UNITED HEALTHCARE MINUTES
November 6, 2017 RIC/RAC Meeting

UHC REPRESENTATIVES PRESENT:
Mr. Gregg Kunemund
Mr. Michael Jones

FACILITATORS PRESENT:
Ms. Karen Northcutt
Ms. Debbie Rubio

MS. RUBIO: We're glad to have United Healthcare with us today, Michael and Gregg, welcome.

1. Can United Healthcare provide a point of contact or representative that the provider may contact regarding to resolve Care Improvement Plus account issues? The issue is the standard customer service department phone numbers and/or any additional contact numbers that have been provided by the payer to utilize have been unsuccessful in nature and led to little resolve.

   Response: Gregg Kunemund to provide contact info at meeting

   Discussion at meeting
   MR. KUNEMUND: Good afternoon. I'm Gregg Kunemund, the CEO for United Healthcare Medicare in the southeast. I'm based out of Atlanta. Care Improvement Plus was acquired by United Healthcare around 2014. We did move it to United Healthcare branding last year, and all our platform and claim changes started last year as well. We were in the state of Alabama for one year about three years ago, but we are very strong with over 100,000 Medicare lives in the state of Georgia. So I will assume that some of these members in this regional PPO Medicare Advantage plan may cross over state lines. And I apologize if you're not getting the responses that you rightly deserve. So what I'll do is I'll give my name, phone number, and e-mail address as a point of contact. And if you're ready, it's Gregg Kunemund, (770)582-4471, gregg_kunemund@uhc.com.

   And, again, that moved to all United Healthcare processing system platform changes, network, etc., just about a year ago, and it should be the same processing procedures that we have in place. But that is a regional PPO plan that has in and out of network benefits, and it gives our members the opportunity to cross state lines.

2. Cancer Centers and patients are expressing concern about this UHC initiative requiring infusions of Yervoy and most of the Immunoglobulins like Privigen, Octagam, etc. to be administered as a home infusion service under the supervision of a certified/trained oncology nurse instead of an Outpatient Hospital setting. UHC is providing Pharmacy authorization for limited visits with verbiage in the letter indicating “Please transition the patient to home/office infusion if clinically appropriate”. This puts patients at risk given the lack of adequate certified oncology nurses being available in most communities for home infusion, along with lack of other medical and/or resources at home. Is UHC looking into reconsidering this requirement?

   Response: There are two parts to this question and response.

UNITED HEALTHCARE MINUTES
November 6, 2017 RIC/RAC Meeting

First, per the October Network Bulletin Article – due to recently published changes in the treatment of adjuvant melanoma, United Healthcare will no longer be updating our coverage policy for high dose Yervoy to include site of service information and site of service reviews will not occur for High dose Yervoy.

In that October Network Bulletin we announced that we were NOT going to require a site of service review on outpatient Yervoy.

Second, it was stated "to be administered as a home infusion service under the supervision of a certified/trained oncology nurse instead of an Outpatient Hospital setting. UHC is providing Pharmacy authorization for limited visits with verbiage in the letter indicating Please transition the patient to home/office infusion if clinically appropriate".

UnitedHealthcare is unaware of this language being used for chemotherapy drugs and based on your comments it sounds like a pharmacy statement. To ensure an accurate response, we need details on a case/patient to review if this is from our pharmacy department.

UnitedHealthcare medical director and physician advocate to provide specific response to the hospital questioning this in 48 hours – Michael Jones coordinating with hospital.

Discussion at meeting

MR. JONES: Hi, I'm Michael Jones. I'm the executive director for Medicare and retirements. I report up to Gregg, so Gregg is my boss. And I'll take this question and probably the next two. One of the recurring things that you're going to hear me say as we go through some of these questions is some of these are so case specific that we would really like the opportunity to work one on one with you when you have these things, proactively, so that we can solve these going forward.

This is one of those examples where we would love to partner with you on these going forward. And I know that Ann Downs is the hospital advocate who serves this area. But I'll also leave you my contact information, which will be included in the answers too. So if you please will involve me in these as well, we'll make sure to take care of these on the front end.

The response to the first about the Yervoy is that part of the October Network Bulletin United Healthcare announced that we are not going to require a site of service review for outpatient Yervoy. So that part, starting in October, that's not required.

The second part is something that really gets to the meat of this question. It was stated to be administered as a home infusion service under the supervision of a certified trained oncology nurse, instead of an outpatient hospital setting. UHC is providing pharmacy authorization for limited visits with verbiage in the letter, indicating, please transition the patient to home infusion, if clinically appropriate. And the medical director and the clinical team as we reviewed this is unaware of the language being communicated to you in these responses. So we want to ask you to again partner with us when you get this letter, to involve us to get this reviewed, so we can look at it proactively, because we are not aware of this. And this is from our perspective, not coming from the team that we're working with, but from the pharmacy team. And if we can involve them in getting that answer resolved, we want them to work with you on that. So that's the second part of that.

The first part is that it does not require the review. The second part is that when these come up, please let us know as soon as you see them, so we can work this and get it resolved with you quickly.

AUDIENCE: This was our question, and I have sent all of the examples, along with the letter to Ann Downs; she has all the information on this. And we also met with a physician during our joint operations meeting.

MR. JONES: Probably, Dr. Karen Cassidy.

AUDIENCE: Yes. We had talked to her about it, and she said that she will take it back and address this with UHC.

MR. JONES: Yeah. I think we met probably within the last 60 days about that one with the onsite meeting. I was out there with her. So have they given a response to you on that yet?

AUDIENCE: No.

MR. JONES: I apologize for that. That's something that I will work with Ann and Dr. Cassidy, to see where they are on that. So let me follow up on that for you.

AUDIENCE: Yeah. Because they have all of the examples, the letters, everything has been sent in. I just wanted to add that other than the Yervoy, which we did come to know of it, what we are seeing is mostly immunoglobulins, like Privigen and all of that, all of them, you're getting similar letter.

MR. JONES: Okay.

MR. KUNEMUND: We'll get an e-mail to you within 48 hours.

3. We have an issue with United Healthcare denying claims with a rationale that the claim is for a clinical trial and should be billed to Medicare; however, the majority of these claims are paid under the Coverage with Evidence Development (CED) methodology, which are the responsibility of the Medicare Advantage Plan unless Medicare specifically takes responsibility for the procedure. We have provided documentation to United that confirms their responsibility for these claims, but we continue to get denials. For example, Medicare Claims Processing Manual (PUB. 100-04), Chapter 32 – Billing Requirements for Special Services, Section 340.4, clearly states that the Medicare Advantage Plan will be responsible for Transcatheter Mitral Valve Repair (TMVR) procedures, but continue to receive denials. What steps is United taking to correct this issue and to accurately pay these types of services in the future?

Response: Please contact Michael Jones about this for further review. Part of the responsibility is with the member notifying United timely, and the other part is in United

working collaboratively with providers and members. Please let us know when we need to process claims for clinical trials, and let us know the specific case for us to review.

Per Evidence of Coverage
Section 5.1 Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study. Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study and you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers. Although you do not need to get our plan's permission to be in a clinical research study, you do need to tell us before you start participating in a clinical research study.

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2 When you participate in a clinical research study, who pays for what?
Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- **Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.**
- **An operation or other medical procedure if it is part of the research study.**
- **Treatment of side effects and complications of the new care.**

Original Medicare pays most of the cost of the covered services you receive as part of the study.

After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your costsharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This

means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe.

Please see Chapter 7 for more information about submitting requests for payment. When you are part of a clinical research study, neither Medicare nor our plan will pay for any of the following:

- **Generally, Medicare will not pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were not in a study.**
- **Items and services the study gives you or any participant for free.**
- **Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.**

Discussion at meeting

MR. JONES: Again, this is one of those situations where we need to work with you one on one, because you are correct, and in the Evidence of Coverage Section 5.1 and 5.2. But when United Healthcare is notified by the member of participation in a clinical trial, United Healthcare should be reimbursing those claims as a normal claim. So there are two keys there. The first is the patient notifying United Healthcare of participation in the trial. They don't need permission to do that. But there are certain things, number one, for a patient to get reimbursed for any out-of-pocket cost, if there are any that come there.

But number two, the notifications. If it's a Medicare approved trial, there are concern conditions where Medicare wouldn't approve it. But if it is a Medicare approved trial, we need to know about that from the patient to be able to trigger that in their file to be able to pay those claims. So that's one of those also we need to work with whoever that is that's having that issue and get that flagged in the person's customer service record to get that claim processed, and that's looking retroactively. Looking proactively, when members participate in a clinical trial, if they will notify United Healthcare customer service, so if you'll call provider services, and there's no approval process, it's just a notification process. If you'll notify us on the front end, we can have that flagged in the member's customer service record, so we can be proactive about it. So, again, to recap, we need know to which member that is that's having a clinical trial and which of you are having the issue with it, and we'll get that reviewed by our clinical team also.

MR. KUNEMUND: If the person is in here, just have them call me on that. I will certainly look into that. I gave my name and e-mail, and if you need it again, I'll do it. But I would like to see those claims.

4. Can we bill for multiple episodes of CPR performed on a patient in the emergency room? For example, if CPR is performed at 1pm and the patient is stabilized, but then requires CPR again at 1:45pm. Can we bill for 2 units of 92950? Is there a certain time that should pass in between doing CPR before it is considered a separate episode? Or should we only bill for one unit no

matter how many times CPR is performed while the patient is in the ED? Should additional units of 92950 be reported with modifier -76?

Response: CMS Digest: Chapter 12; § 30.4 Cardiovascular System (Codes 92950-93799)
Providers may bill for up to 2 occurrences per day of CPT Code 92950 using modifier 76.

Section 30.4 content:
30.4 - Cardiovascular System (Codes 92950-93799)
(Rev. 979, Issued: 06-09-06, Effective: 07-10-06, Implementation: 07-10-06)
A. Echocardiography Contrast Agents
Effective October 1, 2000, physicians may separately bill for contrast agents used in echocardiography. Physicians should use HCPCS Code A9700 (Supply of Injectable Contrast Material for Use in Echocardiography, per study). The type of service code is 9. This code will be A/B MAC (B)-priced.
B. Electronic Analyses of Implantable Cardioverter-defibrillators and Pacemakers
The CPT codes 93731, 93734, 93741 and 93743 are used to report electronic analyses of single or dual chamber pacemakers and single or dual chamber implantable cardioverter-defibrillators. In the office, a physician uses a device called a programmer to obtain information about the status and performance of the device and to evaluate the patient's cardiac rhythm and response to the implanted device.
Advances in information technology now enable physicians to evaluate patients with implanted cardiac devices without requiring the patient to be present in the physician's office. Using a manufacturer's specific monitor/transmitter, a patient can send complete device data and specific cardiac data to a distant receiving station or secure Internet server. The electronic analysis of cardiac device data that is remotely obtained provides immediate and long-term data on the device and clinical data on the patient's cardiac functioning equivalent to that obtained during an in-office evaluation. Physicians should report the electronic analysis of an implanted cardiac device using remotely obtained data as described above with CPT code 93731, 93734, 93741 or 93743, depending on the type of cardiac device implanted in the patient.

Discussion at meeting
MR. JONES: And this is one where I will not sound like a broken record. There is detailed response in the CMS Digest, Section 30.4. But the response to that is you can bill for multiple episodes of CPR, that CPT code or the procedure code 92950. You can bill a maximum of two per day per a 24-hour period. You should use modifier 76 when you bill for those multiple increments. So you can bill for a multiple increment for CPR Procedure Code 92950.

5. If a patient receives care at a hospital on the same date of service as the beginning date of a hospice episode and the care is related to the hospice diagnosis, but the services were provided prior to hospice accepting the patient, can both the hospital and hospice receive payment from Medicare? For example, a patient presents in the morning to receive observation services and the decision is made to move the patient to hospice. The patient is discharged at 3:00 pm to home hospice care. The hospice nurse comes that evening and the hospice begins care at 6:00 pm.

Additionally, if both the hospital and the hospice can be paid by Medicare – what about patients who are enrolled in a Medicare Advantage plan? Would Medicare or the Medicare Advantage plan be responsible for the hospital care received prior to the start of hospice?

Response: UnitedHealthcare is notified by CMS on eligibility dates, not specific time, and we start hospice the date that a member starts hospice, not the hour.

Please work directly with the hospital advocate or Medicare team on questions as specific as this one. We can cultivate relationships that will allow questions like these to be answered much more quickly and efficiently through a one on one consultation.

Discussion at meeting

MR. KUNEMUND: I'll go ahead and take that. So for Medicare Advantage Plan, as soon as the member is certified as hospice, fee for service of Medicare picks up, and Medicare Advantage plan would pay the non-hospice related items, prescription drugs or maybe if they get the flu or something like that. So, really, the key would be the start of the election of hospice and getting in the certification through our member's physician. So once that's noted in our records, hospice would kick in, and then United Healthcare would cover the non-hospice replace topics. So the question then would be what's the effective date in a Medicare Advantage plan? So we get notified something in the transaction reply report, and it should be the date of the election of hospice, because unfortunately, people once they're elected hospice, they have a short lifespan. So once our systems are updated from CMS and the hospice is certified and received, then the hospice would be covered under fee for service Medicare, and then United Healthcare would pick up the non-hospice related items.

AUDIENCE: This scenario, though, the patient had not signed up for hospice yet. They were observation in the hospital that morning, discharged, went home, and then were signed up for hospice. So would United Healthcare pay for that observation visit to the facility separate from the hospice admission?

MR. KUNEMUND: If hospice wasn't certified, then elected, United Healthcare would cover it. We would have to look at that particular case to see when CMS noted that the member was hospice certified. And then if they weren't hospice certified for that admission, then United Healthcare would certainly be responsible.

MS. RUBIO: I think the issue is, is there a way to tell the time of day versus just a date of service on the hospice summation?

MR. KUNEMUND: It's definitely not a time. It would be the date. So it would start at 12:01. So we wouldn't get a member certified at 3 p.m. and then have the admission at 4. So it would be the actual date. Because, again, the way Medicare Advantage Plans get paid is based on many things, included RAF scores, age, sex, location, and hospice. So once a member is certified as hospice, our payments are drastically cut, because fee for service Medicare is going

to cover those services. So it would be the date that the member is certified as hospice, not the hour.

AUDIENCE: I think that's where the confusion is. We got different answers from different Medicare Advantage programs. Actually, different answers from two different MACs, Medicare Advantage Contractors. So you're saying it's the whole date. So if someone goes into hospice, they're enrolled at 6:00 p.m., but they were discharged from the facility at noon, let's say a day earlier, that would be something United Healthcare would cover?

MR. KUNEMUND: We would cover any service related as long as the member wasn't that day certified as hospice. So it would go back to the effective dates, so I could help you if there's a particular patient. But I will tell you, CMS is not going to notify United Healthcare that a member is certified at 3 p.m.

AUDIENCE: I know the answer we got earlier was, the impression I got was you would have to file an appeal and you would say this patient left at lunchtime, but they were not actually enrolled in a hospice provider until 6 p.m. And where that's coming from is pushed back from hospice providers on the hospital saying, hey, this person left the hospital five hours before we actually received them and did the intake work on them. So Medicare, or in the case of Medicare Advantage recipient, both plans are responsible. We're trying to verify that with the payors.

MR. KUNEMUND: Yeah. Well, I don't want you to have to file an appeal. I want you guys to service the sick patient. So, again, I would love to look at if it's an individual, if it's a United Healthcare customer, I can tell you the exact date of the hospice election. But, again, we're going to cover things that are not covered under hospice. And the date of hospice is going to be once CMS certifies and notifies United Healthcare. Now, there could be a time lag. We get updates sometimes daily, weekly, monthly, but hospice is definitely not monthly. We'll get notified from that transaction reply report, and it may take up 24 - 48 hours to load. But there's not going to be any break in that patient's or our member's coverage. It's either going to be United Healthcare or hospice. And there's no way you should have to file an appeal for that; especially, for United Healthcare. So please give me a call or send me a note if it's a particular patient.

AUDIENCE: I think one thing that may be helpful, and I didn't think about this earlier when we were having this discussion with some of the other payors that were represented, but maybe the individual Medicare Advantage plans could issue some sort of an educational document to any hospice services that basically say what you're saying-- because what I'm understanding you to say is United is going to consider it day of; whereas, some of the other ones, we're getting down to a timestamp issue. And so what we might could do is take that back to the other payors as well and encourage the payors to give that feedback to the hospice agencies so that we don't have all of these back end issues, because it does become like a tennis match between the hospice agency and Medicare and the MA plan.

MR. KUNEMUND: Well, I think that's a great idea, and I'll follow up on that. CMS makes these guidelines, so MA plan to MA plan should not vary. It's going to go based on the election of hospice and another MA plan. So that should be consistent in our message. We're required to do that. So I'll double check on all of that for you. But I want to be sure that we're not going to make you have to appeal or have a patient go to another facility with them and their family going through it, no. I think it's an excellent idea for a notification. In fact, United used to have our own hospice division, and we would enroll members on Medicare Advantage, and that has spun off to another company. But we'll be glad to do that.

AUDIENCE: I guess I'm not completely understanding, because the understanding that I'm trying to grasp is that if the patient is in the hospital, discharged at 1:00 o'clock, and then at 3 o'clock becomes a hospice patient, isn't that still going be the same date of service?

MR. KUNEMUND: The hospice election period is either going to be retro for 12:01, the date of admission or the following day. It's not going to be a midstream. So either hospice is going to cover it, or the MA plan is going to cover it. It's not going to be your admission, and this part is MA, and this part is hospice.

AUDIENCE: Okay.

MR. KUNEMUND: Well, it sounds like education is needed. So we will definitely follow up on that.

Additional discussion at meeting

AUDIENCE: And I have one other question that doesn't have to do with that topic, just to move to a different topic that had to do with PEEHIP patients. And I know internally we're already in discussions with United, but I thought maybe this would be something that would benefit the room. The preservice determinations for inpatient rehab facilities; those apparently have been waived for some time with the PEEHIP members, because everyone has so many people transitioning over. And it is our understanding from Ann Downs that starting 11/1, that there are enhanced discharge planning processes in place for postacute care discussions and all that. So that might be something that needs to get rolled out more than just to our facility. And, again, we only know about it, because we've been having active discussions over that, and our medical director at inpatient rehab has been very actively involved in that. So that just might be something to talk about how that's changing and transitioning on the first.

MR. JONES: Yeah. So the specific question is around inpatient discharge, planning process, the changes are not in place yet. We have a team internally in the state. Pamela Warwick is director who is over that. I'm going to notify her and get this rolled out on a global basis across the state, so you understand that. I'm going to send another e-mail. I'm going to send this one about that right now too. So we'll find out all the details about that for you.

MR. KUNEMUND: When they were lifted, there was a communication, so if they're coming back, and it sounds like they are, then there has to be a communication through our provider portal. So we'll make sure that that happens. You know, we were very excited to bring PEEHIP

on. So PEEHIP brought about 70,000 members into a group, MA plan, so to speak, when traditionally it was a Medicare and then almost like a Medicare supplement. You know, we did substantial savings. We gave them different benefits, moved them to the MA plan, but there were growing pains with 70,000 members and having managed care into play. Dr. Randall, our chief medical officer, who oversees the PEEHIP and our group members, realized that PEEHIP, brought it to our attention, they're recognized here in Montgomery. I met with her several times. So with all of that feedback and the confusion, they were away for a certain period of time. So, if they are coming back, it sounds like it may have started this week, we will definitely make sure that that gets communicated. We have to make sure the members know too.

AUDIENCE: I have a question about contracting. I know I was talking to Linda Cotton and about two months ago in the midst of trying to get some clarification on our ancillary contract, ancillary agreement, her e-mail was no longer valid. I had another contact in Birmingham. I said, well, who do I talk to? I was given the name of Roxanne Childs Jackson out of Louisiana. I had one conversation about eight weeks ago with her, and since then, I've sent several e-mails and a few voicemails. I had forwarded her all of the questions I had for Linda, but have not had any response. And I checked with my friend in the Birmingham office, and he said he would try to find out something, but he's on the physician side. So who do I need to talk to in order to get my questions answered?

MR. JONES: I'll get your contact information, and we'll get that to the right person.

MR. KUNEMUND: Michael meets every week with our contracting team, and we have many local contractors here in the state of Alabama, whether they live here in Montgomery, Mobile, Birmingham, at the corporate office. Their manager, I think, is in Louisiana. But we have at least eight hospital, physician, and ancillary right here in Birmingham. So we'll make sure we take care of that.

AUDIENCE: Okay. Thank you.

MR. KUNEMUND: Now, when I was here a few years ago, with some of the network changes, there was a lot of noise. We had spoken. We had lifted that, re-added almost all the physicians back. Our network is open. We are taking from Medicare. We did some real big expansions in Medicare Advantage this past year for 1/1/2018. I think, Michael, you're into 14 more counties. So we can share our 2018 benefits with you as well, if you think that will be helpful, just so you're aware of the changes and where our service area is. For example, I believe it was Elmore County. CMS did an audit of our network when we did some expansions, and we were missing, I think, a rheumatologist, or it was one specialty. And we've been in the county for 12 years, and CMS made us exit because we had that gap, then they since had rescinded that, because we did have one across within that mile. So we're back in Elmore County. It was unfortunate we had to do a service area reduction for 1/1/17 for those members, some who were with us over ten years. So we're back in Elmore County and in more bordering counties.

MR. JONES: And I've got three follow-up items that I've sent two of those to the e-mails, so if I can get with you. Also, I'm going to give you my card. If I can get your contact information,

just so that will verify that I have the right thing on the chemo, on the clinical trials, and on the contract issues. I'm going to make sure that I follow up on that for you personally.

MS. RUBIO: Thank you so much, Michael, Gregg, for being with us.

MR. KUNEMUND: Thank you, everybody.