

Problem Definition

This small, Midwestern, acute care and rehabilitation hospital has just under 100 beds. It is one of over 60 hospitals in a network stretching across 25 states. The facility's small patient accounts staff deals almost exclusively with Medicare and Medicaid claims; it has relatively little experience in handling commercial insurance submissions. In spring, 2002, the hospital admitted a patient in his 50s; he was treated as an inpatient over many subsequent months for 13 illnesses including, among others, excessive obesity, diabetes, renal failure, infected non-healing wounds, lower respiratory tract infections, congestive heart failure, sleep apnea, etc. Upon exhaustion of Medicare benefits, the patient's commercial HMO coverage became his primary health-care insurer. That HMO denied \$700,000 in unpaid claims on this account, largely due to authorization and medical necessity reasons. Up until this account, denials were not an issue to the hospital's management.

Actions Taken

Because Human Arc was already under contract to the hospital (to provide Medicaid eligibility enrollment services), it agreed to review this particular account. Three of the firm's PayerLogicSM Denial Solutions group began analyzing the whole box of paperwork the hospital had accumulated on the account. Although hospital staff was not sure authorization was required, pre-certification was discovered to be a necessity after all. Medical necessity issues were found to stem from the HMO case manager's failure to find another facility for the patient who was too ill for nursing home assignment.

It took approximately 60 Human Arc man-hours to gather all UB-92s and other paperwork, pinpoint the problems, resolve pre-certification issues with the insurance carrier, help the patient secure placement at a specialty care facility, construct the comprehensive appeal package and then submit all relevant records (and subsequently relocate and resubmit them after they were misdirected by the delivery service).

Results

Within weeks of Human Arc's appeal submission, the hospital was delighted to receive an initial reimbursement on this account in the amount of almost \$335,500, followed a week later by a second reimbursement of over \$51,000. In addition, the HMO is waiting on Medicare EOBs to determine what additional payments on the secondary need to be made to the hospital.

Human Arc's PayerLogic specialists were able to *produce upwards of \$400,000 for this client on its first appeal*. That effort required both private and public healthcare insurance expertise, acumen with the subtler ins and outs, abilities to quickly act as the client's ombudsman, exceptional contacts and relationships within provider networks, plus other skills as well.

Upshot:

With Human Arc PayerLogic Denial Solutions, this hospital quickly turned a large receivable into very **healthy six-figure cash flow from a single account**, and leveraged valuable Human Arc expertise to its own benefit **without outlay of a single dollar**.

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