not require any action by the Consortium but is an area he feels Excellus needs to improve on.

Mr. Locey will be prepared to report back to the Committee at the next meeting as he will meet with Excellus will take place prior to that.

Appeal Process

Ms. Dowd spoke of the need to articulate the appeals process in a more streamlined way and presented the Committee with draft flow charts that outline the steps taken, timelines associated with each step, and reviews that are performed during the process. She said she has reached out to Excellus for input on these and the terminology being used as it may be outdated. Ms. Dowd said she will update the flow charts and present them again at the next meeting.

Mr. Shattuck suggested a notation be made on the charts that the timeframe included on the chart is for the member and that Excellus expedites its review as quickly as possible through each of the steps. Mr. Shattuck also suggested timelines be clearly indicated on the claim denial chart as he and other members felt the charts would be helpful to members, particularly in letting them know there are next steps in the process.

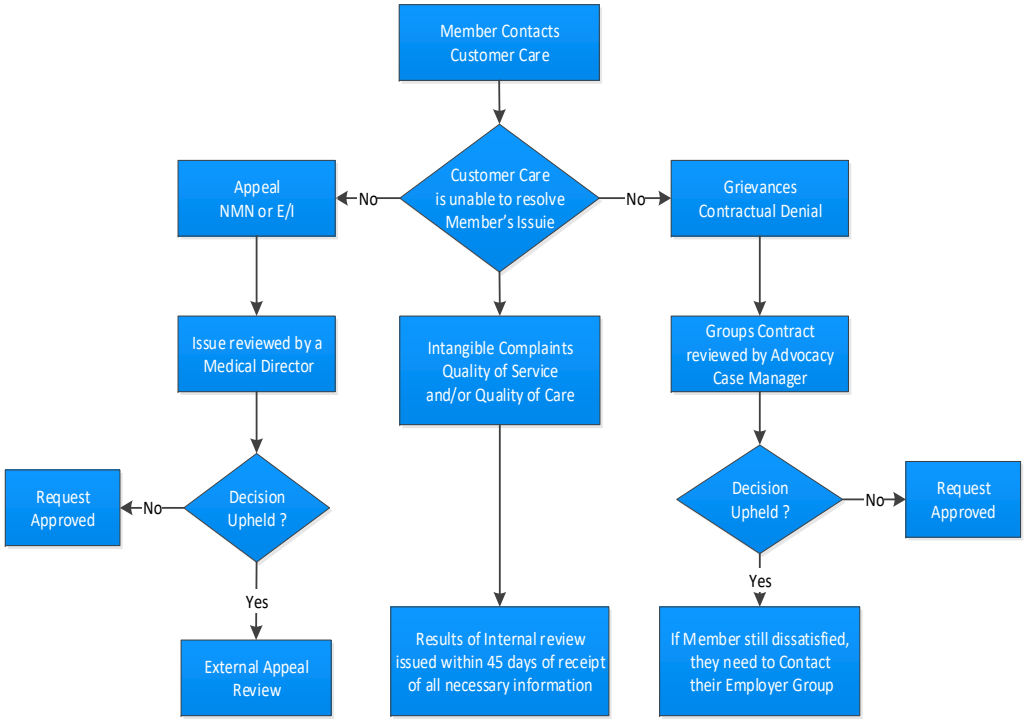
Next Meeting

The next meeting was scheduled for June 21, 2021 at 3:30 p.m.; this was later rescheduled to July 20, 2021.

Adjournment

The meeting adjourned at 4:32 p.m.

Greater Tompkins
Internal Appeals / Grievance Process



Appeal: Not Medically Necessary or Experimental / Investigational Denial

- Member, or an authorized representative, has 180 days following receipt of the notification to file an Appeal regarding the decision.
- Excellus has 15 days to acknowledge receipt of the appeal and has either a) 30 days for pre-service appeals, b) 30 days from receipt of all necessary information for post-service appeals, not to exceed 60 days or c) for urgent cases it is the lessor of 72 hours or 2 business days to respond. If upheld, Excellus will issue a Final Adverse Determination.

External Appeal:

- Member, or an authorized representative, has 4 months from the Final Adverse Determination to file an External Appeal with NYS Department of Financial Service. Notice of decision will be issued directly from NYS.

Grievance: Contractual Benefit Denial

- Member, or authorized representative, has 180 days following receipt of notification to file a grievance regarding the decision.
- Excellus has 15 days to acknowledge receipt of the grievance and 30 days to respond for both pre-service and post-service grievances. If upheld, Excellus will issue a notice of determination.

Appeal to Employer Group:

- If member, or an authorized representative remains dissatisfied with the plan's decision, they can file an appeal directly with the employer group.

Complaint: Dissatisfaction with Services or Quality of Care Issue

- Member, or authorized representative can file a complaint.
- Excellus has 15 days to acknowledge receipt, request input and / or medical records from provider. Results of review will be issued within 45 days of receipt of all necessary information to conduct review.

EBSA: Employee Benefits Security Administration

- For questions about your rights, this notice for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

PROACT PHARMACY BENEFIT MANAGEMENT

Your Fully Integrated Pharmacy Benefit Manager

Here is what you should know if your prescription rejects for Prior Authorization:

APPROVED
(Get healthy and remain healthy)

DENIED
(For Prior Authorization)

STOP

DO NOT LEAVE THE PHARMACY

HAVE YOU BEEN ON THE MEDICATION BEFORE?

YES

NO

If ProAct can verify that you've been on the medication previously and it is covered on your plan...

PROACT WILL GRANT A ONE-TIME OVERRIDE *(up to a 30 day supply)*

YOU WILL NEED TO CONTACT YOUR DOCTOR TO INITIATE THE PRIOR AUTHORIZATION PROCESS

CONTACT YOUR DOCTOR
(Notify them your prescription has been denied due to a Prior Authorization requirement.)